JOURNEYS OF DISORIENTATION & DISLOCATION: WOMEN/ INVISIBLE DIS/ABILITY IN AND OUT OF SOCIAL WORK. A TRANSDISCIPLINARY EXPLORATION

by

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THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

THE UNIVERSITY OF NORTHERN BRITISH COLUMBIA

December 2009

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ABSTRACT

Research Question:

Please describe your experience of invisible illness/dis/ability and what this has meant to you both professionally and personally.

This is a qualitative, exploratory study in which six women (including myself) who work/have worked within the social work profession, responded to the research question employing an online-email method. I developed a variety of "self-monitoring" questions to assist the process. These questions were designed to be used as conversational prompts only if necessary, and to make up for absence of face-to-face contact. The participants were found using a snowball sample.

This research is an exploration of female social workers' experiences with invisible illness/dis/ability. Specifically, the study explores the intersections and subjectivity of a variety of women's oppressions, including socialization, media/body image, sexual identity, and aging in relation to the effects of gender violence and women's health, sense of well being, and social worker retention in rural, isolated, and northern communities. Gender violence will be understood to include a continuum of violence extending from economic coercion to outright physical abuse.

I explored the possibilities (and potential linkages) that there may or may not be a relationship between women's previous experiences of marginalization and oppression, including trauma, abuse, neglect, poverty, and abandonment, which might increase the likelihood of further such experiences within a social work setting, and that gender violence is contrary to social worker retention, specifically in rural, isolated, and northern communities. "The fact that

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1 In order to accommodate my own illness, a minor reconfiguration of a semi-structured interview format was employed to obtain the data.
they seemed so eager to please made them more vulnerable to exploitation” (Transken, 2003, p. 168).

This may include that women position or allow themselves to be positioned in social work environments paradoxically to re-encounter such situations that would not likely be experienced in other non-caring, or traditionally “male” professions. Our choices are shaped by our structural contexts and vice versa. Our choices are also influenced by subconscious and subtle dynamics. More specifically, in this initial exploratory research, I am interested to know how becoming invisibly ill impacts women’s overall existence, working environments/ work relationships, and how these women maneuvered through the various systems 2.

Please note that the dynamics I am exploring in my research are not limited to women. I have personal knowledge of male workers who have experienced situations of violence and abandonment. Male workers who experience illness/disability frequently feel “impotent” and often are feminized within the agency hierarchies, left effectively powerless and alone. However, this is not the focus of my research study and shall be for another researcher to explore in more depth. But I am curious to know if men with histories of trauma/oppression are also inclined to become social workers and if so, do they experience similar circumstances? And if not, might they instead be disposed towards positions of promotion and leadership (and non-caring professions)?

All sorts of women have known in their daily lives the low self-esteem that is attendant upon cultural depreciation, the humiliation of sexual objectification, the troubled relationship to a socially inferiorized body, the confusions and even the anguish that come in the wake of

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2 As the research evolved, I began to question if there might be a social connectedness component that could perhaps be an important indicator in regard to how women might perceive and maneuver through their experiences with invisible disability/illness. For instance, are the invisible illness/disability experiences of women who are well connected to her family, friends and community versus women who are relatively isolated from family, friends, community (ie ‘transplanted’ for employment) dis/similar? 2
incompatible social definitions of womanhood; women of all kinds and colors have endured not only the overt, but also the disguised and covert attacks of a misogynist society (Bartky, 1990, p. 9).
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Acknowledgements

I thank my thesis supervisor, Dr. Si Chava Transken for her thoughtful, wise, and gentle encouragement and support. I believe that without her guidance and nurturing throughout this process, the likelihood of my completion would have diminished. I am grateful to her for releasing the flood gates that so diligently divide creativity and scholarly knowledge. This was at first terrifying, but quickly became empowering and refreshing. Also I thank the many First Friday Research Group people for their creatively helpful and insightful wisdom, their humorous anecdotes, and for providing boundless inspiration to persevere. This space was ripe with creative, academic, and artistic energy making the journey more bearable by decreasing the isolation, thereby reducing the likelihood that I might become one of many lost and forgotten along the dusty academic trail...

I thank the women, who have become my friends, who were brave enough to speak out for this somewhat risqué and potentially damaging research. It took immense courage for them to disclose details of their stories and I am forever grateful. I offer a huge thank you to the former assistant to the dean, Bethany, because if she had not taken me by the hand, and personally walked me directly to the UNBC wellness centre, it is quite likely I would not be writing this now. She recognized my desperation and suicidal state, and perhaps it was her own fear that made her refuse to let me leave her office that day. Regardless, it was this act of kindness that connected me to the counseling department and I have since been in the care of a superb team of helpers, without which I would not have managed to continue this academic and healing journey.

I offer tremendous gratitude to the scholarship programs, for without the generosity of the donations I would not have had the financial means with which to complete my studies. I also wish to thank the graduate studies department for supporting me through this journey. They permitted medical leaves of absence when I was incapable of producing quality academic material for a variety of interconnected health/financial related reasons which also stopped the timeframe clock making it possible for me to complete my program. And finally, I thank my beautiful son for his amazing, depthful knowledge and appreciation of me as a woman, a friend, and as his mother. His confidence in me is my soul-food. I also must thank my ancestors, my spirit guides, and the Creator for this opportunity to listen and to speak. *The voices of my grandmothers roar loudly as the bear within...*

*All My Relations*
*Kokhemc*
*Mitakuye Oyasin...*
“Until Lions have their own historian, tales of the hunt will always reflect the hunter” African Proverb.

INTRODUCTION

“The starting point of phenomenological research is largely a matter of identifying what it is that deeply interests you or me and of identifying this interest as a true phenomenon, i.e., as some experience that human beings live through” (van Mannen, 1990, p. 40). I interviewed women who have experienced invisible illness/disability at some point during their careers as social workers. I have woven their stories throughout the presentation and analysis of the data. These accounts are both poignant and enlightening. (“When you cut off arterial blood to an organ, the organ dies. When you cut the flow of nature into people’s lives, their spirit dies. It’s as simple as that” (Adbusters, as cited in Journal of the Mental Environment Jan/Feb 2004 No. 51).

Saukko describes how research now spills over traditional paradigmatic as well as geographic boundaries (2003, p. 6). Therefore we can not fully understand the experiences of women and invisible illness/disability unless we also examine the intersections of women, health, medicine, socialization, society, power, violence/trauma and her/history. Essentially, this lends itself to the creation of an expanded discourse in women’s studies. Meekosha (1999) refers to Browne et al. (1985); Saxton and Howe (1988); Keith, (1994); and Barrett (1995) when she writes that although disabled women are not widely visible throughout much feminist research, this does not mean that they do not have much to say. It becomes imperative that as feminist researchers we offer them such spaces in the literature (p. 164).

“A phenomenological question must not only be made clear, understood, but also “lived” by the researcher” (van Mannen, 1990, p. 44); this study includes my own reflexive accounts that have been part of this process since my arrival at UNBC for the purpose of my MSW. These

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3 “Holst, The Zebra Storyteller”.
accounts include “extreme journaling” (Denzin, 1997, 1989; Transken, 2000, 2003, 2004) and poetry. van Mannen (1990) wrote that “poetry allows the expression of the most intense feelings in the most intense form. For this reason we encounter the frequent use of lines from poetic texts in hermeneutic or phenomenological writing” (p. 71) like the following passage:

The trouble with you ‘s you’ve lost a screw I’m sorry it’s you but there’s nothing to do
There’ll be no abatements there are no replacements Don’t make a to-do just say toodle-oo
I’m sorry I can’t help you you’d cost too much to redo You’ll have to be abolished report to be demolished (Ralph, 1976).

Reflexivity begins from the very moment that we have an idea for a research study. It shapes the questions that we ask and how we ask them. It shapes why we ask the particular questions that we do, and it guides our thoughts. Reflexivity exemplifies the subjective nature of human interactions. Reinharz (1997) suggests that if we, as researchers are unaware of how we affect the people being studied, we cannot begin to understand the phenomenon being studied. Referring to Carolan (2003), reflexivity illuminates and helps us examine the deeper meanings of the phenomenon we are exploring. It both allows us to view the data through the eyes of the participants and it helps us identify potential systemic barriers as it makes visible the lens of one’s own philosophy. Reinharz (1992) wrote that “feminist researchers frequently present their research in their own voice” (p. 28). Carolan (2003) agrees with psychologists Michelle Fine, Stephanie Riger and Margaret Gordon (N.D.) when she discusses the importance of locating ourselves within our research as necessary so as to not further perpetuate the “historic silencing of women” (p. 63). She also mentions that when we make ourselves visible in our research, we are essentially outing ourselves, but this opens up the process for discussions about the “often passionate reactions to our research” (p. 63).
Reflexivity is not a process of looking back but instead it is a dialectic process of living in the moment and although it cannot be seen, it is very much visible to the skilled interviewer, and so it should be. Reflexivity then can be understood as the unseen entity that is the intersection between the researcher, the participants, and the conscious and unconscious energies between the research and the people. Referring to the work of Cutcliffe (2000), Ellis et al (1997), Okely (1992), Rice and Ezzy (1999), and Turner (1981) Carolan (2003) describes qualitative research as a process involving interactions between the researcher and the data. Keeping with this, both reflexivity and reciprocity will be crucial and visible throughout the entire process of this research.

The Concise Oxford Dictionary (1995) defines reciprocity as “a mutual give and take” and the “interchange of privilege” (p. 1147). Reciprocity is widely understood in North American culture as the exchange of goods and/or services/ideas with others for mutual benefit. Carolan (2003) refers to Oakley (1981), when she explains how there can be no intimacy without reciprocity. Reciprocal self-disclosure was built into my research design in that I was also a participant and my responses were viewed by the participants and woven through the paper as well. Reinharz (1992) describes researcher self-disclosure as good feminist practice. Reinhartz suggests that by locating oneself within the research as an equal, the researcher is able to share space with other women and potentially to reduce perception of power imbalances between researcher and researcher. Alvesson and Skoldberg (2000) agree that intimacy and reciprocity help researchers to build rapport and mutuality within the interviews and that this fosters genuine empathy. Carolan (2003) argues that “engaging in empathetic sharing makes the interviews more honest and morally sound”. This argument was also supported by Fontana and Frey (1998, as cited in Carolan 2003). And Davidson (2001) described ‘processual methodology’ which is a feminist-based concept involving reciprocal sharing, specifically the use of empathetic
humor, as a means by which to reduce the imbalance of power between researchers and interviewees, in order to more fully appreciate the research experience. This will be discussed further within this thesis.

I first defined some of the terminology that I used within the paper to clarify any potential misunderstandings. I then provided analysis from a reflexive, auto-ethnographic, “polycentric” (Delaney, 1999, p. 13), feminist perspective, how structural oppression is manifested against women working in the social work profession, and how these factors are non-conducive to the positive emotional/mental and physical health of women. And I attempted to illustrate how implicitly, overtly, and/or unintentionally condoning the oppression and marginalization of women is contrary to the retention of social workers, specifically in rural, isolated, and northern communities. Mackelprang & Salsgiver (1999) write this:

We create the context that acknowledges the devaluation and oppression of persons with disabilities, that recognizes the development of a culture built upon that oppressive experience, and that suggests the need for an aggressive political struggle to remove that oppression (p. xvi).

It is my hope that this research reflects and honours the “frustrated efforts” (Sass, 1998) of early activists, such as “Jane Addams, Florence Kelley, Alice Hamilton, Lillian Wald, Rose Schneiderman, Francis Perkins, Karen Silkwood, Connie Greenwood and the many other courageous and dedicated women” (p. 25). Their activism created “workplace health and safety legislation and policies and regulations during the first half of this century and later led to the Occupational Safety and Health Act in the United States in 1970 (p. 26). “They acted against status quo policies as if policy-makers were drugged and oblivious to the human condition” (p. 26). Sass writes also:
Their unpopular investigations, political activity, and whistle-blowing kept alive a tradition inspiring hope and the condition of possibility for action against a capitalist corporate elite hungrily devouring whatever stands in their greedy path. It is a tradition in which the labour movement is also embedded (p. 26).

I do not imagine that this style and tone of research will make me popular among all policy makers. Neither do I expect the job offers to pour in subsequent to my thesis defense, and due to the nature of my own invisible illness, I am in no physical position to accept employment anyhow.

Prior to the onset of this research, I looked but did not find any specific research studies that pertain to the experiences of women who grew up in working class environments, chose social work as a profession, and later became invisibly ill/disabled. The contemplation and discussion of these intersecting realities is where my potential original contribution to the social work literature may exist. There were, however, numerous studies that included women, poverty, oppression, trauma, illness and violence. And I was fortunate to find a surplus of substantiative literature that included women in academia. For instance, Isaac (1995) stated that in academia “class inequalities are rendered invisible and middle class norms are maintained in the name of professionalism” (p. 12, as cited in Coldwell, 1998, p. 4). This will be further explored within this paper, as will women’s body-image perceptions as they are shaped by portrayals dominated in contemporary North American media; this is very relevant to women’s experiences of dis/ability.

It is not my purpose to expose the profession of social work as an unkind profession who chews up and spits out its own young, although I suppose that is an arguable point. It is my intention, however, that this research becomes my own resistance, in the spirit of women such as Bridget Moran who was only finally embraced and honoured by the profession and by her
peers in death. This research is my refusal to tolerate and condone, in disabled silence, the continued devaluation of social workers: “Self reflection is the way in which pedagogy reflects on itself while serving other,” (van Mannen, 1990. p. 89). This paper, therefore, is a political action statement written to honour and reclaim the voices of the women who give of themselves to a profession that offers in return, little in compensation despite the continued sacrifices of its members:

They acted for life and integrity of both body and mind. They bridged the false dualism that inhibited thinking about the actual experiences of workers and introduced a definition of working conditions which now exists in all occupational health and safety statutes in Canada—“the physical, mental and social” well-being of workers (Sass, 1998, p. 26).

My argument is that the same profession which mandates its employees to protect the “intrinsic self worth and dignity” (BCASW, 1985) of clients, offers nothing of this philosophy to those whose front-line work benefits the masses. Instead as Sass, 1998, wrote, “on the contrary, they opposed mediation of economic considerations with worker health and safety. Their ‘voice’ introduced an ethical judgment into our conversation and praxis about working conditions” (p. 26).

As social workers, despite that we continue to sacrifice our emotional and physical well being, to protect and help others, the profession itself neither respects our dignity, nor does it reflect our value as employees in regards to wages and benefits, job expectations, job security, job safety, or overall employee health: “My request for compassionate transfer on ‘medical grounds’ was denied due to lack of supporting medical evidence (my physicians refused to complete forms). And further requests for part-time work were also refused, prior to me becoming permanently disabled” (2009, participant interview, Hel). This blatantly
contraindicates the statements referenced from the Canadian health and safety statutes and the BCASW.

Sass, (1998) wrote, “the political experiences of these women, reformers represent the possibility of ameliorating suffering, degradation and humiliation for those marginalized and for the worst-off” (p. 25). And sadly, this is despite the tireless efforts of past and present social activists (feminist and women’s movements) whose attempts to create change within the existing structures, seem almost futile: “During these dark and dangerous times both movements must be more and more in harmony. There must be polis for both” (p. 26).

It is as if regardless of policies and legislations implemented to protect marginalized groups, social workers have been overlooked and disregarded:

Incremental improvements by regulatory agencies without any consideration of an alternative paradigm are dismissive of existing worker-suffering...existing policies marginalizes the sufferer, colonizes consciousness, and bureaucratizes the mind (p. 26).

And in this manner our work is negated in such a profound way because the profession itself is comprised largely of women, and it is we who were supposed to be protected from inequality, exclusion and other oppressive means of domination in the first place. Ironically, it seems to me that we have we cut off our noses to save our faces: “While the notion of caring incorporates both labour and love, the assumption that they are inseparable can call into question the integrity of a woman’s caring about when she is no longer able to care for” (Baines, Evans & Neysmith, 1991, p. 15).

Invisible dis/ability is a sensitive and heated political and private issue. Because of this, I have done my best to honour the voices of the women who were brave enough to share this journey with me for the purpose of bringing to the forefront that which is necessary.

“Provocateurs, oppressors, all those who in some way injure others, are guilty, not only for the
evil they commit, but also of the perversion into which they lead the spirit of the offended’’
(Alesandro Manzoni as cited in Sass, 1998, p. 27). The following poem illustrates this:

If health were wealth spread like clean air in Eden then companies would have changed their
paradigm, banks wouldn’t control the world, authentic complex democracy would exist,
neither employment nor unemployment would make us sick, we’d live long enough to
profoundly know love in multiplicity, other currencies would find equality with money, the
words patriarchy & duplicity would be archaic & attendance at the academy would be free

As this paper progressed, and the research unfolded, I began to question the potential
connections between women’s experiences of invisible illness/disability, including recovery,
management and the progression of disease, in regard to our perceptions, support systems,
friendships, and work environments. Is the relationship between ourselves and our invisible
dis/ability affected by social status, class or financial position? For instance, does where we live
have any bearing on our ability to access medical care and treatment? Who takes care of our
children (if we have any) when we have appointments? How close in proximity to our home, are
those appointments? Are they in the same community? An hour’s drive away? Ten hours? Who
do we turn to for support? Who takes care of us after surgery? Spouse/partner? Family?
Friends? Self? These concepts will be explored within the paper.
DEFINITIONS in alphabetical order:

1. **Abuse and neglect**, as derived and adapted from the Child Family Community Services Act (1998), shall mean, for the purpose of this paper, the non-accidental physical or mental injury, sexual abuse, negligent treatment or maltreatment of a female person. It includes situations in which a (female) person has suffered physical trauma, deprivation of basic physical and developmental needs or mental injury (MCF, 1998; CF & CS Statistics, 1999).

2. **Able-ism** is defined as “stereotyping and making negative generalizations about people with disabilities” (Barker, 2003, p. 1).


4. **Alienation** is a capitalist *divide and conquer* tactic of worker dehumanization, in which the “structurally imposed breakdown of the interconnectedness that is, to Marx, an essential part of life…” (Barbalet, 1983:53 as cited in Wright, 1992, p. 56), and structurally creates “social isolation”, “conflict and hostility” between workers and “competition” for maximum “productive output” (Wright, 1992, p. 56). It effectively “turns workers into ‘crippled monstrosities’ and ‘reduces them to animals, beasts of burden, or inhuman machines’” (pp. 56-57).

5. **Burnout** is understood as described by Maslach as “a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment in response to chronic emotional strain from dealing extensively with troubled people” 4. Gilliland and Roberts suggest some

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4 Schmidt, 2003, Classnotes, November 19th.
reasons for burnout including large caseloads, lack of worker expertise, demanding
employers, unbending institutional rules and procedures, unending paperwork, and 16 hour
work days. Other factors to be understood when referring to burnout, for the purpose of
this paper, include a sense of powerlessness and isolation. “The nature of work that feminist
professionals do, and the institutional refusal to fully consider what is involved in our work,
can lead to burnout” (Transken, 2003, p. 87).

6. Caring “is a particular kind of relation between two people—a carer and a “cared for”
(see also Noddings 1984). It may occur in a brief episode or in a relationship extended over
time (p. 160).

7. Compassion Fatigue means the natural, consequent behaviours and emotions resulting
from knowing about a traumatizing event experienced by a significant other, also known as
vicarious traumatization.

8. Counter-transference refers to the “feelings, wishes, and defensive operations of the
clinician towards the client” (Barker, 2003, p. 100). Reflexivity/ Transference/ Counter-
transference are essentially the same concepts within research and clinical practice.

9. Culture can be understood as a network of shared meanings and taken for granted as
reality by those who interact within the network (Zapf, 1993, p. 696).

10. Dialectic is a concept that helps us to understand and manage reflexive processes. This
is a concept that describes our understanding of all things in relation to each other and
within a process of contextual basis. It speaks to the fluid and changing nature of those
meanings as they are shaped by social and cultural values (Ritzer, p. 43). It seems that if one
understands how systems theory works, in that all units are in fact connected and
interconnected, the concept of dialectic processes are similar and related in theory.

5 Schmidt, 2003, Classnotes, November 19th.
6 Schmidt, 2003, Classnotes, November 19th.
11. **Disability** as cited in Barker (2003) is the temporary or permanent reduction in function; the inability to perform some activities, that most others can perform, usually as a result of a physical or mental condition or infirmity (p. 121).

12. **Empowerment** as defined by Gutierrez (1991, p. 201) is a process of increasing personal, interpersonal, or political power so that individuals can take action to improve their lives (as cited in Transken, 2003, p. 86, as cited in Dana Hearne (ed.).

13. **Gender** “is the cultural or social construction of sex” (Wright, 1992, p. 140).

14. **Feminism** as described in Dominelli & McLeod (1989) is based in the concept that “there are two types of people in the world, the dominant and the subordinate” (p. 1) and analysis of social relations from this superior-inferior standpoint must be posited in terms of gender and equality. Feminism, in theory, is the intellectual, philosophical and physical resistance against discrimination (oppression and marginalization) including racism, classism, heterosexism, ageism and able-ism. Bartky (1990) wrote that “to be a feminist, one first has to become one”. She added that this process of “profound personal transformation” extends beyond simply the “political spheres of human activity”, and in reference to the work of Paulo Freire, alters one’s consciousness and intensifies awareness of self and others (Bartky, 1990, pp. 11-12). “Feminists are no more aware of different things than other people; they are aware of the same things differently” (p. 13). Weedon (1987, p. 1, as cited in Durand, 2003, p. 8) provides the following definition of feminism:

   Feminism is politics. It is a politics directed at changing existing power relations between women and men in society. These power relations structure all areas of life, the family, education and welfare, the worlds of work and politics, culture and leisure. They determine who does what and for whom, what we are and what we might become.
15. **First-hand experiences** shall include, as derived from the Oxford Dictionary of Current English, any “from the original source; direct” (Thompson, 1998, p.327) emotional, physical, mental or sexual experience(s) where a female person was subjected to, witnessed (saw or heard), or intervened in a situation where she perceived herself and/ or her companions, including family members, children, spouse, or other persons to whom she is emotionally attached, to have been in some way threatened, or in danger, and facing negative or stressful repercussion of that situation.

16. **Interdisciplinarity** (Andermahr, Lovell, & Wolkowitz, 2000) “draws upon more than one discipline”. It differs from multidisciplinary in that it has the tendency to blur the confines of methodological boundaries within the disciplines. It is particularly beneficial to analysis of women, gender and culture (pp. 135-136).

17. **Interpersonal Violence** as defined in Wagner (2008) is a particular form of trauma, specifically, having “experienced either physical or sexual abuse at some point” in one’s life.

18. **Marginalization** (Andermahr, Lovell, & Wolkowitz, 2000) is “an interdisciplinary term”, which refers to “the process in which a subject is rendered marginal through the exercise of power” (p. 150). “Within patriarchal cultures women, despite their numerical majority, are marginalized by a range of practices and discourses including employment law and academic disciplines” (p 150).

19. **Negative**, for the purpose of this paper, shall mean “lacking positive attributes,” (Thompson, 1998, p. 595).

20. **Northern Rural and Remote Social Work Practice** “Hamelin, (as cited in Henning, 2006) identified ten fundamental elements of northernness (latitude, summer heat, annual cold, types of ice, total precipitation, natural vegetation, cover, accessibility, by means other than air, air service, population, and degree of economic activity” (p. 45). Henning noted
that the relevance of Hamelin’s work in that “he recognizes that the influence of human activity and northernness can change over time (Johnston, 2004, p. 2 as cited in Henning, 2006, p. 45).

21. **Patriarchy** is the focus of “men’s power, authority and dominance over women in the economic and domestic workplaces” (Dahlerup, 1987, p. 95 in Baines, Evans, Neysmith 1991, p. 19). Particularly important to an understanding of patriarchy is women’s role in reproduction-giving birth and rearing the next generation- although feminists differ in their interpretations and their emphases (p. 20):

“…all human societies are patriarchal in that they are segregated by sex such that women are oppressed in social and political institutions; they divide productive and reproductive labour by sex and discriminate against women economically; they privilege men over women generally, guaranteeing men greater and nonreciprocal access to women’s material and immaterial resources; they value men and masculinity more highly than women and femininity; and their discursive and symbolic systems centralize, standardize, and normalize male subjectivity and points of view while casting women as the objectified other (Payne, 1996, p. 394, as cited in Henning, 2006, pp.3-4).

22. **Polis** is discussed by Sass (1998) as a crucial space within work environments where there is a conversation without pre-assumptions and preconditions (Sass, 1998, p. 26).

Here workers openly discuss their experiences and feelings and moods which inform them. This is the condition for the possibility of political action and the saying of “no” to dangerous conditions. This is the negation of negative working conditions. It is a moral response to the objectification of workers, their superfluity and commodification. Aristotle referred to such a space as the *polis* (p. 26).
23. **Polycentric**, means that the social worker may draw knowledge from an eclectic, multidisciplinary source. In other words there are bits of information, outside of the traditional field of social work that might help the social worker in her analysis of a perceived problem. The social worker might adapt information from studies that are useful from such disciplines as psychology, sociology, anthropology or gender studies (Collier, p. 35).

24. **Poverty**, for the purpose of this paper, shall be defined, as outlined in Barker (2003, p. 333), poverty is the state of being poor or deficient in money or means of subsistence. People who are impoverished may be considered transitional poor (a brief, temporary poverty related to specific environments in one’s life or environment), marginal poor (moving in and out of poverty because of job insecurity, inadequate skills, or limited education), and residual poor (long-term and intergenerational poverty).

25. **Power** is “the process of accruing and maintaining influence (and is)…measured by the extent to which another’s activities conform to one’s preferences” (Mondros & Wilson, 1994, p. 227, as cited in Geisbrecht, 2003, p. 157).

26. **Psychological Oppression** as defined in Bartky, (1990) “can be regarded as the ‘internalization of intimidations of inferiority’” (p. 22).

27. **Reflexive Process** “Ahern (1990) provides a further conceptualization of reflexivity, one that involves two processes; self-reflection and the subsequent identification of the researcher’s feelings and preconceptions; and second, the ability to put aside (emphasis added) these feelings and preconceptions (as cited in Cutcliffe, 2003). “In the process/relationships with each other and with the text production we recreate and redesign some aspects of our selves as we invent the books. We design the books and they redesign us” (Transken, 2003, p. 11).

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28. **Reflexivity** “can be defined as thoughtful, conscious self-awareness”. “The reflective ethnographer does not simply report ‘facts’ or ‘truths’ but actively constructs interpretations of his or her experiences in the field and then questions how those interpretations came about” (Hertz, 1997, p. viii as cited in Finlay, 2002, p. 532). “The researcher strives to capture some of the connections by which subject and object influence and constitute each other” (p. 533).

The range of what we think and do is limited by what we fail to notice. And because we fail to notice that we fail to notice there is little we can do to change until we notice how failing to notice shapes our thoughts and deeds (Laing, as cited in Zweig & Abrams, 1990, p. xix).

29. **Repercussion**, for the purpose of this paper, shall mean “indirect effect or reaction following an event or act” (Thompson, 1998, p. 768).

30. **Social Class** as described by Oilman, are “reified social relations” or “the relations” between men [that] have taken on an independent existence” (1976:204-205 as cited in Ritzer, 2000, p. 64). “Social classes arise out of the acts of production; people come to reify classes, and as result these classes come to have a life of their own that constrains the actor” (p. 64).

31. **Social worker**, as defined by the Social Workers Act (1979), is a person who has these traits: The qualifications will include 1) A bachelor’s or master’s degree in social work; or 2) a degree or certificate deemed by the Board to be equivalent to a master’s degree in social work or the postgraduate degree in social work; or 3) to be a “registered social worker” or “professional social worker” in another province where the standards are not less than the minimum standards prescribed under this Act and regulations (R.S.B.C., c. 389). sic.
32. **Transference** refers to the transfer of positive and negative feelings/emotions from clients to clinicians (Barker, 2003, p. 439).

33. **Trauma**, "as used within constructivist self-development theory (CSDT) is a process definition" (Pearlman & Saakvitne, 1995):

   We define it as the unique individual experience, associated with an event or enduring conditions, in which, (1) the individual's ability to integrate affective experience is overwhelmed or (2) the individual’s experiences a threat to life or bodily integrity. The pathognomonic responses are changes in the individual's (1) frame of reference, or usual way of understanding self and world, including spirituality, (2) capacity to modulate affect and maintain benevolent inner connection with self and others, (3) ability to meet his psychological needs in mature ways, (4) central psychological needs, which are reflected in disrupted cognitive schemas, and (5) memory system, including sensory experience (p. 61).

34. **Vicarious Traumatization**, as defined in Pearlman & Saakvitne (1995), "is the transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with client’s trauma material” (p. 31).
CHAPTER ONE
THEORETICAL PERSPECTIVE FOR COLLECTION AND ANALYSIS OF DATA

Cultural Studies

"Cultural studies is an extremely valuable tool" for social researchers to utilize daily "because
it is a sphere in which class, gender, race and other inequalities," including dis/ability "are made
meaningful or conscious" (Henning, 2006, p. 9). "Self-reflexive autoethnography has been used
relatively widely in cultural studies" (Saukko, 2003, p. 86). "Cultural studies gives the female
audience a place to discuss the meaning of caregiving because the cultural economy does not
circulate the same way as wealth does in the financial economy" (Fiske, 1987, as cited in
Henning, 2006, p. 11). Hochman (2004) wrote "the words tell us who is owned, and who is
free, who really counts and who is merely secondary" (as cited in Shaw & Lee, 2004, p. 320).

For the purposes of this study, I will be incorporating literature from multiple sources and
genres. There will be some authors whose work I refer to more frequently. These include the
1984).

Hermeneutic Phenomenology

In phenomenological research the emphasis is always on the meaning of lived experience…
"borrow" other people’s experiences and their reflections on their experiences in order to better
be able to come to an understanding of the deeper meaning or significance of an aspect of
human experience, in the context of the whole human experience…we wish to understand what
being…is like for this or that person as an aspect of his or her life and, therefore, by extension,
as an aspect of the possibilities of our being human" (van Mannen, 1990, p. 62). Spiegelberg
(1982) also explained that descriptive phenomenology is concerned with meanings (as cited in Coldwell, 1999, p. 30).

"Phenomenological human science begins in lived experience and eventually turns back to it" (van Mannen, 1990, p. 35); we are able to collect the data from the participant’s stories, uncover the meanings buried within the words and write the rich descriptions of these lived experiences. We then bring the analyses back to the respondents to have them confirm or correct our interpretations. If we are effective in capturing the essence of the described experiences, evoking emotion and recognition, it is then we become successful in researching the specific phenomenology we sought to examine.

Saukko (2003) wrote, “slightly differently, rhizomatic understandings of dialogue helps to flesh out both commonalities and contradictions between different views, paving the way towards a nuanced research practice and action plan…” (p. 78). She elaborates on this:

The question that these contradictions and challenges raise is whether we can still find some common ground to determine what constitutes ‘good’ or ‘valid’ research. In traditional methodological parlance, ‘validity’ is the beginning and end of all research, referring to a series of litmus tests that determine whether the research is ‘true’ or ‘objectively’ describes how things ‘really’ are. The current discussions point out that there are multiple realities, raising the question, whether research is a matter of opinion (p. 15).

van Mannen (1990) writes that “lived experience is to the soul what breath is to the body” adding that “lived experience is the breathing of meaning” (p. 36). He further elaborates “in the flow of life, consciousness breathes meaning in a to and fro movement: a constant heaving between the inner and the outer, made concrete…Thus a lived experience has a certain essence, a ‘quality’ that we recognize in retrospect” (p. 36).

One could argue then that the written product of hermeneutic phenomenological research is
the means by which a researcher captures the essence of the participants' souls. When performed rigourously and reflexively it serves to effectively breathe life into, capture and share the richness and meaningfulness of that which is being examined. It is contrary to what much other research ignores in its fixation with quantification. Phenomenological research is not so different from the ocean, in its liquidity, an ever-changing, living and breathing entity. It is unfixed, and immeasurable, yet recollected in memories and pictures, frozen timeless, if only for a moment.

van Mannen (1990) refers to Brown (1996) when he argues that similar to poetry, phenomenology is comfortable with silence as it is comfortable with voice. Specifically, “it wants to be implicit as it explicates” (p. 131). He further states that we must be sensitive and attentive in order that we do not fail to hear what is being said from within this silence, that we don’t “miss the forest for the trees”, for example. If as researchers, we fail to comprehend what is being offered from between the lines, then the misfortune is that we fail to capture the essence of what has been shared. The greater tragedy is that this also lends itself to the further silencing of many.

Critical Social Science Perspective

I will also utilize aspects of Critical Social Science (CSS) as illustrated in Neuman (2003): “social science as a critical process of inquiry that goes beyond the surface of illusions to uncover the real structures in the material world in order to help people change conditions and build a better world for themselves” (2003, p. 82). “Versions of this approach are called dialectical materialism, class analysis, and structuralism” (p. 75). “CSS is often associated with conflict theory, feminist analysis, and radical psychotherapy” (p. 76). “Freire’s Pedagogy of the Oppressed (1970) also falls within the CSS approach” (p. 76).
The critical approach uses praxis to categorize theoretical applications. CSS enables the researcher to utilize theory within her research and adapt the applications to make the theory more relevant to the problem: "Praxis means that explanations are valued when they help people really understand the work and to take action that changes it" (p. 80). One goal of my research is to empower women within the social work profession. "CSS holds that knowledge is power" (p. 81). Similarly, a participant in this study wrote, "I would change how people are educated. Education is power...gain strength from other's journeys" (2009, participant interview, Venus).

Saukko (2003) explains how critical analysis is useful in our research as it "eschews individualist strategies of challenging self-constitution and stresses that self-transformation needs always to be understood as part of social and collective change" (p. 87). "The critical science approach argues that social reality has multiple layers...the critical researcher questions social situations and places them in a larger, macro-level historical context" (Neuman, 2000, p. 78).

Saukko, 2001 also recognizes and welcomes potential similarities and contradictions, in discussions of 'rhizomatic' analysis and 'polyvocality' within lived research.\(^8\)

The data was analyzed first from a micro-analysis, in relation to the individual respondents. As the themes emerged it became evident the participants described many similar experiences. I interpret this to imply that further research is necessary regarding women's experiences of invisible illness/disability. And it would be beneficial to better understand the specific challenges women experience negotiating the various systems.

This is a qualitative, exploratory study, of the lived experiences of six women who have an invisible dis/ability. The ability to generalize findings and to infer cause and effect, to a population outside the parameters of the study, is limited and is not the goal of this research.

\(^8\) Also these might soon be referred to in feminist circles as "polysensualities" as coined by Cathy Denby, Socw603 Class notes (2003).
Feminist Perspectives

Neuman, 2000, states that Feminist research is action-oriented and is largely conducted by women (p. 82). Nielsen (1990) wrote that feminist research is “grounded in older positivist-empirical tradition and in newer post-empirical one...and represents a fundamental shift away from traditional social science methodology” (p.1). Coldwell, (1999) refers to Reinharz (1992) when she writes that “feminist research recognizes that women are worth researching ‘as individuals and as people whose experience is interwoven with other women’” (p. 24). And Coldwell agrees to Reinharz’ (1992) suggestions that feminist research utilize a variety of research methods to illustrate women’s experiences.

Feminist research has been criticized for its failure to acknowledge issues specific to poor, working class, and visible minority women within the literature, and because much of the present feminist literature was written by white, middle and upper-class feminist researchers, it does not yet fully, reflect the layers or ‘polyvocality’ of women’s subjective experiences of domination, subordination, and oppression. Specifically, as described in Meeksosha (1999), feminist work has not managed to portray an accurate or fair illustration of the “intersection of gender and dis/ability” and how this has implications pertaining to the “subordinate” status of women and the disabled and how we define and understand issues about the body (p. 174). She also wrote about the absence of women with disabilities in academia and research. Similarly, Wagner, Acker, & Mayuzumi (2008) refer to Titchkosky (2005) in their exploration of “those differences called ‘disability’ are typically lived and studied only as an individual problem and are not regarded as an integral part of our educational lives” and that a “feminist disability studies perspective, enables us to explore “disability as an absent presence within the academy” (p. 61). They further describe disability as a “complex body space” in “constant dialogue with culture” (p. 63), and that it is “a space of interpretive interaction to examine the everyday” (p. 65).
The tendency of feminist literature to explore phenomena as it relates to gender differences between women and men fails to provide multi-vocal, subjective accounts of the experiences of many women, whose voices remain unintentionally, but effectively silenced.

Instead, I hope this research reflects the work of Saukko (2003) in that it becomes a genuine exploration and analysis of the existing intersections impacting the lives of women who have worked within the social work profession, from a variety of discourses including dis/ability, self-image, economic status/class, and gender, and that it does this in a respectful manner.

I employed a “polycentric” (Delaney, Brownlee & Zapf, 1999, Saukko, 2001) feminist perspective, to help illustrate how oppression is structurally manifested against women from within the profession of social work. Using a variety of lenses allowed analyses of the multiple intersections of gender, class, dis/ability, socio-economic status and the gamut of “isms”. This enabled me to illustrate how the existing contradictions between literature and practice realities are non-conducive to the positive health of women, and to retention of social workers in northern remote communities.

“Radical feminists find the roots of patriarchy in women’s reproductive capacity and the control men exercise over it” (Baines, Evans, & Neysmith, 1991 p. 20). Marxist feminists analyze women’s inequality from a gendered basis of access to private ownership and means to production of goods. This analysis does not specify how the dynamics of race, ableism, poverty, ageism, heterosexism exist and further impact women’s options within a patriarchal, classist system. “Many feminist writers maintain that the wage earner/breadwinner/citizen discussed in mainstream perspectives, whether stated explicitly or implied, is almost always considered to be male” (p. 210). Brown (1994) describes this:

The feminist technique from the women’s liberation movement of consciousness raising was a methodology for making the personal political by exposing isolated women to one
another's experiences and drawing forth the secrets that women had held in the belief, fostered by patriarchy and often encouraged by mainstream psychotherapy theories, that they alone were uniquely flawed in some manner. Thus feminism has a powerful deprivatizing force in calling for the secret experiences of girls and women within homes and families to be brought to light, exposed as manifestations of a male-dominated society at work, and used to illumine the lives of men from a new vantage point (p.50).

I will also be using what Swigonski (1994), in reference to Harding (1991, 1987) and Harstock (1983), describes as “Feminist Standpoint Theory” which is rooted in Marxian analysis of the conditions of the working class (Swigonski, p. 390; also see Eichler, Larkin, & Neysmith, 2000). Swigonski further explains that “standpoint theory begins with the idea that the less powerful members of society experience a different reality as a consequence of their oppression” and they “must be attentive to the dominant class as well as their own in order to survive” (p. 390). Consequently, “this gives them a double consciousness” (p. 390). Bartky (1990) expands this to say that “feminist consciousness is a consciousness of victimization” (p. 15) and thus is both “consciousness of weakness and consciousness of strength” (p. 16). To acknowledge that we have been subject to injury then we also realize the existence of power and possibility of personal growth, which releases suppressed energy. Swigonski further extends her analysis of feminist standpoint theory to “encompass social work’s commitment to the empowerment of all oppressed groups which is consistent with bell hooks’ analysis of the interlocking nature of all oppressions” (p. 390).

Bartky, (1990) elaborates additionally that “feminist consciousness” is “a little like paranoia” (p. 18) when she explained how when we consciously begin to recognize fully (almost as if an awakening occurs) “the full extent of sex discrimination and the subtlety and variety of the ways in which it is enforced” (p. 18) new feminists begin our journey into crazy-making. “Its agents are
everywhere, even inside her own mind, since she can fall prey to self-doubt or to a temptation to compliance. In response to this, the feminist becomes vigilant and suspicious” (p. 18).

Similarly, we are unable to uncut ourselves, once the bleeding begins, and it is equally impossible that we unknow a secret...

A feminist disability studies perspective essentially blends together relative elements of Marxist, Feminist Standpoint, and Radical theories with elements of disability/body theories which enables exploration and interpretation of rich data, so as to capture its essence and profundity. This depthful, critical analysis provided the language in which my findings have been reported. By illuminating the intersections of the multiple oppressions impacting of a variety of women who have experienced invisible illness/disability, in and out of social work, hence began the process of weaving of a quilt, more accurately describing their experiences.

In her book *Reclaiming Indigenous Voices and Vision*, Marie Battiste (2000) reflects the concepts put forth by Reinharz regarding the essence of the feminist perspective. First Nations and feminist perspectives both seek to give voice to those who have been silenced and both perspectives attempt to do a re-humanizing and consciousness raising effort that ultimately reflects the work of Paulo Freire (1983; 1974; 1973). Both perspectives acknowledge that research is an ongoing process and that it is not a conclusive end to a means.

Acknowledging that stories are layers like the generations of our ancestors and sisters before us, we all are connected and from uncovering the untold stories, the research, we are more able to add to the unfolding picture that becomes visible. Both perspectives recognize that scholarship and academic status are not what make for credibility of research, but rather it is the telling of the story, and from whence the story originates, that in fact validates the research.

Neither feminist nor First Nations perspectives seek to simply answer questions, but rather both
seek answers within the process of reclaiming lost voices. Many of those voices were lost in translation or taken out of context and misconstrued through patriarchy and colonization.

**Locating Myself within the Research**

“The universe will reward you for taking risks on its behalf” (Cameron, 1992 p. 63; also see Gawain, N.D.; Transken, 2004). Meekosha (1999) writes “reconstructing subjectivity is risky business—we might be seen as spectacle (p. 166). I accept this challenge and I dare to include segments of my own journey, from the perspective of a white-skinned, Métis, working-class, blue-collar, heterosexual, feminist woman who has lived much of her life in varying degrees of poverty, within this research. I am/was a social worker. And I have been living with a variety of dis/ability and violence/trauma/abuse induced challenges my entire life. My experiences with the progression of ever-emerging challenges is what brings me to this place…

Atwood (2002) refers to Transken (2000) illustrating how we sometimes write from within our shadows: “Possibly then, writing has to do with darkness, and a desire or perhaps a compulsion to enter it, and, with luck, to illuminate it, and to bring something back out to the light” (Atwood, p. xxiv). A substantial portion of this paper has been written from the shadows of my own psyche. This was unintentional at first, but as the research emerged, and learning happened, it became imperative to acknowledge and honour our shadow selves as it is often due largely to this darker consciousness that we find strength to persevere and endure. For without a sense of humor and the ferocity of a lioness, we might not have otherwise survived, that we expose our bleeding flesh to you:

… I also asked them what they thought of the discourses that define and treat the conditions and them. The intention with this approach was to invite the women to reflect on their experience, and thereby occupy the role of the ‘knower’ and not only that of ‘the known’ (Saukko, 2003, p. 91).
"Processual Methodology"

Maynard (1994) describes “one of the hallmarks of feminism is the legitimacy of women’s own understanding of their experiences” (p. 17; also see Davidson, 2001). In a feminist study of agoraphobic women Davidson (2001) utilizes “processual methodology” and ethnographic concepts including the organic intellectual, to empower the participants by interviewing and analyzing the data using the same language as it was expressed by the women, thereby qualifying each as expert in her study. Davidson’s study reflects what Maynard (1994) describes in that when participants feel that their participation is a valid contribution to social change, the interview process can have therapeutic benefits (Davidson, p. 165).

The concept of ‘processual methodology’ is beneficial to women’s studies because as we witness each other’s stories, sharing intimate and personal details (often of a painful nature), the dynamics inevitably change and we ultimately engage in the journey together, not one-over-and-dominant over the Other, but as one-to-one, as partners, as equals. The shared experience can be validating when the distance between researcher and interviewee is minimized in this way. And essentially, when as researchers we reciprocate in this process, there is opportunity for an A-ba moment(s), in which we identify with aspects of the dialogue. Thus, as we gain a deeper understanding of the lived experiences, and this can be equivalent to momentary ‘token’ membership, as in this moment we are accepted by the group. ‘Processual methodology’ provides the opportunity for reciprocal sharing, thereby allowing us to actively contribute to the process, and validates our position of equality rather than dominance, lending itself to “mutual understanding” (Davidson, 2001, p. 168) of the shared meanings.

Davidson writes that “humour often entails a form of dramatic irony”, and that it often eludes to a secret “knowledge about something or someone” (p. 169). More importantly, she describes that when someone has “not lived through” or “had the experiences recounted to
them, they will inevitably fail to find them funny, indeed they may not even recognize them as a joke at all" (2001, p. 169). She also describes that "jokes can act as a perfect indicator of belonging to, or being excluded from, shared community of meaning" (p. 169). “For the ‘outsider’, it can come as surprise that subjects frequently discuss difficult issues with a remarkably light touch” (p. 173).

In my own experience with invisible dis/ability, humor is a useful coping mechanism, as is the use of metaphor. Humor and metaphor were also littered throughout the interview transcripts. But typically, as indicated by the participants in this study as well as in my numerous off-the-record conversations with women in a variety of settings, neither humor nor metaphor is typically appreciated, acknowledged, or comprehended contextually, by medical or agency professionals. Perhaps what I found so compelling about Davidson’s article was its particular relevance to this study. The genuine reciprocated sharing in a language mutually understood (and verified) in the interviews between myself and the participants seems to imply that there was ‘shared community of meaning’ as presented in this article. There were no ‘inside jokes’ (to which I felt excluded).

In her study, Davidson (2001) discusses the use of purposeful reflexive humor as a means by which to conduct interviews, while simultaneously reducing the traditional “objective distance’ or power imbalance between researcher and participants” (p. 166). She added that in order to successfully achieve this desired power balance, a “comfortable relationship” must occur at some point, “between the researcher and interviewee” (p. 166). She concludes that this “processual methodology” is required in circumstances where “managing the research process is often as much a matter of coping with as directing change” and she found that this was especially useful when the participants had strong group cohesion, with shared interests and experiences, such as “those suffering from specific disabilities (p. 164), as was the situation in my study.
My research is an exploration of the experiences of women who have found themselves caught somewhere between able and disabled. For me, participating in the triumphs and tragedies encouraged me in my own journey, and unexpectedly, I was inspiring to the participants: “Silence is the condition of one who has been dominated, made an object; talk is the mark of freeing, of making one subject” (hooks, 1989, p. 129). And as Davidson (2001) points out, “humour is then used to linguistically manage what sufferers themselves perceive to be an ‘abnormal’ state of affairs” (p. 173) despite potential offensiveness to Others.
EXPLORING THE LITERATURE: PART I
CAUTION: Social Work Is Hazardous To Your Health!

An Historical Overview of the Profession of Social Work

“Social work evolved from women who wanted to give more power to the disadvantaged, the poor and the rejected” (Rondeau, 2002, p. 217). Individuals and groups of women wanted to make differences in the lives of those less fortunate. “Jane Adams and the first University Settlement in Chicago attempted to do this” (p. 217). Transken, (2003) asked, “how did we begin with the goal of empowering women and arrive at this outcome of violating women” (p. 87)?

An interesting discussion of altruism written by Benzon (2003) illustrates that “what we observe in animals as well as humans, is that individuals often do things that benefit the group but that cost them individually” (p. 36). Essentially, by becoming visible targets to predators, “these individuals are more likely to be killed than others in the group” (p. 36). Benzon offers further that “groups containing altruistic individuals are more likely to survive than groups without them”, and he proposes that “this might explain how altruism can be inherited from one generation to another” (p. 37). In addition to what Benzon suggests, I argue also that social work is especially ripe with altruistic energy to its core, in that by nature and/or nurture, altruism and self-sacrifice accurately describe the character of many women working within the profession. This will be discussed throughout this thesis.

Within the profession of social work there is a great deal of diversity. This diversity is like a maze. This maze is constructed of strips or sections that when joined together, become whole. For example, there are strips of social work that may be associated with the Christian Charity movement, such as the Salvation Army, community missions, and church based outreach

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10 This type of social work would reflect the early social work of Francis Perkins (Sass, 1998, p. 23).
programs. And there are strips that might be associated with the Settlement House Movements\textsuperscript{11}, such as anti-poverty agencies, and homeless shelters. Gustofson (2000) and Transken (2003) identify that strips perhaps belonging to the Feminist activist movement\textsuperscript{12} would include sexual assault treatment centres (SATs) and (SACCs) sexual assault crisis centres (p. 127). There are also strips of the social work profession that may be associated with social control and social containment. Examples of these would include child protection, probation, parole, and corrections agencies. And the Canadian Census (1996) and (CASW, p. 7) indicated that 93% of those in the social worker occupational category are employed either in the health and social services (74%) or government industries (19%). Relatively few social workers are employed in private practice offices, but the number almost doubled between 1991 and 1996.

Historically social work has had the tendency to abandon its sisters who were too far to the more radical, risqué side of arguments. These women are essentially shunned or silenced by their organizational professional bodies and not celebrated for their attempts to fight for the rights of working class women. Women, such as Emma Goldman (1983) advocate for the process of unionization of women's rights, safe sex, and birth control issues (Transken, 2003) but they are not embraced by the social work profession, their sisters, despite their countless hours of labour, lobbying for the rights and privileges that we take for granted today. Rather, they are jailed, and abandoned by their social work sisters for being too radical, un-professional and perhaps unladylike. They were excluded from celebrating in the accolades given to other women, more suitable to the profession of social work.

This phenomena of martyrdom illustrates what Benzon (2003) referred to as "altruism", in that some sacrifice self for the benefit of many. It continues today within the social work profession with the "policing" of girls and women which Baines, Evans, & Neysmith (1991)

\textsuperscript{11} This is reflective of the work of Jane Addams.
\textsuperscript{12} This is reflective of the work of social-Marxists, Florence Kelly and Emma Goldman.
described as "socialized encouragement" and "techniques of regulation" including "subtle, helpful pressuring and monitoring of behaviors and attitudes that are built into daily norms and interactions...Girls are policed to learn their lessons of caring and pay the attendant costs" (p. 123).

Frankly, little has changed in that social work continues to abandon its sisters who are too radical or too feminist. Those of us who advocate too loudly and too passionately are labeled with phrases such as "menopausal", "pms" and "cranky", "bitch", "man-haters" and frequently we are viewed in a dehumanizing manner which equates us to our body parts and functions, or lack thereof.

Social work leaves an ugly taste in the mouths of many social workers, who instead prefer to associate with schools of sociology or gender, women's, and equity studies. The unflattering media portrayal of social workers, whether in newspaper articles or cinematic portrayals, is reflective of this. Sadly, these images are not always far from the truth. But more unfortunate is the fact that there are many good social workers practicing in relative isolation, with little support, encouragement or nurturing from employing agencies or colleagues. Sometimes there is no-one else working alongside them. And sometimes these social workers are too far removed from the agencies' administrative mandates and they are consequently viewed as deviant:

i am a hairy fuchsia elephant possibly from a future galaxy my rage is glorious, magnificent, glimmering but scraggly grey chickens peck, peck, scatter, peck peck at my huge boots & their noise irritates me. the edges of this town are visible only from my eye level & position. I see no other fuchsia elephants; I never forget i could crush these chickens or kick them but that is outside of my nature & futile because there is an infinite supply of them anyway. every which way chickens populate & dominate this sullen terrain & I ask – which way to where the herds of shimmering fuchsia elephants graze? remember: elephants have excellent
memories, are led by the oldest female, are loyal only to their own, live a long time & may be on the verge of extinction. sadly some fuchsia elephants survive only by submitting to the depleting demands of the circus circuit. fuchsia elephants certainly cannot blend into the chicken crowd (Transken, 2008, p. 222).

Referring to Mullaly (2002) Transken (2004) described how it is that despite social work’s outspoken commitment to social change and social justice, “its members are still susceptible to oppressive practices and to reproducing dominant-subordinate relations – not only with the people they serve, but also with each other along lines of gender and race (and other social divisions)” (p. 22).

Production Equals Destruction of the Masses...

Contrary to the “Marxist assumption that people need to work cooperatively” in order to get what they need “to survive”, capitalism is structured in such a way that instead forces workers into an alienated state of “outright competition, and sometimes conflict, with each other” as a means by which “to extract maximum productivity and to prevent the development of cooperative relationships” (Ritzer, 2000). In this way, capitalism structurally implements isolated working environments which results in hostility directed among and between workers and their peers, deflecting hostility that would more appropriately be aimed at organizations (Wright, 1992, p. 56).

Further to this, Obholzer, & Roberts (1994) extend their analysis of organizations and suggest that the interpersonal structures within many agencies have adapted a somewhat familial dynamic, and that employee conflicts are sometimes seen are “more akin to sibling rivalry between brothers or sisters competing for resources and power”, resulting in “interpersonal difficulties between agency members” (p. 126). Adams and Crawford (1992) and Obholzer & Roberts (1994) similarly point out a marked increase of what appears to be scapegoating in
agencies wherein specific individuals are targeted, and subjected to bullying and other abusive conditions, resulting in those employees leaving the workplace. Social workers continue to advocate for their clients and strive to provide client-directed services by stretching and bending policies in order to do so. They often work long hours over and above the requirements of their positions. They do so because of a desire to make a difference:

Would you lie for your clients? Would you take risks that could leave you unemployed and stigmatized among your professionally accredited peers? Would you look the other way when it meant courage was required? How fare would you go? How far would you want someone to go if it was your rent money; your child; your loved one; your future; your dignity; your health; your coreself... (Transken, 2002, p. 80)?

But do to the reality of inadequate funding and competitive work environments, many women working in social work are unkind or marginalizing to each other. Thus, in a profession where 80 per cent of the workers are female, (Gibelman, 1998[1995]) there often is little compassion amongst colleagues. Instead, these women work in a profession where the underlying principles are both innately assumed and legislated to be nurturing, caring, concerned for humanity and empowerment, have succumbed to the capitalist creation of battles for funding, and permanent positions, within agencies that offer nothing of the core concepts that likely brought these women to this profession in the first place.

Communities of Women and Social Work

To help explain some of the underlying influential dynamics within the spheres of women and social work, I have borrowed literature from social geography, a branch of human geography that is interested in an historical analysis of social processes, including the role of gender, in the development of community, and the way social resources and phenomena are
distributed (Halseth & Sullivan, 2002). Incorporation of a social geographical framework provided some thoughtful insight and allowed me to realize a variety of contributing factors that might otherwise be less visible from the analysis, including geography as it relates to community, and the relevance of social capital and social cohesion in gender studies.

Halseth (2000) summarizes the concept of social capital as “the outcome of individuals working together in groups” (see also Sullivan, 2002; Hofferth and Iceland, 1998; Wall et al., 1998). Halseth (2000) defines social cohesion as “the process of the interaction of individuals working in groups” (p. 101). Sullivan (2002) describes two main types of social cohesion as “bridging, which refers to linkages made between groups” and “bonding which refers to relationships within groups” (p. 90). Referring to Flora and Flora (1996), Putnam (2000), and Le Blanc (2001), Sullivan describes the benefits of social cohesion within communities to include favorable social outcomes, strong economic performance, and less crime (p. 90). Referring to Portes (1998; 1999), Halseth (2000) describes that the downside to strong group cohesion is that it can lead to the exclusion of newcomers or those with conflicting ideas or goals, and associated with the potential for exclusion, is the demand for group conformity.

Halseth & Sullivan (2002) discuss place-based and interest-based communities. Collectively, women share many of the qualities that define both types of community and I have expanded the concept of community to make the argument that women are then effectively both a place-based and an interest-based community. This argument intensifies when the community of women shares a profound common concern such as invisible illness/dis/ability: “Communities of interest are bound together by an identification with a common issue... they are held together by sets of relationships and personal ties... cohesive bonds may form which are not linked to direct face-to-face interaction” (Halseth & Sullivan, 2002, p. 8). Halseth & Sullivan (2002) explain that “place-based communities can become even more important in rural and small town British
Columbia, where large distances separate settlements” and that bonds between residents in small towns are reinforced when they share common interests such as employment (Halseth, 1998, p. 7).

I argue that the profession of social work is an interest-based community, in that the functions of community “support both individuals and groups”. Halseth & Sullivan (2002) illustrated that “it is through community that individuals organize their daily lives and make sense of the issues and concerns they encounter...under pressure people may energize their community bonds and membership to meet challenges” (p. 7).

Within the communities of social work and women, exists a variety of similar and conflicting personalities, ideologies, philosophies, agendas, and experiences. Further to this, within the profession of social work, the power dynamics, including “policing” and “guilting” that are employed to enforce cohesion frequently result in the negative consequence of reducing social capital, (the relationships between the women/ workers) and as Halseth (2000) describes, “social capital is something which must be maintained and nurtured in order to be effective”.

Additionally, if women are socialized, individually and collectively, “to seek and value social connection, sociality and moral ideals of care and nurturance” and are therefore “bound by a sense of community” described further as a type of un-chosen, relational attachment discovered through a sort of subjective positioning, as described by Friedman (1989), then the negative attributes of the capitalist system, which works to divide and conquer in order to increase production, would instead be reduced due to a breakdown in community spirit (1989, p. 105). And if women, by definition, are a community, and collectively they work within the parameters of the community of social work, then as per the dynamics of social capital and cohesion, failure to conform to a prescribed agenda, may likely result in exclusion and/or reprimand, which is noted as a negative outcome of social cohesion. (This is exactly what happens to many women
within the profession according to their descriptions). By dehumanizing and negating the innate social, physical, economic, and spiritual needs of the community itself, in this case the community of women, (more specifically, dis/abled women) and the community of social work, a reduction in production, contrary to the desired capitalist outcome, is produced.

Ultimately, this also results in a further reduction of social cohesion, if we regard social worker burn out and illness, and overall poor working conditions as described by many women. Referring to Schulgasser (1999) & Astone et al (1999), Halseth (2000) explains that social capital is different from other types of capital because “it will degrade with lack of use and it is not so readily transferable” (Halseth, 2000). This negative cycle of social capital and cohesion then, is counter productive to social worker retention as well as it is not conducive to women’s health. Neither does this practice/process of human engagement measure up to capitalism stated goals of ‘production’. Frankly, this lose-lose system is a prescription for failure.

**Structural Domination**

Patriarchal structures that govern our organizations ensure that women remain in subordinate, dependent positions within those agencies. The legal system contributes to the oppression of women by keeping them both dependent upon a partner for financial support as well as its policies effectively keep women poor outside the confines of the institution of marriage, forcing many women to remain in abusive partnerships for fear of financial destitution. Funding cuts to programs accessed and operated by women make it so that competition becomes ferocious between agencies competing for the monies to operate their programs. This further exemplifies the **divide and conquer** strategies controlling women’s behavior. Overall patterns are in place (on an individual level and on the larger organizational level) that we compete for the scraps that are offered to us because we legitimately fear that there is nothing else! It is my opinion that the oppressive, patriarchal, and classist structures that are in
place to insure the dominance of the male-centered gaze in the profession of social work are the
very structures that work against women in our struggles with invisible dis/ability.

I argue also that many women are led to careers in social work because of life histories
involving trauma, neglect and abuse. I suggest that these women either experienced these
injustices first hand, or they were directly involved in assisting loved ones through such ordeals.
I am not suggesting that to become a social worker, a woman must have endured lifelong
neglect or abuse, but that the likelihood that she became a social worker increased if she had
direct personal experience with these issues. It is my opinion that her exposure to trauma likely
contributed to and shaped her decision to become a social worker. It is unfortunate then, that in
women's genuine attempts to assist those who are disabled and struggling, that women continue
to be subjected to trauma, neglect and abuse from within the very profession that they turned to
both for assistance and sustenance.

The very nature of what influences many women to become social workers is exactly the
same structural beast that dismissed or diminished them in the first place. Rather than make the
lives of other women less uncomfortable, they are re-victimized, systemically discouraged and
abandoned by their peers, and left to fend for themselves within the system that offers little
compassion or compensation. It seems that the old saying, “if you can’t beat them, join them,”
is appropriate. It is no wonder many of our sisters make decisions to work for their pay-
cheques, ask few questions, make no waves, and look forward to benefits and retirement
pensions, all the while praying not to become “the one the wolves pull down” 13.

Yet despite the reality for many social workers, “the primary mission of the social work
profession is to enhance human well-being and help meet basic human needs of vulnerable,


Consider this; Hill (1996) argues that “class also has been muddied by the assumptions that we make about it: that people are the class that they deserve to be., that class is correlated with how hard one works or how smart one is, that class is primarily a matter of income or owned assets rather than of access” (p. 2). Similarly, Coll, Cook-Nobles, & Surrey (1997) define “permanent inequality” as “unequal due to characteristics that are ascribed at birth such as race, gender, class, nationality, or religion” (p185). One might argue that the potential to escape this prescribed sub-standard existence is futile for all but a few fortunate women. The unfortunate rest of us rather, if we take to heart what Hill & Rothblum (1996) describes, are fatefuly doomed to the hum-drum of the working-class, drowning in destitution, disadvantage, depressed, undereducated lives threaded with of a multitude of abusive circumstance.

Social workers, most of whom are women, are included in the realm of the disadvantaged and oppressed, and many of us have been struggling with situations of oppression and marginalization. We have also been socialized to gravitate to positions of employment where we are expected to provide the caring for others, but we have not yet successfully managed to find adequate caring for ourselves. During our careers, many of us have struggled with issues of illness/dis/ability of an invisible nature, and we are subjected to further marginalization, oppression, and emotional and epistemological violence within this profession that claims to respect human dignity and self worth. But when we complain, we find ourselves fighting losing

14 I began my MSW journey at UNBC in 2003.
15 See Succulent Supplement /Appendices Section at end of thesis.
16 I was unable to locate the book/article for this reference at UNBC library. It was cited from Nobiss, J. (2003). Classism and feminist therapy: Counting costs. Book Review: Social work 613
battles within our employing agencies and within the medical system as we attempt to find answers to our often elusive and intensifying medical symptoms. "I think after awhile the stigma gets inside and I know I am always fighting with my head feeling broken, feeling I am not a valued resource because I have this thing wrong with me that you can't see, that the more I have to try to convince you I have the sicker I sound" (2009, participant interview, Danu).

Frequently, rather than receive compassionate professional and medical care, we are instead labeled as troublemakers, whiners, and hypochondriacs. Radomsky (1995) writes about the issue of violence as a health issue, in regard to women's powerless positions within the family and social systems (p. 133) and their experiences with various abuse and illnesses, including chronic pain. She argues that women remain unheard despite their stories of abuse and neglect by parents, husbands and partners, and she criticizes the "male-dominated" medical profession for its failure to address women's complaints from something other than a medical model based, gender attack. Radomsky is a physician and she herself was forced to "think like a man, not like a woman" (p. 54), and she was taught to devalue subjective personal knowledge favoring instead the rational and objectivity of science.

Brown (1994) explains that exposing isolated women to each other's secret experiences through feminist research has the empowering ability to deconstruct the psychotherapeutic theories which convinced women that they were alone in their flawed existence, and that in bringing forth this truth, we manage to better understand women's collective experiences and we contribute to the reduction of women's oppression. What Brown describes supports BARTky's (1990, p. 80) analysis of Foucault's notion of self-"surveillance" and how women contribute to normalizing the collective "feeling of body deficiency" (pp. 80-81), as it illustrates how external processes (not just an internalized, biological, flawed character) effectively contribute to the marginalization and oppression of women. These analyses are largely reflective of Paulo
Freire's (1970) pedagogies which are referenced here by Delaney Brownlee & Zapf (1999): “It is critical that any effort to liberate and empower oppressed people begin with helping the oppressed to see that their dehumanization is not their history or their destiny, rather it is ‘the result of an unjust order that engenders violence in the oppressors, which in turn dehumanizes the oppressed’” (p. 12).

The current health care cutbacks (often labeled as ‘reforms’) regarding policies and changes in mandates have taken what little ability we have as social workers to pragmatically assist our clients—we are left with few resources with which to help clients in regard to their issues. The quality of care is being reduced, and the “clients are caught in the middle of multiple power struggles between the funders and administrators” (Brown, p. 134). This creates a cycle in which we struggle as caregivers to offset program cuts, and our own health becomes negatively impacted rendering us unable to provide care. This ultimately places more burden on an already depleted system. Unfortunately, despite the increasing need for health/social programs and services, the care budgets in British Columbia continue to be cut in these areas and the areas affected most tend to be rural and northern remote communities where services are already skeletal. Due to the increasing obstacles to give and receive services (including program availability and access), many of the people requiring these services are unable to afford them and many social workers are left feeling inadequate.

The social work profession professes to be concerned with linking private, individual troubles to public, social issues such as violence, poverty, and trauma, which are at the forefront of both the social work profession and social research. Human rights and social justice are the philosophical underpinnings of social work practice. The “primary professional obligation” of social work is that social workers practice within a framework that “regards the well-being” of the persons served (BCASW, 1999, p. 4). However, little has been done to examine and address
women's experiences of violence from the perspective of relevance and prevalence within the social work profession itself.

The Overall Oppressive Nature of Female Socialization

Bartky (1999) writes that not only are women and men “situated differently within the ensemble of social relations” (p. 83) but women are “actively subordinated to them” and “feminist philosophers have argued that women’s ways of knowing are different than men’s” (p. 84). Bartky presents these points as a “contribution to the phenomenology of oppression” (p. 84). It is my opinion that patriarchal socialization processes discourage women from seeking “non-caring” and typically non-traditional professions or vocations. Wharf, (1993) defines family patriarchy as the power and authority over women that is exercised by the male in the home. He defines social patriarchy as the laws and regulations of the state that support male control over women. Benoit (2000) similarly illustrates patriarchy such that “underpinning this system was a sex bias—the assumption that women could always depend upon economic support, in part or in full, from a male relative, either a father or a husband” (p. 59).

Throughout their socialization, women seem to develop aversions to mathematics and sciences which channels them into the more traditionally female, caring professions, such as social work. Women are still somewhat invisibly groomed to be caregivers and to sacrifice selfishness for the good of others. Wagner, (2008) discusses how “education plays a more subtle and unrecognized role in reinforcing dominant ideologies, some of which can do harm to persons oppressed by other aspects of their lives” (in Wagner, Acker, & Mayuzumi, 2008, p. 91).

This exploration of the experiences of women who have become invisibly disabled at some point throughout her career, has similar implications for social work as does a study of academia

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17 “Women make up the majority of full-time students in most university departments. They remain concentrated in the humanities and social sciences, fields with weaker labour market outcomes but are making inroads into traditionally male-dominated fields” (Status of Women Canada N.D.).
by Herman (1992), & Brown (1995): “acknowledging that interpersonal violence is a fact of life for many women this research was designed to explore how women’s experiences of trauma may affect their pursuit of university education” (Wagner, 2008, as cited in Wagner, Acker, & Mayuzumi, 2008, p. 91). It is my opinion that not only does the socialization of women facilitate gender violence, but the same oppressive, and patriarchal structures from which our socialization processes are developed, discourages women from seeking “non-caring” and typically non-traditional professions or vocations. Baines, Evans, & Neysmith (1991) refer to (Messer-Schmidt, 1987; Smart, 1985) when they describe how the “breeding grounds for medical professionals to treat female problems as largely psychosomatic rather than as legitimate health issues” is largely due to the lessons of caring, in which girls are socialized to focus on the niceness of outward “appearances and behaviours”, where “girls too often find their bodies and spirits pay the price” (Baines, Evans, & Neysmith, p. 121). This is also evident in the following participant quote:

Since I was a little girl I had always taken care of people, it was my job, my life, my purpose; I didn’t know any different. I made others happy, not worried, sad or uncomfortable. That wasn’t what little girls were meant to do... I did care what others thought and that wasn’t okay” (2009, Kali participant interview).

A study of social work research by Gripton, Nutter, Irving, & Murphy (1995) included an examination of the research interests and activities of faculty members of Canadian social work schools. The four clusters studied were male doctorates, female doctorates, male non-doctorates and female non-doctorates. The interpretation of the findings is that of the women doctorate cluster, research productivity was found to be less than that of male doctorates. Female doctorates had authored and edited fewer books and had published fewer book chapters and refereed articles than male doctorates. The female doctorates also reported less confidence in
their research capabilities than male doctorates and they were less likely to teach research courses than male doctorates. They also served less frequently on university level research ethics or grant application review committees, despite reporting that they spent as much time collaborating with colleagues in other disciplines, as well as more time developing interdisciplinary research proposals.

The findings of the cluster of female non-doctorates found that scholarly productivity was the lowest of all four clusters. This group was least likely to read non-social work journals. Female non-doctorates’ attitudes towards research in social work and their own research capabilities included “fear, indifference, cynicism and antagonism” (p. 392). Female non-doctorates “appeared to have become a marginalized and alienated group among social work academics…they taught a disproportionate share of practice courses and were largely responsible for organizing and administering the field practice component of the curriculum” (p. 392).

This study by Gripton, Nutter, Irving, & Murphy is especially relevant to my own research in that their conclusions specify that “in professional interests and values, they more closely represent the typical social worker in practice” (p. 392). Bartky (1999) refers to Bourdieu (2001) arguing that this situation reflects the masculine order of academia, in which certain realities are affirmed at the expense of others, thereby perpetuating “masculine domination” (Bartky, p. 88).

As supported by the literature, it appears that the socialization of women in regard to both caring and academic attitudes may shape their career paths and outcomes of the relationships within. It seems possible then, that if oppressive socialization processes become internalized, the potential for women to re-experience marginalization and epistemic violence within their

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18 “A 1997 report by the Canadian Institute of Child Health entitled ‘The Canadian Girl-Child: Determinants of the Health and Well-being of Girls and Young Women’ has stressed that ‘gender identity determines how boys and girls experience their environment and the life paths they choose’” (Status of Women Canada, N.D.).

...across all major occupational categories in Canada, even today, women continue to earn less than men. This inequity applies no matter the level of education attained...female university graduates employed full-time earned 75 percent of what their male counterparts did (Benoit, p. 74).

Godenzi & DePuy (2001) discuss Ecological theories that regard the concept of non-violence as a secondary effect of healthy environments. They suggest that non-violence reduces high risk factors of isolation, marginalization, and stress within people’s lives. They connect violence prevention to improvements on the macro-social level, including the struggle against poverty and inequality (p. 463). Although this was not a study of social work profession, it has implications for social work and it supports the argument of this paper. And when we examine Moreau's structural analysis of oppression (Carniol, 1992) we learn that the primary structures including racism, sexism, classism, ableism, and patriarchy, are the foundation for and uphold the secondary structures of oppression, such as government, education, families, communities, and human service organizations, thereby perpetuating and reinforcing the ideologies held by those in power. This results in the continued marginalization and oppression of many, ultimately creating sub-classes of citizenship, enslaved by fear.

Beth (1999) conducted a research study to examine a possible link between history of abuse and fear of negative evaluation, and negative self-statements regarding male to female interactions. The findings suggest the possibility of risk regarding the social interactions between men and women, if the women had experienced sexual abuse. The differences on the Child Abuse and Trauma (CAT) scale between men and women were significant and implied that girls suffered a higher level of negative home environment neglect than boys. This has
relevance to my paper, in that although women hold approximately 74 percent of the positions in social work, men (who are less represented in the profession in general) hold most of the positions in upper and middle management. In 1994, 70 per cent of all corporate managers were male (Benoit, 2000, p. 72). If women who have experienced trauma and victimization are fearful and passive in relationships with male counterparts, this is conducive to further marginalization and oppression within their working relationships due to organizational and systemic structures.

Women are doubly impacted by structural changes as service recipients and service providers. Lavingne, Burke, Lemonde, (2001) argues “...current home care policies and practices have a negative financial impact on women who make up the majority of home care users, paid workers and unpaid caregivers (p. 55). A feminist analysis of these issues addresses women’s lack of access to power within the structures of social work. If we fail to address this, we risk further oppressing and marginalizing women’s experiences as they relate to gender-violence.

As well as exploring how the oppressive and marginalizing factors impact women in and out of the social work profession, I am curious about potential relationships in relation to women’s decisions to become social workers, in the first place. “Gender socialization shapes and limits the lives of girls, especially their education and career choices” (Status of Women in Canada, N.D.). In other words, I am curious to know if female socialization, as it is connected to the marginalization and oppression of women, particularly in the area of science and mathematics, might contribute to the possible aversions to math and science-based, “non-helping” professions, and if the socialization process then might impact the future decisions of women to become social workers.

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19 This reference is not specific to Social Work.
Heifer & Kempe (1988), suggest that when a child is raised in an abusive home, the tendency for that child to remain in situations conducive to violence increases. Many women somehow rationalize the violence in that they have internalized the belief that violence is acceptable, perhaps due to generations of dysfunction (Busby, 1996). Gondolf (1988) reiterates Busby’s arguments writing “…evidence suggests that a substantial portion of the battered women experienced abuse as a child, rather than the kinds of social encouragement that were found in the childhood of the resilient individuals” (p. 24).

I am not suggesting that females simply become social workers due to histories of marginalization, but that due to a variety of factors (including altruistic nature/nurture), women who have experienced oppression may be more inclined to become social workers in order to help make a difference in the lives of other women who may be experiencing similar situations. It is also plausible that these women are caught within a cycle of trauma and violence. For instance, the following quotation reinforces Busby’s (1996) arguments that many adults are suffering from unresolved trauma of abusive childhood themselves: “Trauma is like a big cloak that covers you and sets you apart and you go through the world under this cloak. So there is this really deep sense sometimes—that I’m not like other people. And other people can go into things with relative ease, but I can’t” (Julia, graduate student as cited in Wagner, 2008).

And Baines, Evans, & Neysmith, (1991) write that “a girl learns quickly that to be different or bad is not to be more like a boy, with the attendant privileges, or to be regarded as a more rounded person, an individual, or maybe a new breed of girl” (p. 127). They also refer to Heidensohn (1987) and Schur (1984) describing “the double jeopardy and double failure deviant girls face…in brief the very high costs of deviation police girls to continue paying the high costs for the way they care for others and themselves” (Baines, Evans, & Neysmith, p. 127).
Women and Caring

Historically, in both native and non-native societies, women have been responsible for the work within their homes (domestic labour including child rearing) and men have been responsible for the (paid labour) work outside their homes (Doyle & Pauludi, 1985). As (industrialization) urbanization occurred, it became necessary for both men and women to work outside their homes in order to provide materially for their families. This changed the roles of women in that their portion of the labour increased, but the value of their labour input did not increase accordingly. Gordon, Benner, & Noddings (1996) refer to Marx (1992) in their observation that “ignoring the most important fact of human society—that we are constituted by other human beings…the duty to care is imposed on the individual with no social support” (Gordon, Benner, & Noddings, p. 49).

The socialization of women and men ultimately sets the stage for the types of employment and professional endeavors they will seek. Baines, Evans & Neysmith (1991) imply that women tend to flock towards the social work profession because they are socialized into caring roles (p.53) and they argue that for some women these career opportunities become options to marriage (p. 53). Coldwell (1998) building on the writing of Freedberg (1993) states “long seen as a natural attribute of women, caring is associated with social work as a profession as well as with society’s conception of the mothering, nurturing role. There are two kinds of caring: nurturing and social caring” (Coldwell, p. 22). and Baines, Evans & Neysmith (1991) write: we need to have an understanding of why the messages of caring are directed to first-hand experiences of trauma, neglect, abuse, and/ or poverty prior to careers in social work women involves an appreciation of the inextricable linkages between socialization, patriarchy, and the

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20 “Total working time is similar for women and men. However, there is a distinct division of labour between the sexes. On average, women spend more of their time on unpaid work, especially when there are children, while men spend the majority of their time on paid work” (Status of Women Canada, N.D.).
relations of family and labour in advanced industrialized societies (p. 17).

Gripton, Nutter, Irving, & Murphy (1995) discuss a study of students at a rural, southern university in Georgia, where it was found that college-aged women are much more likely than men to report trauma relating to experiences with interpersonal violence. The authors wrote that traumatic events can have long-lasting effects including somatic complaints and loss of memory, and recall. The suggestions provided in this study included that appropriate workplace accommodations for victims suffering from Post Traumatic Stress Disorder (PTSD) be implemented under the Americans with Disabilities Act and the Rehabilitation Act of 1973. Although this study was American, it has implications for my paper in that it recognizes that women more frequently than men tend to suffer from the effects of trauma, and as well it acknowledges that the symptoms of PTSD should be viewed under disability mandates. Undoubtedly, to recognize these PTSD 'injuries' would mean altering the whole world of patriarchy and capitalism. To recognize that there are a number of women who have some kind of PTSD before they enter the social work profession and to recognize that the social work profession may add another layer of PTSD — and that this is a compensatory injury — would alter the entire work world as we know it.

**The Economics of Caring**

A common occurrence has been the 'guilting' of women by other women and within organizations providing social services. In my own work experience as a social worker I found this to be true. Many of my peers (during presentations of this research I have been doing) have given anecdotal support to this pattern. This 'guilting' has had a negative impact and further oppresses women who provide such services (Baines, Evans, & Neysmith, 1991). Obholzer & Roberts (1994) discuss how frequent organizational changes create stress and confusion for the workers who must adapt their practices to reflect the changes. They propose that hierarchal,
top-down organizations are being replaced by sub-systems of organizations with fewer levels of hierarchy. They suggest that we are shifting from “patriarchal and matriarchal structures” towards a familial model and that many of these organizational conflicts are more similar in nature to sibling rivalry between brothers or sisters competing for resources and power. They also refer to Adams and Crawford (1992) noting that there is a notable increase in ‘bullying’ in organizations and other forms of scapegoating of certain individuals within organizations who are then subjected to intolerable pressures and are often driven out in one way or another (Obholzer & Roberts, p. 126).

The struggles that women are having within the profession are complex. The competition between organizations is about the scraps of funding available for the women who provide the services forcing workers into competition for job security within the hierarchal structure. There is tremendous concern that further funding cuts will be implemented, creating a fear-based health and social service system. These fears create a flow from the top down, affecting the specialists, physicians, management, nurses, social workers, and other paid and unpaid staff, and of course these cuts affect the patients/clients. There is pressure to conform, and to do more for less. What stance do we take? Do we succumb to the pressure to be quiet, “good little social workers” and “cross over to the dark side,” seduced by the possibility of job security? Do we continue to engage in the battles for our rights as women service providers and clients while risking the likelihood of further program closures and loss of employment? And what do we do when we become ill? There is much at stake, yet there is little funding supplied for health services and the goal of the government to increase profit by decreasing duplication in services. Everyone is concerned about their piece of the pie.

Gordon, Benner & Noddings (1996) reiterate Tronto (1993) when they describe how “care’s absence from our core social and political values reflects many choices our society has made
about what to honor” and “through that exclusion, those who are powerful are able to demand
that others care for them, and they have been able to maintain their positions of power and
privilege” (Gordon, Benner & Noddings, p. 49). And Baines, Evans & Neysmith (1991) write:
“we are so exhausted. It’s the divide and conquer thing at the moment where you know, those
of us, and there are so many of us [advocates for women’s issues and survivors of oppression]
that are marginalized or disenfranchised because we can’t gain access to the resources that we
need in spite of our hard work” (p. 139).

The restructuring (downsizing and outsourcing, etc.) increases the antes for the parties and
between paid labour and wageless labour. This often breeds animosity among the women and
the tactic becomes successful when employees turn on their peers and each other: “My boss
was really falling apart at the same time and her insight was gone and she had serious symptoms
and it was easier for her to just focus on me as a problem” (2009, Danu, participant interview).
Essentially it becomes a survival of the fittest. She who is left standing, shall stand alone, with no
support staff, no one (agency) to refer patients to, and with no collaboration or support. The
resulting prize will have been at the expense of both the worker and society’s best interests in
regard to positive health. This ultimately conflicts with the very nature of ethical and non-violent
social work practice.

I believe that Western society supports this unspoken economics of caring. Baines, Evans,
Neysmith (1991) argue that “an analysis of women and poverty must be based on an
understanding of the interrelationship between the labour women do in the home and their
employment in the workplace” (p. 177). MacDonald, Phipps & Lethbridge (2005) refer to Bird
& Fremont’s (1991) study of gender differences regarding paid and unpaid work including child
care, concluding that “men gain health advantages as well as direct economic benefits from the
gender division of social roles” (MacDonald, Phipps, & Lethbridge, p. 67). Burke (2002) notes
that findings of this study include that due to the imbalance of paid and unpaid labour, in and outside homes, “the stress-related risks and outcomes for women and men are likely quite different…and importantly Burke identifies that “until recently, the literature on work stress and health was based mainly on the experiences of men” (p. 67).

Many women state that they do not feel comfortable asking for help and being in need of care because they feel like they are a burden to partners/spouses and friends and family when they are in need of care (especially due to illness):

…working at a hard and responsible job, I had no right, or time, money or permission to have a bad day, a dark day, or a sick day. I went to my doctor several times and shared my feelings of hopelessness, sleeplessness, sadness, hunger and craving for love in my life and finding nothing for me…(2009, Kali, participant interview).

Shaw & Lee (2004) refer to Emma Goldman’s analysis of marriage as “an economic transaction that binds women in to subservience to men (through love and personal and sexual services) and society (through unpaid housework)” (p. 296) and further, “the institution of marriage makes a parasite of a woman, an absolute dependent. It incapacitates her for life’s struggles, annihilates her social consciousness, paralyzes her imagination, and them imposes its gracious protection, which is in reality a snare, a travesty on human character” (p. 310).

I argue that there is no difference between this description of marriage and the popular definition of prostitution, in which an entirely similar reciprocity exists:
corporate playgrounds from the bedrooms to the boardrooms. Lest we forget that Right bitch?

Right Bitch (2003, Hel)

I believe that what Goldman proposed so long ago remains very much accurate today in regard to how marriage is/not equally beneficial for men and women. Overall, men seem to reap the most benefit from marriage, as they contribute to the financial support of the family, but frequently they do not contribute to an equal share of the unpaid labor within the households. And women tend to pay the dearest in regard to the amount of paid and unpaid labour they contribute, in relation to the economic rewards they manage to withdraw. As the union of marriage has no financial guarantee, and the illusion of economic security and elevated social status appears to be the ultimate desired benefit of marriage, this seems a high price to pay for what Shaw & Lee described as “soul poverty” (p. 309). But perhaps this price becomes more balanced when compared to a potential life in the streets?

Interestingly, in their study, MacDonald, Phipps, & Lethbridge (2005) found that although married women reported “the strongest marginal effects on stress are from eldercare...men are particularly stressed by caring for a disabled spouse” (p. 90), concluding that the “burden of unpaid work is not experienced the same way by men and women” (p. 90). And these findings sadly reinforce the reluctance of many women to ask for help or to say, “no” when feeling overwhelmed or unwell. MacDonald, Phipps, & Lethbridge stated that “stress has known impacts on both emotional and physical well-being” (p. 64) and “the health hazards related to stress are becoming increasingly well recognized, including heart disease, migraines, stomach problems, and musculoskeletal disorders, as well as emotional health problems” (pp. 66-67). Further to this they argue that “stress is also being recognized as an occupational illness, affected by diverse factors such as effort, workload, and control over work” (pp. 66-67). MacDonald, Phipps & Lethbridge (2005) compared the findings of surveys by Duxbury & Higgins (1991;
reporting that “workers have become more stressed, physical and mental health has declined and so has satisfaction with life” (MacDonald, Phipps, & Lethbridge, p. 66). And MacDonald, Phipps, & Lethbridge (2005) also state that “caregiving poses physical health and safety risks and can be stressful, especially when time and resources are insufficient for the work at hand” (p. 66) and “just as a supportive spouse may help alleviate the stress of the double day so too may a supportive workplace” (p. 69).

The social workers I interviewed discussed how the conflicting circumstances of the uncontrollable forces of illness and the imperative necessity of ever-unfailing strength (at home and at work) was invisibly layered upon them. Yet even when illness is medically documented (supported by evidence) social work organizations often do not/ cannot effectively support their own. “…No one wanted me to be ill, not the staff, not the community, not the agency accreditation process that was emerging, due in a very short time” (2009, participant interview, Kali). Women working in social work, are forced (financially and morally) to maintain their employment and their homes, despite the often relentless symptoms of illness and the constant demands of both employing agencies and family obligations.

MacDonald, Phipps, & Lethbridge (2005) describe “employees who experience role overload are more likely to report stress, burnout, or poor physical or mental health” and “higher role overload for women than men regardless of job type” was also reported (p. 66), again reflective of gendered division of labour. “Stress related to income as well as time” were identified as possible factors to the reported outcomes of the study, and it was proposed that “independent and interdependent stress effects of time and money pressures” be studied further (MacDonald, Phipps, & Lethbridge, 2005, p. 66). MacDonald, Phipps & Lethbridge (2005) agree with Floro (1995) that “daily caregiving and provisioning are likely more labour intensive for lower-income families” (MacDonald, Phipps & Lethbridge, p. 66). Duxbury and Higgins
(2001) found that work-family conflict is more problematic for families where money is an issue than where it is not: ‘while money cannot buy happiness, it can sure help people cope with work-life conflict” (Duxbury & Higgins, p. 61). This was reflected in the responses of the participants throughout my thesis research also.

MacDonald, Phipps, & Lethbridge, (2005) offer additional factors found to have relevance to overall participant health outcomes including connection/support of “family and community, job satisfaction, control at work, and employer programs” (see also Duxbury & Higgins, 2001; Frederick & Fast, 2001; Johnson, Lero, & Rooney, 2001). These findings were also evident in the responses provided by the participants in this research study. Ultimately it will take women and men working together, in support of the concepts of equity and reciprocity to create change that will show appropriate compensation and respect for the work that women provide as caregivers in paid and unpaid work.

Poverty / Oppression/ and Trauma Within the Social Work Profession: Caution, Social work is hazardous to your health...

“One is victimized as a woman, as one among many” (Bartky, 1999 p. 15). Many women working within the social work profession have described a variety of experiences of marginalization, oppression, and abandonment throughout their lives. “Women still have less access than men to credit, finance, education, training, employment, and other productive resources, which contributes to their poverty” (Status of Women Canada, N.D.). The economics of caring are far too profitable for men. And those with the finances and the power quite likely wish to keep it that way. Benoit, (2000) writes “…despite the lower bankruptcy rate among female owners of small businesses…women generally experienced more difficulty than men in securing the credit they needed to start up their enterprises” (Prentice et al., 196: 358, as cited, p. 78). Baines, Evans & Neysmith (1991) describe that similar to what happens to female social workers, despite the opportunities these occupations have provided for them, female
teachers and nurses have also been marginalized. In 1981, less than 10 percent of women in teaching were employed at the secondary level while over 80 percent were in the elementary schools (p. 65).

It is unfortunate that for many female social workers, entrapment within the cycle of violence has continued within their social work careers. This is especially relevant for women who are experiencing invisible illness or disability. The sources of these traumas within the profession are multi-sourced: “There are so many women that go through these kinds of experiences and have similar trauma...comes from the inability to move forward and to care for children and home as much as the actual darkness that looms over the psyche” (2009, participant interview, Kali):

My full time position was quickly filled by one of my colleagues. She had been in the running when I was hired and was more than delighted to take my place while I would be gone. She reported to the board at the very next meeting that I hadn’t been keeping up with my work as was expected by them and that she would put the time in to get things caught up. A couple of board members were compassionate enough to make it clear to her and to the office manager that I would be returning to my position and that this colleague would be filling my position temporarily. It wasn’t long until the office manager had made a list of all my delinquencies in meeting attendance, reports, and accreditation requirements due to my illness and that she felt that I needed to be replaced immediately, which I was (2009, participant interview, Kali).

Women have described structural and political abandonment, racism, and isolation from colleagues, supervisors and peers: “I was not contacted by my office or my colleagues regarding anything including my well being, my families well being, my possible return, or if there was anything that they could do to assist me in my illness” (2009, participant interview, Kali).
Referring to Harker (2002), Henning (2006) writes “if they are socially isolated they don’t do well, if they don’t have resources like financial resources they don’t do well and this is especially true for mental health patients (Henning, p. 48). Mackelprang & Salsgiver (1999) wrote that “historically isolation has been a major obstacle for persons with disabilities in developing culture. Isolated from others with disabilities, people with disabilities have been given little opportunity for shared development” (p. 26): “I wondered why I was being left to flounder in my illness while I had truly supported them in so many family needs, in extra time off requests, in workshops, training and in their own mental wellness. What had I done or possibly not done to deserve this silent, isolating treatment” (2009, participant interview, Kali)?

“Society has labeled them as hopeless and has treated them accordingly...Lack of access to employment, education, transportation, and housing has produced poverty and has restricted access to society” (Mackelprang & Salsgiver, 1999, p. 26). As well many women, including those in this research study, have described circumstances of seemingly endless poverty. And we know that violence against women is directly related to poverty and the oppression of women and children. Gender violence is a symptom of powerlessness and lack of control that many women are experiencing, and I repeat that although 74 percent of workers in the social work profession are women, they are concentrated in the lower paying direct service positions committed to an ethic of caring about and for marginal populations (Baines, Evans & Neysmith, 1991 p. 60). Mullaly (1997) also argues that the “greatest preponderance of abuse and neglect occurs among those who have fewest resources to work with, and who are struggling the most to secure the basic necessities of life, as well as having the greatest number and most sustained pressures on them—that is, the poor”. A participant speaks to this:

My benefits included a $1500.00 a month living allowance on both short and long term disability. Before this time, in the year 2000, I was bringing home $68,000.00 a year when I
was working full time, which I had done at this agency for 6 years. My first disability cheque arrived 5 months after the date that I entered the hospital. I took a $50,000.00 a year pay cut over night. I had a mortgage, a car loan, 4 children at home, all of my children’s sports, gas, insurance, etc, etc as we all do. It was 8 short months until I received a notice of foreclosure on my house. I wasn’t able to keep up with it all…I had a few friends that I was able to rely on to drive me to these appointments but I still had to pay for the gas (2009, *Kali*, participant interview).

Glenday & Duffy (1994) describe that women constitute 59 percent of Canada’s poor and that employment frequently fails to provide escape from poverty. “This objectification of workers does violence to both their bodies and spirit” (Sass, 1998, p. 16). It is this sad reality that makes this research so imperative. Despite that the women of this study are educated and work (or have worked) as professional social workers, when we examine this from a perspective that illuminates the disadvantaged social positioning and lack of monetary and human value placed on both the work we do and the gender we were prescribed, our experiences derive from a disadvantaged position. When we become ill, that disadvantaged positioning is exacerbated, further impeding chances of physical, mental or financial recovery. And when we recognize that in addition, many women working in social work have traumatic histories and they are often struggling and seeking positive ways to cope as well as many are managing ongoing impoverished circumstances (despite education and professional status). This was reflected in the data, as all but one of the participants in this study disclosed histories of trauma and abuse in a variety of messy ways: “Childhood abuse and addiction issues drove me to create space…I created distance to protect myself…A double edged sword” (2009, participant interview, *Venus*). “HoldinOn … LettinGo… Choices… Misery… FuckRacismViolence …bigass trigger for me,
visually…not showing the rape scene, but showing her after it happened…damn fuckin near threw up, got very light headed” (2009, participant interview, ChaChaCrowBear).

I personally know many women who have described experiences of similar marginalization and violence prior to them becoming social workers, and some identify that a contributing factor that led them to careers in social work was the desire to make a difference in the lives of other women, who may also feel trapped in their own oppressive situations. Interestingly, many women state frustration and helplessness due to their own inability to be helpful to their clients, due to the organizational structures that make helping an impossible illusion, as one of the most crippling aspects of their profession. Gondolf (1988) describes the notion of “learned helplessness” as “ironically prevalent in the system of helping sources” and further states that “it is more likely that agency personnel suffer from insufficient resources, options, or authority to make a difference, and therefore are reluctant to take decisive action” (p.23): “I tried to tell my colleagues of my feelings, they didn’t want to hear anything of it, we already had an employee out on sick leave and we were all feeling the strain of having him gone, no replacement, and no idea of when or if he would return…” (2009, participant interview, Kali).

Burstow (1992) criticizes systems theory not only for blaming (women) mothers for failing to protect their children, but also for fostering the further victimization of women. A Systems Theory analysis supports the notion of the imbalance of power between men and women and how women’s access to resources is limited. Burstow further suggests that violence is a symptom of the more deeply rooted structures of oppression and the marginalization of women.

Benoit (2000) refers to Jones (1990) when she argues how sexuality, reproduction and physical bodies must be examined when discussing gender differences and the concept of...
citizenship. Further, she argues that that the unique hazards of women’s bodied experiences exist in both the private and public spheres of capitalist countries. Effectively, the intersections of these bodily differences becomes that which excludes women’s full participation and citizenship (Benoit, p. 21).

Contrary to the myth of classlessness, which is part of the capitalist structure, both evidence and reason lead to the unmistakable conclusion that gender violence is strongly related to poverty in terms of prevalence and severity of consequences. When we identify who has access to power and resources in our society we begin to discern a different indication of a person’s class position Coldwell (1999) refers to Bishop (1994) in her argument that when defining class, we need to take into account several things, such as income, education, occupation, residence, values, language and the position the person has in the social hierarchy (Coldwell, 1999). “Class lines tend to be very convoluted because there are few firmly recognizable ways in which most people can identify to which class they belong” (p. 5). It is quite common, in my experience, that many people identify as being middle class when comparing themselves to others who have less.

Ehrenreich (1989) argues that middle class can be defined by “economic and social status which is based on education, rather than on the ownership of capital property” (p. 12). She says that most professionals and white-collared managers, “whose positions require at least a college degree, and increasingly also a graduate degree” (p. 12) are included in this class. If we agree with her then by definition, social workers can be viewed as middle class. Many of us live in various states of poverty, while we still aspire to the possessions that create a perception of a middle class standard of living. Coldwell (1999) refers to Kennedy (1979) where the findings of a study of working class women in the United States were that the women “attempted to hide
their poverty, their lifestyles, and their employment, seeking instead to struggle toward at least the outward appearances of middle-class respectability (Coldwell, p. 10).

I find this phenomenon interesting and intriguing both from my own experiences and from witnessing others. These behaviours are reflected in the way we regard invisible disability (illness), in that we attempt to validate, legitimate, and both over and under exaggerate symptoms and severity depending on the desired outcome. For instance, when we are trying to hide our illness (especially during early, undiagnosed stages, and prior to “coming out”) from our employers and work colleagues we diligently attempt to mask the severity and symptoms, typically for fear of risking losing our jobs. And for those of us who are single, when we are seeking a potential new mate, we are often less inclined to lay it all out there, again typically out of fear. But when we are negotiating with physicians and health care programs in our attempts to secure compensation or extended health benefits, most of us recognize the only way to accomplish this is to present the ugly facts of the impairment. We essentially expose our impoverished health during those moments when we have no other viable option. In this manner, we wear multiple cloaks of illness and in/visibility. I believe that this exemplifies the importance and relevance of class when we examine dis/ability.

Marx’s analysis of class, defined it in terms the relationship between production means and labour within the capitalist system. Referring to a study done by Grella (1990) of women who experienced downward mobility after a divorce, Coldwell (1999) indicates that Grella found that these women defined class “as a sense of lifestyle and consumption of homes, furniture, cars….emblems of intellectual interest, such as books, and symbols of middle-class security, such as living in a certain neighborhood” (Coldwell, p. 5). Coldwell (1999) also refers to Andersen (1985) and Weber (1920) when she defines class in terms of access to social and economic resources as they interrelate to economics, status and power (Coldwell, 1999). But
Coldwell criticizes these definitions for their failure to take into account the experiences specific to women, including gender and race marginalization, indicating that “perception of class entails more than financial status” (p. 6), and she refers to Langston (1992) when she states that denying “class divisions functions to reinforce ruling class control and domination” (Coldwell, 1999, p. 9). Class determines who our friends are, what schools we attend, what education we get, restaurants where we eat, etc. Coldwell (1999) writes “when we experience classism, it will be because of our lack of money, (ie. choices and power in society) and because of the way we talk, think, act, move…” (p. 10). And Lorde (1992) argues that “we rob women of each other’s energy and creative insight” (p. 405) when we do not acknowledge class differences.

The Liberalist framework we operate from as social workers suggests that we all have equal opportunity to access resources and to thrive. This equality is a gross misconception. According to Benoit, “the welfare state affects women and men differently…the welfare state can hardly be seen as gender neutral, but rather as reinforcing a deeply ingrained sexual division of labour based on gender inequality” (2000, p. 21). Poverty is one of the largest blockades to access and is essentially equal only to disability and disadvantage.

Eighty-three per cent of solo parents in Canada in 1994 were female” (Benoit, 2000, p. 76), “and their incomes are typically only half of the average family income” (CASW, p. 5). And Statistics Canada, 1989, findings compared “single female parents are almost three times as likely to be poor as male single parents” (p. 171, as cited in Baines, Evans, Neysmith, 1984, p. 194). Considering that 74 percent of the social work profession consists of female workers and many of these workers are in the position of raising families alone, then we must acknowledge, as Duffy and Pupo (1992) write, “when solo-mothers do find employment it is usually part-time and excluded from benefits mandated under employment standards legislation” (p. 250; also see Benoit, 2000, p. 76). And as Sass (1998) argues, economy is structured by laws which are such
that privilege is reinforced, ultimately positioning women (and the work they do) into the "shadows of social policy" effectively silencing those less fortunate (p. 25).

The range of earnings for social workers is between twenty-nine thousand and forty-four thousand dollars, gross annual income (Stephenson, Rondeau, Michaud, & Fiddler, N.D., p. 72). The net, take home pay is around two thousand dollars per month for full-time, entry level positions. This leaves little extra at the end of the month. In fact, a woman raising a family on her own, on these wages is actually living in poverty. A disabled women who is unable to work, will no longer receive her full working wages. If she is fortunate to have extended health coverage, (or an employed spouse with extended health coverage) she will hopefully receive at least a percentage of her regular earnings through such programs. Unfortunately, not all social workers are employed in agencies where there are employee health benefit programs, and still others are excluded for a variety of reasons such as contract-employment and non-union positions. And until a worker becomes ill, she will likely be unaware of the limitations to extended health plans purchased by some employers.

Danu writes: "At my last job whenever I was off my co-worker would have to cut back our work load there was no one else to do my job. I did have so many sick days a year to use up and then vacation time but I had no short term leave... three employers gave me sick time off with no pay" (2009, participant interview). Another participant explained that the "skinny plan" her employer bought is set up so that employees must pay approximately $500.00 for physio/massage therapy, chiropractic etc. (approx. $43.00 per visit) for the first 12 visits in a twelve month period, in order to be refunded $100.00 (1979) ($10.00 per visit), before the 80 per cent extended health discount kicks in, on the 13th visit in that 12 month period. For people with money, this does not present any significant challenge to receiving treatment, but for a
woman barely managing, she is forced to choose between paying for treatment, or paying her rent.

...even my psychiatrist says that I need way more medical care than what I will ever receive here, unfortunately, and suggested that if I manage to get the money and can get somewhere (the States or France) to have a proper full health assessment, (same thing the surgeon in Seattle told me I needed) that's what I need to do. My mom always joked that 'money talks & bullshit walks! Lord knows that if I had the money, I would be fixed...I would not be suffering, reduced to less than an animal...they restored a tree in Stanley park for $30grand! and a 3 legged dog got a prosthetic leg...truly saddens me that I am this disposable and unimportant... some say money can't buy happiness... wanna just smash them in the face...go all joe pecci on their ass! lol. This illness has stripped me of any joy and filled me with such rage! There goes that crazy lady again, scaring all the little children...lol omfg...it's been almost 9 years! that is just too long...but if you're an asshole your an asshole no amount of money changes that! lol... (2009, participant interview, He/).

The observation that a woman is frequently “only a man away from poverty” (Baines, Evans, Neysmith, 1984, p. 180), highlights women’s proximity to poverty and the economic vulnerability of women who are on their own. One participant disclosed that she was forced to remain in abusive relationships (throughout her life), but especially since becoming ill, due to her inability to afford housing, utilities, groceries for her children, and student loan payments (unless she paid one bill but not others) without a partner or a roommate to offset the costs. She thought that a career in social work would bring her financial independence, but rather she says “I’ll be in debt now until I die because there is no way I will ever be able to recover from the financial devastation from this (illness)... I can’t even work one job anymore, let lone the several jobs I need (and used to work) in order to just pay monthly expenses...” (2009, participant
interview, Hel). She describes living in fear every day that she will “end up in the streets” due to “inability to pay her bills despite her education, tons of books, and some “sooper cool clothes that i can’t wear anyway cuz i can’t really go anywhere… but I sure can look awesome when sit on the throne, before I have to strip it all off again due to painful sweats…” (2009, Hel). She does not define herself as middle class, but as “embarrassingly impoverished”. She described having to go through a “loan shark to get financing for a vehicle so she could still at least drive to her doctor appointments, especially since they are in 3 different communities”. She sold all her furniture and jewelry in order to pay monthly expenses and has nothing really left to sell, and she writes, “I’d sell my blood, but apparently I was anemic so I guess I’m running on empty there too, lol, my options are pretty limited, lol” (2009, Hel). She states that if she manages to live through this nightmare, and finally get the required surgeries, she intends to find a lawyer to sue the various organizations… “dead people can’t sue, lol” (2009, Hel)! And Danu writes this:

When I was younger with a small child it was my parents that looked after my toddler when I couldn’t or was in hospital, I understand what a blessing that was. My mom came and lived with me a few times while the anti depressant kicked in to help with cooking and daycare. Now I try to fill my day up with friends, exercise, reading while I wait for better mental health to return (2009, participant interview).

Transken (2003) refers to Diane Meaghan (2001) when she writes “a neo-liberal agenda has increasingly encouraged a close proximity between institutions of higher learning and the marketplace” and there is an intensification of “emphasis on productivity, accountability, vocationalism and privatization that is transforming policies and practices within” (Transken, p. 12). Oppression is often found in such areas as education, the production and distribution of goods and services, public administration, the delivery of health and social services, and the like (Foucault, 1977; Mullaly, 1997). Female social workers may be facing additional challenges
outside of her employment. These include lack of access to services such as daycare, transportation, medical care and sustenance, which are limited by modest incomes. Kali writes this:

I felt alone, afraid, angry, stupid, co-dependent, whiny and pitiful, I felt needy and tiny and sick... Not wanting to feel anything of it, I put on the everyday smile, buttoned up my suit, put on my polished shoes, downed my Excedrin, drove my kids to school in town and all the while wondering how I would go through another day (2009, participant interview).

These challenges increase considerably for many new social workers who are trying to raise families in isolated, rural and northern communities. For those female social workers who are experiencing disability/illness, and specifically, those whose illness is invisible, the challenges can become unmanageable. Danu describes the following:

My experience with an invisible disability is that people are generally skeptical; if you can't see it, it doesn't exist. How do we know you aren't just making it up to get sympathy? Feeling like you have to explain yourself for sitting in an able looking body. In the case of mental illness you have to sell people on the belief it is a real illness on top of it being invisible. No one ever helped me or my child when I was in the paralysis of major depression or when I was hospitalized with depression. I had way more visitors from friends and co-workers when my body was broken. It was a profound difference (2009, participant interview).

In a study about a growing concern of workplace violence, Mama (2001) described that "workplace violence occurs in a variety of settings" and is not limited to employees and employers but also has implications for students. Mama's study also noted that very little literature exists regarding workplace violence and oppression of social work students at either
BSW or MSW levels (No Page #). This is relevant to my research as it has implications for the social work profession.

**Gate Keeping**

Social work is the only program that I am aware of in British Columbia for which a two year period exists between undergraduate and graduate studies? No such policy exists in the province for programs in education, medicine or law. This is apparently to ensure that applicants have some grasp of the nature of the employment (although there have been some "unintentional" exceptions to this rule). And volunteer experience, (along with the personal statement and academic criteria) is a prerequisite to entrance to most reputable BSW and MSW programs. These policies ultimately ensure that applicants remain in disadvantaged socio-economic positions, regardless of intention.

Many present social work students are from blue-collar, working class, low (to low-middle) class backgrounds, rather than from middle (to upper middle) class privilege which used to be more commonly the case, and these students (and hopeful applicants) are likely experiencing a layering of oppressions, including that they are also more frequently single parent females, violence survivors, of rural citizenship, and possibly of minority or aboriginal ancestry. The MSW application process systematically prolongs the time frames between accessing positions where rates of pay increase, which would provide social workers increased ability to repay student loans and to sustain herself and her family. The required time spent in the work force, pre-graduate school, ensures that the social worker receives just enough income to seduce her, but not enough income to enable financial advancement. Therefore, the gate-keeping practices impose a type of gender violence wherein graduates from social work programs are limited in

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22 Social policy in Canada is shaped by what is called the "divided sovereignty" (Van Loon & Whittington, 1976, in Westhues, 2003). This means that jurisdiction has been given to the federal government for some areas of policy development and to the provinces for others.
their employment options from the beginning of their careers. In order to advance in the social work field, due to limited employment options with only a BSW, a practitioner must obtain her MSW (or a nursing degree/diploma, as supported by current postings on a variety of professional/government sites). But, in order to do so, she must also first satisfy the criteria allowing entrance into graduate studies, which first includes completion of the two year requirement of practice experience. Then, to further satisfy the admission criteria, she must find the time to put in more volunteer hours, while working a full time paid position, while (also possibly raising a family and) dealing with her own unique life situations. For many women, those life situations include living with an invisible illness/disability.

The gate keeping practices I have described as they relate to social work education/degree programs are not dissimilar to the structures existing within our health care system, where access to treatment, medical tests, and specialized care is controlled by the general practitioners and one’s access to the financial means with which to jump the queue and pay for services in either the subsidized public system or in the more elite private realm:

When a doctor assaulted me symptoms from a past episode of the chronic medical condition I live with were used to refute the competency of my testimony...When I was assaulted at work and the stress caused a relapse in my chronic medical condition WCB said it could not be attributed to the assault because it was a “pre-existing condition” (2009, participant interview, Danu).

One participant writes that it is the four year anniversary of when she went to the USA for medical tests (she first became ill in 2002), and she has not yet received surgical repair. She describes a situation where she was given the name of, and asked to see a diagnostician, whom used to be the head of the colo-rectal surgery department at the hospital down south where she “had the misfortune to see the most abusive and condescending surgeon EVER” (2009,
participant interview, Hel). Her request was denied with no explanation. "I still don’t know why" (2009, participant interview, Hel). She states also that during one of three meetings with the senior medical advisor for the (region withheld) health authority, to discuss her ongoing medical battles and lack of adequate/timely medical/surgical treatment, he said to her, “you jumped the queue. You know as well as I, that it is political” (2009, participant interview, Hel). Interesting to note is how the politics and outcome of the “queue-jumper” in the following article vastly differs from the participant’s described experience:

Canadian medical association president Brian Day yesterday admitted that he pulled strings to get a same-day CT scan for his then five-year old daughter. “To me, it's completely unacceptable, sending a mother home for six days not knowing whether her daughter has a malignant or a benign bone tumor. I made the phone call...I made them do it that day”. Day recalled his experience during a discussion with the Ottawa Citizen’s editorial board of what he calls the “parallel public system”, a system of social connections that makes it easier for people in certain class of society to get quick access to treatment. He said himself used the system when he needed knee surgery, jumping a long queue to get the procedure done within a week. It’s not unrealistic, Day said, to expect people not to use connections to queue jump (Tuesday December 4, 2007, p. A10).

Professional Absurdity

I believe that women are entitled to work within a social work profession where the working environment fosters support and encouragement and positive health, rather than an environment that is conducive to victimization and abandonment. Rather, there is an absurdity within the profession of social work I which the female employees are obligated to extend themselves far and beyond what would be expected of (unwritten roles within job descriptions) employees in other non-traditionally female types of employment.
For example employees working in accounting firms, law firms, computer companies or within the construction/trade labour industries would not be requested or guilted into working unpaid overtime, (either in the office or at home) hours, either in the office/jobsite or at home. It would be neither fathomable nor ethical for these employees to be implicitly or explicitly coerced to provide after hour services to clients, free of charge. It is also expected that we attend countless functions and sit as members on numerous committees, (again on a non-paid basis, over and above regular scheduled working hours). And in our spare time, we are also expected to bake/buy cupcakes, muffins, and cookies for these benefits, fundraisers, board and committee meetings. Is this perhaps due simply to our “nurturing and caring” temperaments?

It has also not been my experience to witness society demand free labour from physicians (consider the provincial medical system’s mandated fees charged by doctors for completion/signature of simple medical-related forms). And can you imagine if physicians were expected to provide free consultations, work countless hours of unpaid over-time, experience reductions of benefits, and loss of wages for government claw-backs (as was the case in 2002 for provincial ministry positions)? Or if under-educated, para-professionals were contracted to do fill positions, (some on a volunteer basis), resulting in job losses and pay-reductions? Yet this is condoned, perpetuated, enabled, and built into the very structures of the profession of social work (and some other traditionally caring professions). This marginalization of social workers (and the profession) is reflected every time a worker goes on medical leave and her position is not filled, but instead the other workers (if there are any) are expected to manage her caseload in her absence. We see this when social workers struggle to complete paperwork for court dates and paperwork for their files, and update files on their online systems, while the intake calls pour in and they attend one crisis after the next, and when traumatized workers request debriefing for
situations, but none exists or it is extremely limited, and when junior workers, need and request supervision but none exists.

“Our entire social system relies on the massive economic exploitation of menwim. And because not a single wom is capable of thinking of the world ‘manwom’ without thinking ‘sex’, menwims’s entire rebellion is put down as a sexual rebellion” (Brantenberg, 1985, p. 228).

Ultimately, without the unpaid work of, and the altruistic nature of those females employed within the social work profession, the social welfare system would be immobilized. Our profession implicitly relies largely upon the fact that women are socialized to nurture and care for others and that many women will naturally assume such responsibilities when called upon to do so. Our budgets depend upon this fact. The social welfare system is designed in such a way so as to utilize the unpaid “volunteer” hours of those who are dedicated and caring. Benzon (2003) wrote “these individuals are likely to attract the attention of these predators and so are more likely to be killed than others in the group…” (p. 36).

If we understand that oppression and marginalization of women is conducive to gender-violence and that although gender-violence is an individual problem, it is also very much linked to the larger systems of community and society. It is essential that we deconstruct female oppression and marginalization in order that we are able to appreciate that it is a symptom of capitalism, patriarchy, classism, sexism, able-ism and power imbalance. We must also identify how it is manifested within our profession and how it works against the very concepts and principles that are the basis of our work. We must view female oppression and marginalization as a public issue, as it relates to our practice and as it relates to the overall health and well being of women. Our role as social workers is crucial to our work with marginalized and oppressed individuals and groups. We are, in essence, the liaison between society and the clients we support. It is part of our jobs to make private troubles public issues. We must have patience
and be as gentle as humanly possible when we are working with the effects of discrimination and violence. We must be educated and culturally sensitive to the dynamics of oppression and the meanings attached for the individuals. We must remain compassionate, empathetic and objective when working with our clients.

So why is it that when women (social workers) experience these same oppressive, marginalizing and traumatic factors, which have clearly been linked to issues of mental and physical health and social worker retention, that our needs, as supported by the literature, are ignored and we are left isolated? And not only are we unable to help our clients, but we are equally unable to help each other: “In general, support to service providers is irregular and inadequate. Supervision is not available everywhere. In the health care and social services system it has become a relatively rare commodity, so that service providers must mutually support each other” (Baines, Evans & Neysmith, 1984, p. 152). Female social workers effectively experience a dual victimization in that we are immobilized in our workplaces to be of help which violates our spirits and when we experience physical symptoms we are further violated when we ask for help: “I would just fuckin cry when People were kind to me, they are so few...” (2009, participant interview, ChaChaCrowBear). Gondolf argues that “women meet an equally tentative response from the helpers” and that “malpractice suits, no-risk clauses, privatization of services, severe funding cutbacks, and a laissez-faire public attitude have brought reluctance rather than initiative to the helping professions” (1988).

Many aspects of female socialization cumulatively “accomplish” women’s identities in ways which are perceived as inconsistent with leadership identities. Benoit (2000) writes “in management, for example, women are clustered in the least responsible and lowest paying jobs...” (p. 72). Social workers often appear to possess significant amounts of power within agency frameworks; however, the individual social workers within those agencies are relatively
powerless. Visible minorities and disabled equity groups are somewhat underrepresented within the social services sector as a whole. They are also somewhat underrepresented in management positions (CASW, p. 6). Those in power are generally, upper class, white, heterosexual men (Carniol, 1992). It is understood that the farther one gets from this description, the less access to power one has. Without access to power, one is underprivileged or marginalized. Therefore, it could be stated that as a group consisting largely of women, social workers essentially have little access to power and its privileges (Glenday & Duffy, 1994).

These descriptions have led me to question how it is that a profession that subscribes to the philosophy of “respecting the intrinsic self worth of persons” (BCASW, 1999, p. 4) would condone situations of workplace abuse, abandonment, and ultimately the “consumption of its own”? These behaviors appear to be especially relevant when a social worker becomes ill, and requires special treatment or time-off. Moreover, when the illness is invisible, or not automatically apparent to onlookers, the behaviors seem to elicit animosity, and the disabled worker is frequently subjected to damaging treatment by her colleagues.

Much of the time it is her coworkers who are left to manage the resultant increase in case-loads, with nothing by way of additional support. It is this phenomenon that I will concentrate on for the bulk of my research, one in which I refer to among similar-minded peers as, “how the profession of social work consumes its own (young)”: “This last time I was having a hard time, people were diagnosing me behind my back. Making excuses for me instead of saying or describing aggressive, angry behaviours even if it was justified” (2009, participant interview, Danu).

Although women make up the majority of social work students, workers, and clients, women have the least access to power to ensure that their needs and interests are reflected by social work education and practice (Reamer, 1994, p. 309). Reamer describes that people have
conceptualized that the “really big problems” of social work, including poverty, racism, and chronic physical and mental illness, are more important than and unrelated to nonsexist practice or attention to women’s distinctive needs, and are unable to see how women are disproportionately affected by these growing social problems (p. 317). Gondolf, (1988) describes what they called “a more fundamental problem to be addressed—that of learned helplessness among social services, where service staff face the ‘uncontrollable’ environment, noted by the proponents of learned helplessness, in terms of unchanged clients, overwhelming caseloads, and insufficient resources” (1988, p. 99). They state that this in no way negates valid “claims of sexism and systematic neglect” and that there was “no compelling motivation to draw on some survivor instinct to halt learned helplessness, because most of their jobs are assured despite their work conditions” (1988p. 99). I took liberty to assume that they were referring to social work positions protected by unions, in which regardless of circumstance, workers receive payment for services.

I am exploring this subject because the absence of these crucial elements within many working environments is conducive to female oppression and marginalization as it is experienced by social workers, most of whom are women. I have outlined some of the factors that I believe are relevant and contribute to the ongoing oppression and marginalization of women that occurs within the profession of social work. It is my intent that my research provokes some thoughts and discussion about how we have become sensitized to the nature of gender-violence, and the oppression and marginalization of women, and as a society we have condoned and reinforced it within our structures. My core assumption is that agencies employing social workers should value and enhance people’s dignity, self esteem rather than destroy it. As a social worker, I feel saddened that in an environment where I am to promote the “intrinsic self-worth” of my clients, I have little value to my employer, to the profession, or
as a woman. I am in essence, a commodity, and I must adhere to the CASW expectations, or as per the Board of Registered Social Workers, I could be subject to "disciplinary measures including but not limited to, an educative warning, reprimand, limitation of right to practice social work, suspension or cancellation of membership". But conversely, there is little accountability of the profession itself to those of us, who enforce its mission as the "Dobermans to the Gestapo" (Transken, 2004): "Worker discourse is silenced, and workers are subjected to a cost-benefit analysis and trade-off" (Sass, 1998, p. 18). This is reflected in the following participant quotation: "But when it came to supporting one of their workers the company's high moral stance on assisting those with a disability was thrown out the window. This of course was because I was costing them money. I mean they loved me when I helped make them money but their financial compensation was pathetic" (2009, participant interview, Venus).

EXPLORING THE LITERATURE: PART II
CONFLICTIONS & PRESCRIPTIONS: Reality vs. Delusion: Social work and the North

Vicarious Traumatization, Transference/ Counter Transference, Compassion Fatigue and the Social Worker

The very nature of much of our relationship as social workers/researchers is likely to be uncomfortable and often traumatic. We are exposed to many detailed, explicit accounts of an often uncomfortable and potentially damaging nature. Vicarious trauma experienced by us through our clients, is an "occupational hazard" to trauma work, and has the potential to trigger our own memories. We react to this on both conscious and subconscious levels. This makes us inevitably vulnerable to vicarious traumatization and compassion fatigue. The experiences shared by my participants included gripping accounts of a highly sensitive and personal nature. These stories evoked thoughts and emotions from myself, as well as from the participants. "Emotions can be used as "markers" to recollect and relive field experiences during the analysis. Angen (2000) outlines the dangers of secondary traumatization for qualitative research staff
(undergraduate interview transcribers) and concludes with advice on how to emotionally protect and prepare one's assistants. I question how, if simultaneously women are experiencing (or are still processing previous) trauma within their private and/or professional lives, are we able to balance the factors that are consequential to the profession? How we manage this phenomenon is imperative to the work we do as social workers/researchers so that we neither cause harm to ourselves nor others. The very essence of what we need to protect ourselves conflicts with the practice realities described by female social workers.

For instance, social workers claim that large portions of their work is done within a context where the staff is under-supported, and under-supervised clinically: Ingebrigston (1992) writes “unfortunately, most social workers experience lack of support and absence of supervision” (p. 154). Similarly, Pearlman & Saakvitne (1995) offer that much of this work is done in relative isolation. Many agencies recruit new, inexperienced social workers and provide minimal training and supervision. And Ingebrigston (1992) reiterates that this is especially relevant in a northern context where there typically fewer resources as compared to larger urban centres, and therefore the social worker role is expanded to include a variety of duties that might otherwise be contracted to other/outside agencies.

Many women describe working in isolation, and are on call within their communities, twenty-four-seven, and have no adequate clinical supervision. Therefore, due to lack of balance, we become more vulnerable to a variety of traumas. For example, if we are unable, due to budget constraints, to refer a client to a colleague, and we do not benefit from time off, or receive therapy for ourselves, then we risk becoming mentally or physically ill. Thus begins (or resumes) the cycle of violence, as we then might require (medical) time off work, thereby leading us deeper into impoverished states, and despair: Pearlman & Saakvitne (1995) argue that “not
having a consulting relationship within which to speak these feelings leaves a therapist in a place of perpetual isolation, doubt and shame” (p. 383).

Worker traumatization is especially devastating when we work in small agencies with violent, abusive people in positions of leadership and power. The experiences of women who have worked in such environments are littered with “HORROR” stories: “I saw the system persecute the victim and create a haven for the offender...nothing new for Indianz and poor folk...Bout that time we got a real sick fuck for a director... transference ...he was a terrorist, manipulator, racist “inRecovery” dude... (2009, participant interview, ChaChaCrowBear).

Pearlman & Saakvitne (1995) refer to Louden (1992) when they explain how “both rest and play can allow us to connect with interests and parts of ourselves not present in our work” and they discuss “laughter is a powerful antidote to the gravity of our work, the use of humor a kind of restorative exercise in perspective taking” (Pearlman & Saakvitne, 1995, pp. 394-395). Terr (1999) illustrates “…by maintaining a connection to the lighter, playful side of life”, (p. 199) we are better able to manage the darker nature of things that may be uncomfortable or frightening and we are then more able to assist our clients. She adds, “play is a good barometer with which to measure mental health” (p. 199).

Stephenson, Rondeau, Michaud & Fiddler (2000) write that sometimes social control or social containment oriented agencies accidentally (or intentionally) reproduce various forms of violence, such as trauma, abandonment, and poverty on its own members because the structures we are embedded within make it almost impossible to do otherwise. Ultimately, “the combination of funding constraints and increased and intensified service needs contributes to very stressful day to day working conditions, with high employee burn-out” (p. 83). For example, many non-profit organizations are given such poor funding that they cannot provide adequate compensations such as pension benefits, maternity benefits, or sick leave, for their own
staff: “Social workers in the private or not-for-profit sector have fewer benefits than their counterparts in the government and hospital industries” (p. 84). Many staff in these types of organizations can become to feel abandoned, or abused by a structure within a larger structure, which, in effect is symptomatic of oppression. Social workers are overloaded with massive caseloads, pressure to close cases and limited resources to provide services, and many social workers within various agencies are doing contract work, part-time and underpaid work, emotionally draining, and demanding work, and even physically abusive work (such as the work in many group homes, nursing homes, hospitals where social workers are working with mentally ill patients). “Contract employment also has added stress to the lives of many workers. It is personally difficult and it is also challenging to do social work, especially counseling, if you’re not sure that you’ll be staying in the job” (Schmidt, 2002, p. 93).

Pearlman & Saakvitne (1995) refer to the work of (Farber & Heifetz, 1982; Guy & Liaboe, 1986; Kaslow & Schulman, 1987; and Pearlman & Mac Ian, 1994) when they describe that balance is crucial to clinical social work. Maintaining a balance and wholeness between our physical, psychological, professional and personal health is crucial to our well being as social workers and as women. I emphasize that we must not separate ourselves from the work we do, but rather we must complement it with the entire self. This whole self includes our conscious, proper-self, as well it includes the darker, shadow-side of our psyche. The Social Work Code of Ethics (2000) legislates that we promote the value and dignity of our clients. It is impossible to adhere to this code if we are not fully capable due to structural limitations within our profession. It is our responsibility to our own mental well-being to remain aware of our own needs, set our limits and access resources within our social work practice. In order to facilitate this, we need to

23 “Good health—physical, emotional, social, and spiritual well-being at all stages of life—is key to women’s equality. Conversely, gender equality is a necessary condition to achieving good health” (Status of Women Canada, N.D.).
have balance between work, rest, and play (Pearlman, & Saakvitne, 1995). Sadly, it is almost impossible to for many social workers to actualize this.

Pearlman, & Saakvitne (1995) also describe limiting caseloads as a useful strategy to minimize work related stress and burn-out. This includes the ability to “say no” to certain cases. The reality of this when working in rural, or isolated northern contexts is slim. Often social workers are working in relative isolation and may be the only worker available to do this work. Pearlman & Saakvitne stress that there are ethical, clinical and personal considerations to continuing to do stressful work when a worker is already depleted (p. 390). Other essential components to overall positive worker health, as outlined by Pearlman, & Saakvitne (1995) include “adequate pay and time off, health insurance with mental health benefits, access to continuing professional education, weekly clinical supervision by experienced clinician” and they suggest that “becoming involved in social action to help increase the rights of victims can help reduce the negative impacts of the work” (p. 393).

“The importance of personal therapy for the therapist cannot be overemphasized, and has been recommended by others as a way of remaining open to ourselves and our clients” (e.g., Farber, 1983b; Freud, 1937; Guy & Liaboe, 1986; Kaslow & Schulman, 1987 as cited in Pearlman & Saakvitne, 1995). These elements are quite absent in many contexts within the profession of social work, and I argue that this absence colludes to the gender-violence that is imposed on social workers, many of whom are women: “The truth of the matter is that worker experiences and their making sense of their work environment is subsumed by “scientific” certainty which does violence to the truthing process of their questioning their actual working conditions. Occupational health and safety professionals structure this reality” (Sass, 1998, p. 21).
This professional reality, as experienced by many social workers, is contrary to what the literature presents in relation to post traumatic stress disorder, trauma debriefing and in regard to worker retention, especially in isolated, rural, and northern communities, and this reality conflicts with maintaining positive (mental) health. Purewal & Ganesh (2000) criticized the mental health profession regarding its failure to recognize the psychological trauma that women are exposed to in reference to gender violence.

For instance, Lewis (1980) describes that social workers are being pulled in so many directions and are facing so many pressures that they warrant the description “battered helpers.” (Jayaratne & Chess, 1984; Pines & Kafry, 1978 as cited in Soderfeldt, Soderfeldt & Warg, 1995) similarly states that social workers are at “above average risk of burnout.” Tranter and Vis (1997) also describe the need for ongoing self-care and importance of team work and debriefings in regard to work with traumatized clients.

It seems that the organizational structures of the social work profession are either unaware of these oppressive and ultimately violent working conditions, or rather is it that the women who are working within the social work profession are so devalued, that there has been little consideration for their protection from within the profession itself? Stephenson, Rondeau, Michaud, & Fiddler explained that the retention of social workers can be more difficult if their occupation is undervalued, and that this can have a negative impact on workers (p. 86). Rather than acknowledging unhealthy work environments, and attempting to remedy the situations, more frequently some workers are identified as non-complacent, problematic, incompetent or merely trouble-makers. “Others not so close decide that it is my bad behaviour, bad manners, character defects that cause my mental instability not the other way around. They judge my difficulties with mood, employment, relationships as the consequences of my choices, my deficits” (2009, participant interview, Dana).
Stephenson, Rondeau, Michaud, & Fiddler (2000) also mention that a particular challenge to employers is the retention of Aboriginal service providers. They state that this is difficult in remote communities, due to the environmental stress of these communities and also they note the challenges faced when working in one’s home community. (p. 84). “The additional toll on workers in rural or northern settings, often serving high proportions of very high needs clients, is a particular concern” (p.83).

Aboriginal Communities

The north has the fastest growth rate of senior citizens and 13 percent of the population is Aboriginal, the highest proportion in the province. And in regard to retention of social workers in northern communities, a strategy has been to promote the higher education of Aboriginal women in order that they return to their communities to practice. But it has been a struggle to find Aboriginal women with the academic qualifications necessary to fill positions in social work within Aboriginal communities. CASW (1996) statistical data indicated that there are “disproportionate numbers of Aboriginal peoples using services” which has created a greater need for “available, qualified, Aboriginal service providers to serve Aboriginal persons in northern remote locations” (p. 9).

Narrator: And ...the silent voice of the invisible Indian says...

Invisible Indian: But what about “me”?...Are you so afraid of “me” and “my truth” that you can not listen to “me” and “my story” without having to dehumanize “me” and “my truth” by assigning numerical scores to do statistical analysis on “me”? “All I wanted you to do...was...to just to listen to “me”...with an open heart and an open mind.

Narrator: And the human rights activist Indian goes on to say...

Human rights activist Indian: Where is the “heart” and “soul” in White Nation social work research and clinical models? In our Red Nation research and healing conferences, we rise above their “scientific
dissecting” and “intellectual oppression” to hear our voices and open our hearts and souls to share our sacred truths with others.

Narrator: And...the courageous Indian whispers...

Courageous Indian: this is what happened to me...this is what it is like to be dehumanized...this is what was done to me... (2003, Hosanna Waa ksis to akii, Sow613, Book-review notes, p. 4).

A disproportionately large percentage of our province’s impoverished people, are Aboriginal women. “In 1996 about five percent of all lone-parent women were Aboriginal” (Status of Women Canada, p. 31, N.D.). Many First Nation women remain at the peripheral of our communities and are isolated further by a lack of access to services that may be available to them within larger community centres (Glenday & Duffy, 1994; Duffy & Mandell, 1999). Not only are First Nation women both oppressed and marginalized but they have suffered tremendous indignities throughout colonization such as the residential school era, when their traditional beliefs and familial roles were stripped from them (English, 1995).

In reference to Morissette (1993), Henning (2006) writes that First Nations women have “experienced assaults on their spirituality, lifestyles and communities and have described feelings of worthlessness, inequality, and self-blame” (p. 52). English (1995) describes how “Canada has a mosaic that is stratified according to class, race and gender” and that this “classification causes grave problems for women of colour, other minority groups, and especially Native women who appear lowest on the hierarchy” (p. 112). She includes in her argument that native women “have low incomes, poor education and minimal political authority” (p. 112).

Many First Nation communities have been subjected to the traumatizing effects of the residential school syndrome, when their families and their cultures were torn apart. Colonization created dysfunction that has contributed to violence within First Nation communities (English, 1995). This ongoing devastation includes lack of family support due to isolation, addiction
issues and language barriers. It is the racist and patriarchal nature of our society that contributes to this trauma and abuse today. And although it is present in all cultures, and despite that is absent of colour, it remains largely a symptom of the sub-citizen class of women in all societies. But many aboriginal women experience a “revictimization” from the agencies that are supposed to provide services (p. 225).

The agency was/is a very Unbalanced triangle place of employment…it should be a mother Fucking CIRCLE For the Good of the People. TeamLeader and admin are held by non native people, one is in the pocket of the other…One is a woman notorious for controlling to the zenith…always wearing more than “one hat” and “deferring money around, does not build up capacity, does not train, takes admin fee off the top of every program, makes $33.00 an hour while the Indian girls…many in their Own Territory make $9.00 an hour…tried to make me be her “token Indian” and I refused, I work for/with the People….It is their agency… alas it is NOT and they know it and they won’t use that place, very few, some urban skinz go there. (2009, particiapant interview, ChaChaCrowBear).

Burstow (1992) writes that “we owe it to our Native sisters to acknowledge that we are dealing with sub-oppression, as well as oppression”, and that we must acknowledge that “all have been robbed of land, language, religion, and self-governance”, and “many were systematically brutalized in childhood” (p. 73). She describes that “a way of life for First Nations people was accommodation” which is “derived from a deep respect for all beings and from a fundamental sense of connectedness”. She explains that although accommodation in a cooperative world is “unproblematic and wonderful”, for many Native women, accommodation

24 “Women who face barriers due to factors such as race, ethnicity, Aboriginal status, disability, marital breakdown or the experience of violence and abuse, often do not compare favourably to other women or to men within their population” (Status of Women Canada, N.D.).
has been witnessing white people “plunder, steal, and rape what is Native”, ultimately becoming party to “one’s own subjugation” (p. 73).

Batiste (2002) writes that “Indigenous peoples worldwide are still undergoing trauma and stress from genocide and the destruction of their lives by colonization. Their stories are often silenced as they are made to endure other atrocities” (p. xxii). Woman (Rose von Thater) writes about the knowledge and experience she gained at the gathering:

We were bringing to conscious recognition those elements foreign to our knowing that had entwined themselves within us, sapping us of our natural strength. We were seeing the experiences that had defined our lives with new eyes. We were looking at our history, accounting for its impact, taking ourselves to the doorways of understanding, discovering new possibilities, other strategies, watching as sources of power and strength emerged to reveal themselves in a new light. From this place and from these days together we were selecting, like artists, the elements that would tell a new story, taking from the past, re-ordering the present, envisioning a future that felt very much like a vision that had been held for us until we could reach out and hold it for ourselves (Personal communication, June 27, as cited in Battiste, 2002, p. xxii).

Transken (2004) honours the work of Mihesuah (1998) and Smith (1999) when she discusses the importance that we do not misappropriate, the knowledge shared with us in confidential sharing circles (ie. research interviews) by our participants. These kinds of thefts have contributed to the oppression of First Nation women: “Appropriating – taking something for one’s own use – need not be synonymous with exploitation. This is especially true of cultural appropriation. The ‘use’ one makes of what is appropriated is the crucial factor” (p. 23).

Education has been important in regard to the empowerment of First Nations people as well as it is essential to the reclaiming voices that have been taken due to colonization and oppression
of Aboriginal women historically. But sadly, First Nations women working in social work have
described experiences of extreme trauma including verbal attacks, nepotism, and racism.

*ChaChaCrowBear* describes this:

Always as is HumanNature there is scapegoating goin on there. I raised issues, having just
*come from residential treatment where you gotta clear each crisis as it presents...* when I got
manic, I decided after 2 and a half yearz of hustling, trying, frying bread, practising integrated
case management...I decided to up and leave...fuck it...I was now feeling like a sell out at
this facade of a aboriginal family centre......they wanted me out, so they were
like..byeee...and made me sign a paper , before ANYONE could get their cheque that “I
would not be returning to my job after medial e.i. claim” found out later this is
illegal...(2009, participant interview).

Social workers in small, rural, isolated, and northern communities seem to identify the same
practice difficulties regardless of whether the workers are local, or transplanted. Factors of
visibility, isolation, safety, lack of supervision, and lack of privacy are reported to be
commonplace and present as some of the primary challenges to implementing programs,
efficiency of care plans, and social worker retention. “We need to rely on community members
who want to get a degree or a diploma, and then come back to the community” (Schmidt, 2002,
p. 112). “It’s very difficult to get employees at all [up north]. It is hard to find people to work in
the wilderness” (p. 112). Interestingly, I find it strangely ironic that many ‘new’ methods
proposed by policy makers which we are currently exploring in the social work field, are not so
unlike the methods of First Nations (and ethnic) communities prior to assimilation.

Study results from Schmidt (2002) regarding retention of northern social workers listed
various isolation factors, including professional, global (ie. internet and television) and personal
isolation, as reasons workers leave communities (p. 207). Visibility within the community, lack
of anonymity and privacy were also identified in this study. As well, opportunities for professional development and high costs of living were identified. Importantly, lack of clinical supervision, lack of mentoring, and lack of access to supervisors were noted as factors that contribute to workers leaving their employment in northern communities. As well, lack of orientation/training for new social workers and rapid advancement to supervisory positions, without relevant increase in practice knowledge, contributed to the challenging experiences of some social workers. Centralized decision making was also noted as a challenge, as this represents the lack of support and understanding from upper management and an ill-fit of policy to northern practice realities. As one participant states, "I could have sued, raised hell at best, but it's a small town, I gotta pick my battles..." (2009, participant interview, ChaChaCrowBear).

The CASW (1996) study found that "social workers who were visible minorities and Aboriginal reported lower earnings than the average for this occupational group" (p. 7). The study failed to mention that the opposite is the case for Aboriginal workers employed by Aboriginal agencies, working on reserve land. In these instances, Aboriginal employees are income tax exempt. Taxes are not deducted from their gross pay. So when we compare the take home pay of two social workers who earn the same wage, (dollar per hour or salary), approximately $43,000 per year, the Aboriginal worker, working on reserve, actually keeps the full amount, (less agency fees including medical, union deductions etc), whereas her non-Aboriginal colleague loses almost half her pay-cheque to taxes (and other employee deductions), therefore, in actual fact, she only nets approximately $24,000 of her $43,000 salary. This creates a lot of dissention in the workplace, as per the systemic and structural divide and conquer hurtful/hateful strategies.
A little off the top...

Murray (2008) refers to what Sylvia Maracle (N.D.) describes as “blood memory” (p. 105; also see Anderson, 2001), which can be understood as a phenomenon in which we have “the innate ability to carry the memories of one’s ancestors” (p. 105). Murray further offers that this can be “physically, emotionally or spiritually driven” (p. 105):

I have a very old spirit, and though I carry an aching sadness for the fate of aboriginal people, the mirror tells me that I was painted by the Creator, with “white privilege.”

Unfortunately for me, I have yet to experience benefit from the paleness of my skin and not even a university degree brought/bought me ‘privilege’. In fact, while I uphill fight, struggle and bleed for mere scraps, careful to duck when yet another government-induced, political assault is fired upon me, those who have been labeled ‘disadvantaged’ benefit from programs, subsidies (and quite possibly surgeries) from which I am excluded...but I recognize on another level that this is yet a means by which government policies perpetuate hatred, contempt and continued segregation. My internal battle is potentially damaging to my work...and I acknowledge this animal with modest shame...it feeds when it is hungry...ever-fearful, careful not to unleash/release it into a devastating feeding frenzy...

(2009, participant interview, Hel).

“The most difficult task of this thesis journey is peeling back the layers of my conscience at a time when I feel particularly fragile. As a victim of childhood abuse I learned well the art of invisibility” (2009, participant interview, Hel). Delaney, Brownlee & Zapf (1999) offer that “in effect, the process of oppression is a process of dehumanization” (p. 12), I offer that so is the process of invisible illness/ dis/ability, in my experience:

...my home was entrenched in violence, anger, alcohol and drug abuse...I was fortunate there were incredible amounts of love and affection, provided some balance. There were
many issues, including isolation, as we lived in a small, rural community outside a larger community...years of chaos, confusion, clouding of boundaries, resulted in my entire adult life becoming a process of unlearning, relearning, shaping and redefining, through my formal and informal education experiences and finding constructive/productive places to place my rage and contempt (2009, participant interview, Hel).

Delaney, Brownlee & Zapf (1999) explained that the “process of ‘unlearning’ is what empowers effective northern social work practice” and it that by understanding these contexts, northern social workers gain an appreciation of the challenges specific to working in rural, remote, isolated, and northern communities (p. 38).

Retention of Northern Social Workers

Geographers attempt to define north by latitude, climate, and circumpolar zones (Graham, 1990, p. 21, as cited in Henning, 2006, p. 44). There are over 300,000 people currently living within the northern health region which covers almost two thirds of British Columbia’s landscape” (p. 43-44). The largest major British Columbian town centre, north of the Trans Canada Highway #1 and Highway 97 North junction at Cache Creek, is Prince George, (population approx 75,000) is located 850 km north of Vancouver, BC.

Sullivan (2002) provides a modification of the Statistics Canada (Rural and Small Town Canada Analysis Bulletin March, 2001) analysis of urban and rural town definitions wherein she argues that “small towns are those where the population lives outside the commuting zone of cities with a population over 10,000 or more, and where less than fifty percent of employed individuals commute to an urban area” (Sullivan, p. 6).

Northern, Rural, and Remote Social Work Practice has three components from a social geographer’s perspective: First, we ask why/what is our purpose for defining ‘northern’ and what relevance does this have to our work (i.e. access to and availability of services), and how does the
definition determine elements of remoteness? Second, there is a series of Quantitative Measures, including population size, population density, and remoteness that must be considered. And the third consideration is the Changing Social Construct, such as policy changes which may render the location increasingly remote as cuts to programs and services occur. For instance, the community may not have been remote prior to such changes but now geographic distance to larger centre where e-services are available becomes paramount (Halseth, 2004, informal interview).

Geographically, raw resources are extracted and exported to the south, from the north. This economic process occurs outside of urban context, typically in rural and remote settings, far removed from the privileges experienced in more populated, southern communities. Most communities in British Columbia, for example, have less than 100,000 people. They generally rely on one or two large corporations, industry or agriculture to sustain the local economy. They typically are an hour's driving distance apart, with a (half an hour) smaller sub-community located between the larger centres. These driving distances tend to increase the farther north one drives and are largely dependent upon weather/road conditions.

The retention of social workers in isolated, northern communities has been problematic for some time (Whittington, 1985). “Increasing caseloads, difficult working conditions, stress, and lack of peer support present barriers to attracting and retaining social work professionals” (CASW, 1996, p. 25). It is common, in today’s labour market that social workers relocate for employment opportunities:

I had left my hometown and province in order to get this job and be able to support my children. I was approximately 14 hours from all of my family and friends, including the father of my 4 children...Raising 4 children on my own, far away from family support...I had no support!...I was on my own most of the time (2009, participant interview, Kati).
Many new social workers find these opportunities are within northern, rural, remote and isolated communities. New employees are highly vulnerable. It is also common practice for many social work employers to hire recent graduates from university and college social work programs. Unfortunately, all too frequently, little training is offered to new recruits and rather they are thrown into huge caseloads, and are often required to work within several different communities (Schmidt, 2002). This type of movement further isolates a new social worker who is attempting to learn the duties of her position. She becomes less able to turn to her colleagues and supervisors for support due to the fact that she is essentially geographically and physically estranged from her peers. She remains the “new face” in the office. This type of movement makes it also difficult for the new social worker to know her clients or get a feel for her caseload. These dynamics are especially relevant when workers are transplanted from outside their home communities into new geographic locations, and especially when there are significant differences between what workers define as “home” and their new environments.

Zapf (1993) describes that personal history and attitudes may be associated with recovering from the culture shock experienced by relocation to northern communities (p. 694). This study also found that women reported significantly less recovery to the shock of relocation to northern /isolated communities than males. The possibilities of role conflict due to expectations within her home, at work, and within the community were given as potential explanations to this finding but it remained unclear. Stephenson, Rondeau, Michaud, & Fiddler (2002) describe that “social workers in the private or not-for-profit sector have fewer benefits than their counterparts in the government and hospital industries” (p. 84). Many staff in these types of organizations can become to feel abandoned, or abused due to the down-flow of structural power, which, in effect is symptomatic of oppression. And much of this work is done
within a context where the staff is under-supported, under-monitored for protection, and under-supervised clinically (p. 152).

Thomlinson (1999) writes “supervision and consultation practices are guided by a strong emphasis on ethics and integrity (p. 508) in accordance with the CASW Code of Ethics (1996) and the NASW Code of Ethics (1997). She also states that “supervision is the process that gives novice social workers the opportunity to learn, and to think carefully about what they are experiencing” (p. 508). “Unfortunately, most social workers experience lack of support and absence of supervision” (p. 154). And as well, much of this work is done in relative isolation (in urban and remote communities). Many agencies recruit new, inexperienced social workers but then provide minimal training and supervision. This is especially relevant in a northern context. As well, according to the CASW, the “combination of funding constraints and increased and intensified service needs contributes to very stressful day-to-day working conditions, with high burn-out (p. 11). “A particular area of concern identified in the study was “the additional toll on workers in rural or northern settings, often serving high proportions of very high need clients (p. 11).

Ingebrigston, 1992; Abramson (1979) write that social workers need to be aware of the special characteristics and skills necessary for working in rural and remote communities. Unfortunately, due to the lack of adequate supervision, the reality for social workers today is that they do not receive enough information or training to fully prepare them for the positions they assume when they commence employment. This is especially relevant when workers are transplanted from outside their home communities into new geographic locations, and especially when there are significant differences between what workers’ define as “home” and their new environments.
Ingebrigston also states that isolation and environmental stresses as characterizing northern, rural social work. Ginsberg (1976) identifies health problems and poverty as important elements within rural, ethnic communities. Stephenson, Rondeau, Michaud, & Fiddler (2002) write that “the isolation is hard for a person who is not experienced, and it’s hard to understand what it is like not to have support professionally” (p. 93). They claim that “what brings people to social work and supports their career choice is basically the desire to help people and to ease their suffering, the will to fight against injustice, as well as confidence in one’s interpersonal relations skills” (p. 150).

Sass, (1998) describes how power can be perceived as violence when peoples’ experiences are ignored within their work environments. “And here “power” is invested in the “official” language which may or may not be relevant to the worker or workers who are suffering. “These procedures and routinization of employee behaviour of the ‘body’ by discipline is a violence to the employee’s sense of worth, self-esteem and dignity” (pp. 18-19).

Regardless of the situation, when a social worker, whether seasoned or inexperienced, relocates to a new community to practice, from the start, her ability to do good social work is often impeded structurally and by internal forces over which she has no control. Further to this, social workers in rural, northern, and remote communities must possess the skills of care-giver, problem solver, counselor and community activist (Henning, 2006, p. 38). How is she able to advocate for her clients, assist them and in any way help them avoid “unnecessary suffering” when she has not been provided an opportunity to adapt and integrate into her new community? Such structural disregard of “compassion and humanity” for the social worker exemplifies the nature of violence against social workers from within the profession as described earlier.

An exploratory study by Schmidt (2002) addresses social worker retention in northern communities. He used a small urban sample for comparison purposes. Data was collected from
social workers and supervisors. Focus group interviews, anonymous survey questionnaires, and private, individual interviews were the data collection methods used to elicit the responses. The social workers' complaints included high work loads and the "implications for worker stress and burnout" (p.121). The supervisors' comments also emphasized that frequent staff turnover created staff shortages that resulted in poor morale, high stress, and burnout among workers.” Supervisors' comments related the ongoing staff shortages to “short-term budget considerations” (p. 111).

Overall, this study links worker retention to safe work environments. The relationship between safety and retention was connected to reasonable case loads, and supportive working environments. Also noted was that due to the high worker turnover, and worker inexperience, supervisors had less time to develop their own clinical supervision skills, and as well, less time was able to be spent providing worker consultation. Schmidt's study supports the argument that (female) social workers are experiencing structural gender-violence in the workplace, as the complaints included burn out, large case-loads, inadequate supervision and consultation, and working in isolation. Schmidt's findings included that professionals should be effectively prepared for what they were walking into, have training/experiences to develop a northern focus, receive added incentives and benefits to help them adapt their practice to northern contexts (2002, as cited in Transken, 2004, p. 5).

The combination of funding constraints and increased and intensified service needs contributes to very stressful day-to-day working conditions, with high burn-out. The additional toll on workers in rural or northern settings, often serving high proportions of very high need clients, is a particular area of concern...there is also an increasing eradication of a coherent service, with the removal of a supervisory role for a professional social worker.
This increases the isolation and uncertainty of the day-to-day work of the social services employee (CASW, 1996, p. 11).

It is my opinion that these oppressive structures are the source of the unhealthy working environments social workers are subjected to presently. Schmidt (2000) refers to Collier’s (1993) “criticism of current practice and approaches” (p. 343). Schmidt argues that Collier was not proposing a new model and that his argument was based in Marxism and developed from an urban context. I must point out that if we do not examine the challenges within the social work profession from a structural standpoint, then we risk blaming individuals for their circumstances. Regardless of whether we utilize an urban or rural social work model, if we do not first acknowledge the structures that determine and govern our practice, we are effectively immobilized and disabled.

Schmidt (2000) also discusses the ecological approach as presented by Delaney (1995), critiquing its urban origin and ultimately ill fit within northern practice. Schmidt’s conclusion notes the need for a model of practice specific to the north that would address issues of retention, integration and supervision as these concepts relate to both economic factors and a multidisciplinary approach. Although this article relates to service delivery and social work practice in northern communities, its relevance to my paper is important because it addresses the issues that reinforce structural violence and oppression experienced by women, specifically in regard to health/wellness, within the social work profession, and obviously in relation to working in northern, rural, and remote communities.

EXPLORING THE LITERATURE: PART III
CUNTROL: Socially Constructed Female

Are We There Yet? Connecting the dots...

Is there a relationship between trauma, oppression, female socialization and women’s health within the health care professions, including social work? Or might it be simply by chance that
female social workers who have experienced invisible illness/disability at some point within their careers in social work have also described experiences of disdain, disenchantment, and abandonment within the profession and further, they have also disclosed previous experiences of abandonment, oppression, marginalization and gender violence?

As one might assume, from the manner in which I have directed these questions, I subscribe to the belief that there are linkages between the oppressive and marginalizing nature of our society's socialization of females and the fact that women tend to migrate towards professions of caring such as nursing, teaching and social work. Benoit, (2000) writes, “yet in the prestigious fields of natural science, engineering, and mathematics, women remain very much the minority, and in those occupations in which women have made significant inroads (such as management law and medicine), there persists the glass ceiling” (p.72). Perhaps it is plausible that “female socialization that used to chain women to the stove and crib may have performed an incomplete metamorphosis and bound them instead to professions considered helping” (Bruce, 2007, personal conversation) 25.

This research is my initial effort to explore the intersections of, and perhaps expose the possibilities of relationships between previous, first-hand experiences of marginalization and oppression, including trauma, neglect, abuse, poverty and abandonment, which might preclude dis/abled women to similar experiences of gender violence within their social work employment. This thesis research journey is not entirely unlike graduate school, where more formalized, collective teachings are, in fact, unlearning what we know and awakening to the diverse perspectives of others. “We are engaged in the experience of conscious-raising” (Freire, 1973).

25 Jim is the primary librarian at NVIT. He is also Métis and is a dedicated scholar and activist in his community both academically and within the social and artistic realms. I am proud to know him and to call him one of few trusted friends. He is often called upon for his wisdom.
Women / Health / Illness /Body Image/ Media Influence

“An enemy is like a treasure found in my house won without labor of mine; I must cherish him, for he is a helper in the way of Enlightenment” (Santi-Deva, as cited in Zweig & Abrams, 1991, p. 194). And “as repugnant as the idea may seem, we need enemies. Human life seems to thrive and depend upon them” (p. 195). I have used the metaphor of illness/disability as an enemy, to help us better understand the “nest of complex personal, socioeconomic and political nexus of the meanings and experiences” thereof (Coburn, D’arcy & Torrance, 1998, p. 164; also see Kleinman 1986; Kleinman, 1987).

Anderson, Blue, & Lau (1998) described how failure to acknowledge the “social context of illness conceals unequal class relationships (also see Li, 1988), and institutionalized inequities in society and results in the exclusion of those who are most in need of care” (p. 182). In other words, they suggest that “the very ideology that promotes self-care, excludes the possibility of self-care by the socially disadvantaged” (p. 182). And also despite the increasing need for health/social programs and services, budgets continue to be slashed in these areas leaving many of the people requiring services are unable to access/afford them. “Because of the rural locality that I lived in I was having to drive two hours twice a week in order to see my psychiatrist in a near by community” (2009, participant interview, Kali).

Interestingly, in conjunction with the cessation of programs/services, a present initiative in BC health care, as seen widely on television, is that citizens become more active in their own health care. Anderson, Blue, & Lau (1998) explain that the result should be that “they come to rely less on health care professionals” (p.165; also see Steiger & Lipson 1988, p. vii). But for many women who claim to have attempted self-advocacy, actualizing this initiative has been typically met with less than enthusiasm or validation by their British Columbian physicians. This powerlessness is illustrated in the following excerpt from a participant’s poem:
We'll decide who procreates. We'll decide with whom you'll mate. Right bitch? Right Bitch!
We'll decide your access to birth control... Abortion. What kind of birth control will be available to you? Right bitch? Right Bitch! You think you want your tubes tied. But you're young yet. Still in your prime childbearing years. You may not think so now... But one day you'll meet someone a real nice fella. You'll fall in love. You'll make babies. And you'll like it. Right bitch? Right Bitch! We'll decide where you will work. When. How or If you'll get promoted. Right bitch? Right Bitch (2003, Hel).

Another participant stated that when she brought literature to a physician in the USA, she was congratulated for her proactive attempt to learn about her illness, and he in fact, noted the reference information from her, as it was from authors he respected, and he had not yet purchased this book for his own reference purposes. She brought the same information to physicians/surgeons (in several BC communities). Her regular GP told her it was “not his area of specialization” and she would have to “discuss it with the surgeon”. Six months later (and a couple of years already into the illness, still waiting for treatment) her surgeon blatantly refused (“rolled his eyes and huffed”) to acknowledge the book (and medical journal articles), as frequently did other BC physicians and surgeons in the years to follow (2009, participant interview, Hel).

Two years ago, after a “particularly long and bad night”, a participant collapsed onto her bed at 7am, sobbing and sweat drenched. Her (now ex) boyfriend searched her phone and called her surgeon (in the community 12 hours south) to plead on her behalf for treatment. The phone call “became heated”, as her boyfriend became frustrated. He received little empathy from the surgeon, who instead asked if his own abilities were in question and he stated that all his patients were suffering and that she would just have to wait like everyone else, and that she had already been placed ahead of some of his other patients. The surgeon also told the boyfriend that she
would never be fixed. At this point, the boyfriend uttered some loud profanities at the surgeon, and hung up his cel phone. She immediately called her doctor for “damage control” and was reassured not to worry and that “these types of things happen all the time, as patients become emotional and upset” (2009, participant interview, Hel).

Several months later she learned that the surgeon had contacted the RCMP, and a letter had been sent to the college of physicians and surgeons advising them of the situation, wherein he felt his life had been threatened, and would therefore have nothing further to do with her care. She returned to her GP who this time chastised her and asked what did her boyfriend think he was doing? She begged him to contact the surgeon to have him reconsider, as she had done nothing wrong, and she had already waited 6 years for surgery! She received a second letter restating the original decision that she find another surgeon. She has still not received adequate treatment, and continues to advocate on her own behalf, after recently being abandoned by the MP office (for matters relating to an ongoing student loan battle, interwoven with issues of disability), who told her it is in her best interest to handle the matter herself.

Meekosha (1999) writes: “We all have bodies, but not all bodies are equal, some matter more than others: some are quite frankly, disposable” (p. 172). It seems that here in BC, the reality women describe includes situations where they are ignored, unrecognized, laughed at, yelled at and some even reported that physicians were indignant when they were questioned regarding surgical and medical matters. Participants stated that when they asked to see specialists they were refused access.

I asked to see a gynecologist so I could find out if my vaginal tissue had been further compromised by the significant delay/lack of treatment to my intestines. I was told that I had already seen one 2 years previously and so the referral was denied. I had had cervical cancer several years previously, and combined with my extensive family history of cancer-
related deaths, I have legitimate concerns especially due to the amount of bleeding and pain I am dealing with as well as the serious delays in medical treatment... (2009, participant interview, Helen).

A participant shared similar sentiment in this statement: “Somehow if a man had a lump the size of a walnut attached to his balls I am sure that there would be a speedy resolution” (2009, participant interview, Venus). These women’s experiences reflect an overall description of being treated and punished like naughty children. All of them describe various methods of tiptoeing around the situations, fearfully attempting not to make matters worse. This is exactly the same way women in abusive households describe dealing with abusive partners! ChaChaCrowBear describes this violence:

This bitch REFUSED to let me go upstairs in a wheelchair after admittance... (names deleted) were floored and arguing for the damn chair, and I got up and said shhhhhhhhhhh, I would fight for my children but I was toooo sick to fight sooo I told them to quit, I would walk, I knew they would/could be meaner to me upstairs later (2009, participant interview).

Meekosha (1999) writes “the social-constructionist approach to female embodiment suggests that ‘it is not biology per se but the ways in which the social system organizes and gives meaning to biology that is oppressive to women’” (p. 174). Meekosha, (1999) discusses the interesting phenomena of how society worships some female bodies but is repulsed by others. She suggests that “rather than being marginal to contemporary difference theory, these questions go to the heart of our understanding of the body in the social world (p. 163):

Disabled bodies... remain unexplored. For example, bodies that have been transformed by disease or accident, or those considered ‘monstrous’ as to be hidden from view, are not considered the proper territory of feminist scholarship. Similarly the inability to urinate,
defecate and endure spasticity, nausea and pain—conditions that may require medical interventions, drugs or prostheses—is rarely analysed by body theorists (pp. 166-167).

**Don't They Listen?**

"Can't they hear me what I am saying Medications Antidepressants For depression But I am not taking antidepressants Don't they listen? "Why? For diarrhea But I don’t have diarrhea! Not for the past 10 months Not even when the doctor Wrote the report Tell me why Don’t they listen” (2003, Kelly)? Bennet wrote “the idea that listening is central to the care of patients is an old one” (2001, p. 50). He described listening is a “channel for empathetic communication”, and offered that it has the “capacity to validate” a patient’s feelings about their illness (p. 50). Venus replied to me after I had sent her a summary of what I understood from her responses. She expressed surprise that I had actually understood what she had told me and thanked me for actually listening to her. I found her gracious response to my paraphrasing what she said to be quite interesting, and it became more profound as feelings of being ignored and misunderstood are reflected in the responses of all the participants:

I believe that from the beginning of this journey that I wasn’t heard by my doctors. I believe that putting me in the hospital and putting me on heavy sedating medications without any talk therapy, without the coherence to be able to even say what I was feeling or what I may have needed for myself, was devastating for me and for my children...(2009, participant interview, Kali).

One would think that asking intelligent questions, and inquiring about alternative treatments would be regarded as responsibly taking accountability in one’s own health care and that this would warrant respectful treatment of patients by their physicians. The following quotation is referenced from an article in the Prince George Free Press: “She was upset at her doctor who thought she was just a bored housewife when she told him of her constant fatigue… I don’t
have long, she told me, the cancer's in my brain now” (Mallum, 2007, Wednesday, August 15, p. A7). The physician said, “you're fine” (2009, participant interview, Kali). “The psychiatrist's first report had errors, my name was spelled wrong, he said I was 41, I was 51” (2009, participant interview, ChaChaCrowBear). Kleinman (1980) wrote that “western medicine has been concerned with the disease rather than the illness” (p. 72, as cited in Bennet, 2001, p. 50).

This is evident in the following participant quote:

He (the surgeon) was there and I did talk to him. He asked me my name and if he had seen me before. I could hardly believe it. I could hardly walk with the kind of pain I was in. I left the hospital crying. He must have then clued in and pursued me through the waiting area, calling my name (2009, participant interview, Venus).

And Kleinman described also that “disease refers to the malfunctioning of biological or psychological processes while illness refers to the psychosocial experience and meaning of disease as perceived by the sufferer.” This depicts the statements of the participants in this study, as they all spoke to experiences of invisibility and being unheard by their physicians:

I went into my room, put on my wet pajamas from the enema juice, wrapped my little cheetah blanket around me, walked down by the river trail, stopped to Howl/Cry and walked home. The diagnosis was...dieritus??? no bigger word...yu know what I mean???? This was after Woman doctor left and I got one a young white SouthAfrican boyz....I saw him 5 days after hospital discharge and he did not remember me!!!!! Well, I did look like shit in the hospital. Lol (2009, participant interview, ChaChaCrowBear).

Says Who?

This paper is a study of women’s subjective experiences with invisible illness/disability throughout her career working within the social work profession. Wagner, Acker, & Mayuzumi (2008) write that “…many individuals… may experience disability as a disruption or frustration
to normal participation, this experience is not regarded as a collective one” (p.66; also see Titchkosky, 2008; 2007; 2005; & 2003). It is a study about the intersections between invisible gender, disability, and structural/institutionalized violence and oppression. Meekosha, 1999, stated that “disabled women’s bodily experiences are simultaneously mediated through class, racial, religious or ethnic identity and age” (p. 174). And “nowhere is the problem more acute than in feminist discourses on the body; their claim to universality corrupted by their unselfconscious exclusion of disability from their world views” (p. 174). What kind of life did she lead prior to becoming invisibly disabled? Was she active? Was she responsible for caring for others? Did she lose any mobility after she became ill? Is she still able to do the things that were normal to her prior to becoming ill? Does she feel normal?

And on what and according to whom, do we base normal? Regardless of gender, some people are stronger/weaker than others. How can we know what is normal if there is no base line from which to gauge it? We do not test healthy people from infancy into old age to prescribe individual value sets for future reference, in the event they should become ill. Instead we test people when they are ill and we base these tests on a scale of predetermined normal range responses. This practice itself is damaging to those who do find themselves maneuvering through systems trying to get compensation for accidents and the like, as they have no previous evidence of what once was their normal.

When they re-tested my grip strength after some physiotherapy, they told me it had recovered to within the normal range. I was unbelievably strong prior to losing the use of my right arm. Not strong for a girl, but strong...I felt so angry and offended that they would suggest that my grip strength was normal. Whose normal? My lack of strength was hardly normal! Yes I had regained range of motion, and strength had recovered somewhat from the complete lack of use I had endured, but it was and remains, most certainly not even
close to normal. I still can’t even toss a garbage bag into a big bin without help. I used to help pull transmissions and calves; I moved furniture and won awards for arm wrestling and throwing baseballs... now I can’t even take out the trash! Fuck you... normal (2009, participant interview, Hel)!

Meekosha argues that “bodies are not ‘natural’, but socially produced, reproduced and culturally inscribed” (1999, p. 169). Much of how women perceive and define themselves is in direct relation and comparison to what is presented by the media. Those images bombard us with impossible ideals of beauty and acceptance, including education, lifestyle, medicine, fashion, health and fitness and the ever increasing fascination with Hollywood. Henning (2006) refers to similar assertions by Denzin (2002, p. 58) and Walters (1995, p. 40) which “claim that the media occupy a central place in the background of cultural consciousness and that popular media representations shape and define cultural identities” (Henning, p. 72). Acknowledging this reality helps us to understand how it is that the body has become inarguably, central to women’s oppression. Women’s overall identities are shaped by the guidelines that are determined by North American media standards, and this has implications for women’s overall experiences of violence and oppression, and is especially paramount when she becomes ill:

They have been subject to abuse, invasion, remodeling under the surgeon’s knife, regulation, medicalization, normalization, state intervention and rendered the Other vis-à-vis both non-disabled male bodies and (sometimes) disabled male bodies. For disabled women, the oppressor may at times be another woman acting as colonizer, regulator or controller (Meekosha, 1999, p. 170).

Darke writes that “for the disabled, images of themselves are especially important” and that these images reflect society’s perception of disability: “In fact, they are as socially constructed,
illusionary and functional as any other images” (be they of the oppressed or not) (Darke, 1999, p. 181):

I felt like the sky was a dark woolen blanket and every day it got closer to my face and was clouding my mind, my memory and my thoughts. There was a foggy cotton blur in my eyes when I woke in the morning. My head felt heavy and constantly ached. I was too young, too happy, too powerful and energetic to feel this way (2009, participant interview, Kali).

The self-image of women who are experiencing dis/ability has the potential to become distorted based in ableist fear of the “other”. We live in a society that places a vast amount of pressure and emphasis on youth, health and beauty. Illness and disability are the complete opposite of this. This justifies a position of “other”. “Wrinkles and loose skin… muscle deterioration and loss… mass… a foot of hair! used to be playboy gorgeous… still traumatized by this don’t know if I’ll ever recover… my 30s stolen… used to look so youthful and I was so fun… I’ve become a troll…” (2009, participant interview, Hel).

Thus, for a largely ‘normal’ audience viewing a normality drama, an able-bodied audience’s cultural and social baggage will be almost exclusively rooted in the socially hegemonic interpretation of impairment as a medical and individual ‘problem’ to be either overcome or eradicated (Oliver, 1991; 1996) along with a belief in normality (also see Darke, 1999, p. 191).

It is reasonable to assert that humans fear their own immortality and susceptibility to illness. “The difference between other minority groups and the disabled is that anyone can become disabled at any time” (Mackelprang & Salsgiver, 1999, p. 17). We can run but we cannot hide (Meekosha, 1999, p. 164). Also, “disabled women’s bodies signify the opposite—dangerous reproductivity or lack of fecundity or ability to reproduce and hence ugliness (p. 172). Disability

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26 Personal Narrative: Abby Kovalsky LCSW.
touches a place deep within our psyches where our shadowy and vulnerable thoughts recluse. In this way, disability can be viewed as contemptuous and repulsive. Fear breeds the marginalization of groups of people who do not conform to the pre-determined standards.

Cultural, cinematic, images of marginal(ized) social groups—gays, ethnic minorities, women and the disabled—provide and opportunity to identify and deconstruct many of the nuances, trends and the stereotypes constructed in them. Such images offer a measure by which we can identify shifts in social attitudes towards marginalized groups, and an indication of particular sites of resistance to change. (Darke, 1999, p. 181).

Women struggle, now more than ever, to measure up to these unrealistic and often impossible standards of suitable female appearance and behaviour. To further complicate this, Mackelprang & Salsgiver write, “if self-concept has had many years to develop around Hollywood standards of beauty, the integration of a physical disability that affects mobility becomes more demanding” (1999, p. 17). Wendell (1996) discusses how women are unequally represented by disability and that this often results in “early and unnecessary hysterectomies, and women are also more frequently supplied with medications. Wendell further suggests that “the connections between socially induced illnesses such as anorexia an later disabilities, and the disabling effects of cosmetic or medical interventions are all areas for further research” (p. 117; also see Meekosha, 1999, p. 179).

Henning (2006) questions how women might more efficiently manage multiple roles without “sacrificing our physical and emotional health” (p. 36). Henning also asks how this can be realized in a “woman-hating society” where it seems that “feminists are blamed for many of society’s problems” (2006, p. 55).

“An anti-woman government agenda has effectively been implemented in the province of British Columbia, spearheaded by the Minister of State for Women’s Equality, Lynn Stephens
and Premier Gordon Campbell" (CEDAW, as cited in Henning, 2006, p. 59). Gondolf (1988) writes that “the first patriarchal assumption rooted deep in our society is that problems are caused by some individual pathology... allocating resources to women in a way that would increase their social status or power is therefore resisted” (p. 24). To further illustrate this, we have the now infamous KKKruger blunder, “there is no such thing as women’s issues” (Henning, 2006, p. 55), allowing us a glimpse into the dark psyche of society’s kitchen, where the ‘recipe for violent silence’ simmers in the cauldron... In the meantime, funding was cut by 100% to all 37 women’s centres across the province of BC in March, 2003, legal aid cut funding so that only those with criminal matters were eligible for services. MCFD cut 525 positions (many of which were front-line social workers) from an already depleted system. Privatization was rampant in the health care sector, composed mainly of women, where we again lost wages, benefits, and job security (Henning, 2006, p. 56), and years of blood, sweat and tears.

Darke (1999) wrote that “most disability writing to date (populist and academic) is both limited and focused on illustrating stereotypes that fail to represent the reality and the social constructionist element of impairment or disability” (p. 181). But reality, as described by women is such that when we resist and deviate from acceptable societal expectations, frequently the result is illness. Jack (1991) van der Kolk (1987) and Brown (1994) discuss the potentiality of (cause and effect) relationships between trauma, depression, and self-silencing behavior and the neuro-transmissions of the brain. (It would be interesting to explore these relationships in more detail, but that is beyond the scope of this thesis). However, we do know that health problems tend to lead to loss in productivity, which potentially results in more negative feelings of self-worth, and inadequate functioning, hence creating a cycle of inevitable deterioration in all capacities, thereby placing increased strain on individuals as well as social programs. And as women we are well aware of the importance and relevance of the multiple ways in which poverty
limits access to the services we require and provide. Further to this, a study by CASW identifies that “persons with disabilities are more represented in the social services than in the labour force as a whole” (p. 9).

Darke (1999) refers to Longmore (1987); Klobas (1988); Barnes (1992a); and Norden (1994) describing stereotypes including the “noble warrior”, the “charity cripple”, the “curio”, the “freak” and the “Pollyanna” (p. 181). Darke writes also that images of disabled women “have been equally reductive” (p. 182). An analysis by Cumberbatch and Negrine (1992, as cited in Darke, 1999, p. 182) identifies that despite a lack of disability theory, the prevalence with which disability is represented either in a medical context or as something to be overcome in a struggle to become ‘normal’ was significant.

Similarly, Norden (1995) identify “stereotypes that held that of a ‘freakish’ nature” (as cited in Darke, 1999, p. 182). There is currently a shift towards a multidisciplinary analysis of disability which is inclusive of cultural, feminist, sociological and disability theories. As Norden (1995) illustrates, images of disabled people are frequently portrayed within cinematic and literary forms. Darke proposes that “abnormality is in every thing, if not in actuality”, proposing that we use this “cultural imagery to define the parameters of normality, not vice versa” and that this in turn creates the lens through which most “apparently ‘normal people’ live their lives” (1999, p. 183).

Brittan and Maynard (1984) argue that treating ‘culture’ as static, as an ‘objective fact’ that determines illness meanings and the restructuring of life, glosses the harsh reality of poverty and oppression” (p. 20; also see Anderson, Blue, & Lau, 1998, p. 166). I argue that a huge problem

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experienced by female social workers who become ill, is that due to the modest wages they are paid, (especially relevant to the cost of education required to obtain degrees and organizational registrations, among many other job-related expenses) unless they are fortunate to have a partner/spouse or roommate to offset the enormous costs of living, they often are unable to access medical care and necessary treatment.

Money is an important signifier of power. A feminist theory of psychotherapy must address the role and impact of money on the power dynamics of a therapy relationship...current trends...further oppress and disadvantage working-class poor, and underclass women who simply do not have the financial resources to pay for therapy (Brown, 1994, p. 39).

Many female social workers are barely scraping by to make ends meet in the first place. When additional, illness-related expenses arise, this places them in further positions of disadvantage and incredible stress. This is intensified when they are maneuvering through the various disability programs that are potentially available through employment agencies and/or provincial social services. These programs are typically not user friendly and if the illness is not immediately visible, the experience has been described as abusive: “I was terrified, and forced to do whatever I was told, including agreeing to a surgery that made my symptoms worse, in case I’d be cut off from my LTD benefits for “refusing treatment” (2009, participant interview, Hele).

Similarly, another participant describes this:

I did not know that short-term disability and long term had two separate application processes. I just thought it would roll over, I mean it was the same company issuing the payments. But I didn’t find out until I didn’t receive my check and then had to jump through hoops to get my paper work resubmitted and take six more weeks. It was hard not to have that $250.00 per week (2009, participant interview, Venus).!!
The participants in this study described an overwhelming sense of powerlessness and financial despair when illustrating what it was like maneuvering through the various processes.

Not only did I go into debt to Revenue Canada but also I owed the provincial government over $5000.00 in loans because I had to make 3 trips to Vancouver to see specialists and they paid for the $500.00 per month's worth of medication I was on. Because I was making $1100.00 per month on disability I was disqualified from welfare assistance because at the time a single mom with one child received $980.00 per month. I made too much money. They helped me but they also made me sign loan papers. Looking back at how impaired I was on narcotics; it is surprising my signature is legal! I had no choice but to sign the papers...so at the end of 18 months I was over $10,000.00 in debt and they came collecting (2009, participant interview, Venus).

Frequent trips to doctors (and specialists), over and above the regular required (scheduled) appointments are typical requests, and are required of the employee if she wants to continue receiving disability benefits. Physicians charge fees to complete all forms required for proof of disability purposes. (Physicians charge to complete these forms. Fees range from approximately twenty dollars up to almost one-hundred dollars, per form). Grinspun (2000) wrote that "...patients are the most disenfranchised individuals within the hospital structure" (as cited in Gustofson, p. 40). Many women live in communities lacking specialized services so travel requirements frequently increase for these "administrative" purposes. "Living in the north meant having to travel for my treatment...no compensation, not even a tax break (2009, participant interview, Venus)!

CASW (1996) indicated that although "average earnings for professional social service occupations are clearly above the average for the overall Canadian workforce" (p. 7) and despite that "the educational attainment of persons employed in these occupations within these
industries tends to be higher than that of all other industries”, with the exception of social workers “employed in community-based non-institutional social service agencies, who earn less than the occupational average” (p. 8), social workers pay equity is “lower than for occupations such as registered nurses and secondary school teachers. (p. 8).

When disability benefits are received, these benefits are a percentage of employees’ regular wages. So if a woman was barely managing on her full wages, she is quickly plummeting further into debt, the line between herself and complete poverty narrowing with every prescription and physiotherapy appointment. To further upset things, some extended health benefits plans do not cover costs completely, and frequently the patient must pay in advance, and submit the forms for reimbursement. Many women in these positions are simply unable to afford these up-front costs, and are thereby forced to forego necessary treatments and/or prescriptions. This cycle of disability naturally intensifies, as many women succumb to the incredible stress, despair, poverty, and hopelessness. “Money does change how one experiences the system, just the stress level alone is that much less” (2009, participant interview, Venus).

If they were not suffering from depression at the onset, the likelihood increases that they will become depressed, and their physical symptoms will likely worsen due to increasing psychosomatic symptoms, created and exacerbated by the oppressive processes through which she is attempting to maneuver. “The doctors in emergency and in the clinics assumed that I was a hypochondriac, and that I wanted prescription drugs...if they had asked me they would have learned that I don’t even tolerate most medications...they refused to x-ray my shoulder, and they refused to refer me to a specialist and instead referred me back to my GP, who was 2.5 hours drive away…” (2009, participant interview, He/). Sadly, this sets women up to be further victimized within the health care system, as they are so frequently diagnosed with mental disorders, which then potentially minimizes the original presenting physical symptoms which
ultimately blames women for their situations and reduces them to “hypochondriacs” or “psychotic, uncooperative, and non-compliant patients with histories of “stress-related problems”, thereby justifying a lack of adequate and timely health care. Anderson, blue, & Lau, (1998) write that people require money for healthcare management. This puts socially disadvantaged people in a position of exclusion. The irony is that those requiring care but are financially unable to afford it are then labeled as uncooperative, difficult, problematic, unmotivated, and irresponsible due to the lack of care received (p. 182).

Durand (2003) illustrates that “when a female patient argues that she is not being difficult, she has, in fact supported the medical professional’s assessment that she is indeed a ‘difficult’ patient. Leipert (2002) notes that in order to prevent conflict with their physician, women will often endure situations of prolonged pain and increased debilitation while waiting for diagnosis and treatment. For example, Venus describes this:

“...(he physically ran his finger across his belly where the incision would be made!) and he would do it next week! I left feeling horrible not knowing how to process any of it. I was yet again humiliated in public yet I was in so much pain I felt I had no choice...” (2009, participant interview).

In comparison to a study by Stevens (1993) where female patients were found to have been “more likely to be ignored, scolded, patronized, categorized as ‘difficult’ patients, subjected to sexist and racist remarks, and provided fewer explanations of the health care they are receiving” (p. 18), Durand (2003) suggests that labeling women as “depressed” serves the same purpose of “silencing” them. She also refers to Trypuc (1994), who describes women’s sub-standard health care as “because of their upbringing and conditioning” and because “girls are taught not to question, to be unaggressive, and to defer to men and to authority figures” (p. 260, as cited).
In her interview, *Hel* (2009) described that because her illness had been going on now for several years, people questioned why and what was taking so long and that she still wasn’t fixed. Several friends and family asked if she had offended the doctors. She was berated with statements from friends such as, “I broke my leg, I went to the doctor and just like that, it got fixed, but look at you, you’re still sick. What is wrong with you? Why aren’t you fixed yet? What did you do to piss them off? I don’t have any trouble with doctors, why can’t you get them to fix you?” She notes that a couple of her male friends boldly asked her if her doctor was ugly and that maybe she (the doc) was jealous of her looks (2009). However, interestingly, she notes that most of her physicians have been male and that of only four female doctors/specialists, only one specialist was harshly abusive. Two of the most knowledgeable and helpful of those four were still interns and had little power in the hierarchy. And one female specialist and one male psychiatrist have been most supportive, overall throughout her journey.

In an interesting discussion about female aggression, *Shaw & Lee*, 2004 write that “women bond with other women, and yet our strongest aggressions and our most frightening hostilities may be directed against other women” (p. 41). This remains an intriguing phenomenon and it has been described as a remaining fragment of the “ancient primate and neo-hominid selves and of our inherent strategic plasticity, the desire to keep all options open” (p. 142). It is exactly this, that lends itself to the “divide and conquer” tactics that are systemically and socially implemented to keep women (and other groups) competing among themselves for scraps. In this manner, the larger issues slip by in relative obscurity. Sadly for us, by the time the diversion is recognized, we have exhausted each other.

If I had been ‘deceitful and dishonest’ as the Pacific Blue Cross insurance bitch on the phone called me, I would have known to go to an ER, and I would have received the reparative surgery in Seattle, in April, 2005. But due to my naivety, (and because my experiences up
here had so far been so unproductive, I didn’t really think showing yet another bunch of
nurses and doctors my rectum was warranted) so I went instead back to the doctor I had
seen a month previously for the tests (for which I had already waited 3 years in BC, and due
to anticipated waitlist movement, was expected to wait yet another 3 years to receive)! I was
hopeful that he could help me push my intestines back inside, and that perhaps he had the
test results back. Finally, after 2 weeks of me laying on a bed, pushing my gaping, bleeding,
mangled intestines back inside with warm towels, in a hotel in Seattle, BC Medical
authorized one tenth of the cost, a whopping $2000.00! They allotted $50.00 per night in the
hospital. (Our costs here in BC at that time exceeded these ‘discount bargain basement’ prices).
For two weeks, the Seattle hospital searched their out-of-country programs, (the surgeon
waived his own fee) and came up with a package for me to reduce the $60,000.00 cost down to $25,000.00USD. (The Canadian dollar was only approx $0.75 at that time). The package
included 5 nights’ stay in hospital, 3 months post operative care (and laparoscopic incision,
“unless they ran into unforeseen challenges warranting a traditional cut”), and most
importantly, RESPECT. But because PBC decided that I went to Seattle specifically to get
surgery, they refused to authorize payment of insurance benefits further claiming that my
situation was “non-emergency” and that it was “cosmetic”. The woman on the phone also
indignantly said to me “for someone in such dire straights, you certainly seem animated”! If
I could have reached through the phone at that moment I would have grabbed that ignorant
cunt by the throat and ripped her eyeballs out, tied them to a 5 lb bowling ball, and shoved
them out her asshole to see if she liked how it felt!!! Breathing...lol so due to this claim
refusal, all my other insurance providers followed suit and denied payment for any portion
of the procedure...fast forward to 2009... my intestines and other organs remain detached,
gaping, un-silently bleeding out...(2009, participant interview, Hel).
Premonition of Betrayal: Disability/Illness/Health

Goodness can be conceived as health. The linguistic root of “health” connects with “whole.” Evil is then sickness—to be cured, made whole rather than destroyed in the way of the war-maker. Through making ourselves whole we find the way toward the goodness of peace, the fitting together of shalom. And at the core of that is coming to peace with our being the imperfect, sinful creatures that we are (Zweig & Abrams, 1991, p. 191).

Jordan (1997) writes that of the depressed women studied by Weissman and Paykel, some were more hostile and angrier than the women in the control group, which did not support a previous assumption that “depression is a consequence of repressed anger” (p. 230). Jordan describes that “some women have difficulty expressing their anger” but that anger erupts more forcefully for some women as they become less defended and more depressed in response to significant life events” (p. 231). “I feel such intense rage...so much anger...it’s like I am going completely mad...I just want my life, (a life) back” (2009, participant interview, HeJ).

Bartky (1990) writes that “many feminists are perpetually wary lest their own anger be transformed explosively into aggressive or hostile behavior of the sort which would be imprudent or even dangerous to display” (1990, p.19). “…I try not to be offensive or share too much cuz people often get so overwhelmed lol...not much success with that lol (2009, participant interview, HeJ). Bartky also explains that “characteristic of this kind of consciousness too is the alteration of a heightened awareness of the limitations placed on one’s free development with a duller self-protecting sensibility without which it would be difficult to function in a society like our own” (p. 19). And she further describes that “wariness” is the

29 Refer to Appendices (Supplements) Section “Anger” piece represents some of the messages that I found in my research. Interestingly this piece was apparently meant to address women's anger. Although I like what it says, and I do not believe that anger resulting in violence is a viable solution to difficulties, I do believe that as an emotion, anger has positive qualities. Anger expressed constructively is capable of instilling creativity and productivity. Women have been socialized not to express anger, and this has proven itself to be damaging to women's overall mental health.
“anticipation of the possibility of attack, of affront or insult, of disparagement, ridicule, or the hurting blindness of others” (p. 18) and that women “must be always on the alert lest her pervasive sense of injury provoke in her without warning some public display of emotion, such as violent weeping, which she would rather suppress entirely or else endure in private” (p. 19).

Hel speaks of anger:

Rage is an emotion with which I have shared a very intimate relationship my entire life. My struggle has been learning effective ways to contain it and to utilize it in a productive, non-violent manner. And I am grasping right now for methods of managing these violent thoughts...I recall a dream where bizarre, grotesque visions of intestines and blades, sinister, seemingly insane-like smiling, dancing, hacking, carving, playing and laughing while blood stains the floor as bodies collapse, whirling through my mind...” (2009, participant interview).

I believe these dream descriptions reflect what Terr (1999) offers us regarding post traumatic play in that it “spreads into society and creates dreams, fears, and more play in its wake” (p. 203). Our subconscious minds react to these real, lived experiences and threats of further terror that invisible illness/disability have instilled. The participant describes fear that she will become destitute and that her life is at the mercy of her disability. The deep fears that erupt for her evoke a hostile reaction that would be impossible (illegal and immoral) to act upon in reality. Dreams, however, not only reinforce her fears, but also allow her to entertain murderous behaviour within the safety and confines of her own mind. It seems that these dreams are in some way a buffer between reality and fantasy, and help maintain some balance between these two realms. These dreams represent the dark side of the psyche, preventing her from having to repress undesirable feelings entirely, allowing her instead to express and honour them, without fear of societal, and criminal persecution.
Zweig & Abrams (1991) suggest that “premonitions” might serve to somehow motivate us into altered states of “pre-morbidity” wherein we are able to acknowledge and perhaps embrace thoughts that we otherwise suppress and repress, enabling us a safer alternative by which to process our darker less ‘appropriate’ thoughts. “Even though the process can easily lead us astray and, thereby, evoke illness, it also provides us with the understanding for the very reverse, namely, how genius thrives in the dung of pre-morbidity” (Zweig & Abrams, 1991, p. 95). The following rant is a provocative and gritty self-reflective piece:

Undressed Numb to this ever present and increasing UnCUMfortable Probing Questions
Fingers Cold metal appliances Humble? Necessary apologies for UnCUMfortable professional physical and verbal Intrusions It’s fine I say- reASSuring Them of their cautious necASSary but brief embarrassment I’ve beCUM quite numb down there... By now Years of UnCUMfortable unsolicited Verbal and physical probing intrusions Societal’s Sexual norms Moral taboos Quite evident although obscure even in this sterile medical environment Perhaps some illicit deepHER darkHER hidden perverse pleasure Observed Experienced within this sterile medical zone Some Jungian sociological AnalASSis? Interesting that in my rare girly altruistic manner I feel the need The compulsion to comfort Them whilst they poke prod and probe me verbally and physically My Abusers I tell them “it’s ok” “It’s not so bad” After all I have beCUM quite numb down there by now... Really But what about that? Those hidden repressed emotional sensations Separate from the simply physical tactile mechanical processes? Is it really ok? Am I really numb? I ask these questions... It might seem so upon initial glance and first visit but Detached & Dissociated Split & Spaced Out totally Fragmented from this here and now Depersonalized and still Traumatizing examination

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30 Reference Burstow, B (1992). Why is it that women are subjected to regular examinations of such degradation but men are not? Men are not violated routinely in such an intrusive manner. We are told it is for cancer screening, yet men get cancer “below the
Ever Coping with the UncUMfortable Probing AnalASSes Numb from the Novacained and 
bandaid prescriptions offered for symptoms Misunderstood and Maltreated The practitioner 
quite UncUMfortable with his/her UnKnowledge in this area While managing to maintain 
however futiley Some aura of arrogant Power and CUNTrol Effective Domination over this 
process of UncUMfortable probing (2004, Hel).

“The heart of darkness is our own heart. There is a comfort in demonizing the most 
monstrous and destructive among us, as if their being a different kind of creature made their 
example irrelevant to ourselves” (Zweig & Abrams, 1991, p. 190). “but recognizing even a truly 
demonic enemy as made of the same stuff as we is part of the true “path toward peace” (p. 190).

…the feminist anti-racist scholars around me affirmed my right to feel and express anger 
while discussing the unfortunate human realities of oppression. I have had a lot of anger to 
write about/with/through and OISE made my feminism sparkle in a fiercely excited and 
often joyful bright fuchsia-red (Transken, 2008, p. 215)! 

Women Invisible Illness/Disability/Aging 

“If we could read the secret history of our enemies, We should find in each man’s life, 
sorrow and suffering Enough to disarm all hostility” (Henry Wadsworth Longfellow, as cited in 
are simultaneously mediated through class, racial, religious or ethnic identity and age” (p. 174).

belt”, too. We are told also that it is to screen sexually transmitted diseases. Young men are sexually active, yet they 
are not forced to expose their genitals or otherwise have their birth control held hostage. It seems to me that our 
young women (those who need/use birth control) are being used as the markers of sexually transmitted disease and 
procreation control while the rest of the population is free to spread and sow their seeds at large... 

Schuster. Sark, wrote, “I often find it agonizing to tell or hear the truth, and will lie to myself to avoid knowing it” 
(p. 66). “The outcome of telling the truth is not the point. We cannot adjust our truth according to how the person 
will respond. Telling the truth faster enables us to live more freely, lightly, and powerfully ourselves” (p. 67). I 
believe that in acknowledging my true, dark feelings, my shadow, as represented in my dreams, I am able to free 
myself from the potential negative consequences of repression. I also believe that due to the subjective nature of 
truth, it is difficult for people to distinguish from the reality of the truth and what their own agenda might prescribe 
as the truth. I think this is the element that sets us up in such a way as to be vulnerable to the psychological tactics 
employed by our enemies.
Li (1988) argues the “restructuring of life to accommodate a chronic illness does not take place in a vacuum independent of the social context. The disruption of life, and the search for new meanings, are enmeshed in the ideological frameworks that permeate the health care system” (Anderson, Blue, & Lau, 1998, p. 182). Wright (1992) writes that “in old age women are subject to a double marginality at the very least (p. 184). And Meekosha (1999) argues that due to the notion of uselessness and a burden to society disabled women (“in greater numbers than men”) are often “warehoused and incarcerated in prisons, hospitals, nursing homes and a multitude of institutions” and that “disabled and elderly women constitute the majority of residents of nursing homes (Australian Institute of Health and Welfare, 1993, p. 236 as cited, p. 178).

“I am an aging, poor, divorced, female person with a disability, living in a society where value is placed upon gender, youth, and productivity” (2009, participant interview, He/). “Recent statistics suggest a staggering 71 percent of the nation’s 4 million elderly poor are women because they do not retire with enough money” (Henning, 2006, p. 61). It is also notable, as Henning (2006) writes, “many women are forced to leave their jobs in order to care for children or elderly parents, and unfortunately the economic reality of absence from the workplace is that long-range financial priorities take a backseat to immediate needs” (p. 62). Sadly, there is still no financial compensation for the labour performed largely by women, inside our homes, and outside of the productive, capitalist economic spheres. Henning (2006) describes that “it is unacceptable that the people who provide care for the vulnerable, weak, and oppressed do not get any financial remuneration or government benefits but instead are accused of not contributing to society” (p. 62; also see Young, 2002, p. 51).
I walk the fine line of poverty and homelessness every day. In fact there is but a thin fiber separating me from the many homeless women on the streets, and I have yet to clearly define what constitutes that thread. Is it education? Is it luck? Is it a vehicle payment? Perhaps it is the availability of social supports to rescue me when I am destitute? Quite frankly, there are days when the reality of my un/existence terrifies me...I am worth more dead...as long as my son manages to collect the life insurance lol (2009, participant interview, He).

Walker (1987) suggests that “gender is one of the clearest lines along which the economic and social experience of old age is divided” (p. 178; also see Baines, Evans & Neysmith, 1991, p. 189). Neysmith (1984) states: that “poor old women are not exotic plants that live in the special conditions of retirement-rather, poor old women are perennials, their roots are laid down in youth, their poverty merely comes into full flower later in life” (p. 17; also see Baines, Evans & Neysmith, 1991, p. 189). Wright (1992) wrote “the consequences of the dread of ageing for feminism itself need to be addressed” (p. 147). And Barbara Macdonald (1983) argues:

the emphasis on sisterhood, reinforces and produces mistrust and divisions between younger and older women: ‘youth is bonded with patriarchy in the enslavement of the older woman. There would, in fact, be no youth culture without the powerless older woman’ (p. 39; also see Wright, 1992, p. 147).

Women Invisible Illness/Disability/ Sexual Identity

Sexist images of all women have become alarmingly visible in our society. “Lookism” (Transken, 2004) or the “politics of appearance” as outlined in Shaw & Lee (2004, p. 59) is rampant as a basis for both inclusion and exclusion. Women’s sub-citizen social positioning

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32 There is something ironic, a little sad, and surely significant in the fact that most of the frontline persons who have so much power over the homeless people are themselves relatively powerless in their dealings with others (Liebow, 1993, p. 139).
within this voyeuristic submissive framework forces us to refer to appearance in such a ways not exclusive to marketing ourselves for financial benefit, such as in employment or status.

When we become disabled, this new sexuality potentially lends itself to displacement within our own psyches as disabled bodied are viewed with both fear and repulsion. Certainly the severity of this displacement is subjective in regards to the nature of the illness/disability and its symptoms and the manner in which we are debilitated. But also, perhaps more importantly, although I have not seen literature discussing the subjective nature of disability, it also is crucial to note how a particular woman positions herself within the sexual sphere. Does she depend on her body and physical appearance/beauty to help her in life? How intensely does she rely on the opinions and objectifications of others to help her fit into her world? Does she base her self-acceptance on her own ability to perform within the male-female roles as directed by society? Meekosha, (1999) suggests that “sexuality is part of the disability experience, even if repressed, violated or denied” (pp. 168-169). She adds:

"Desire and eroticism are a central part of these analyses, yet rarely do they consider the disabled body worthy of examination... The embodied experience of disabled people leads to contesting normalcy on many fronts—sexuality, political representation and power, the meaning of work, medical practices—as well as contesting the very meanings of body identity (Meekosha, 1999, p. 175).

Wright (1992) refers to De Beauvoir (1978, p. 184) expressing that “the connection between sexuality and identity” must be examined and she asks if there is any more appropriate place than from the lived experiences of women (Wright, 1992). Wright examines this from a “gerontophobic” analysis, proposing that “as men see it, a woman’s purpose in life is to be an erotic object, when she grows old and ugly she loses the place allotted to her in society: she becomes a monstrum that excites revulsion and even dread” (pp. 146-147).
The literature illuminates that a disgusting double standard exists in our society making it possible for women to be valued based on the usefulness or utility of our genitalia and body parts (to the male gender). It seems that our culture has defined it simply that we women must be making babies with our vaginas, pushing babies out of our vaginas or we had better be making (men) more money with our vaginas. “There are parallels between the embodiment of disability and the embodiment of gender. Women’s bodies and disabled male bodies are reduced to their biological (lack of) functioning; as deficient, as not able-bodied males” (Meekosha, 1999, p. 173).

Venus (2009, participant interview) wrote the following:

I love my ovaries and uterus and despite their struggles with endometriosis, they have lasted twenty years being diseased and have served their purpose of hormonal balance. I think that my reproductive organs are possibly the strongest part of my body to have endured what they have. (I am just having these thoughts for the first time as I write this, I knew that deep down inside this exercise/survey would be therapeutic!)

**The Productive Female**

“You steal our labour-power and you steal our bodies. We don’t receive the money we are entitled to for the work we do—whether in the workplace, the home or in bed” (Brantenburg, 1985, p. 228). Eichler, Larkin, & Neysmith (2002) write that “utopian thought is rooted in discontent...For many writers, the goal of utopian thought is the presentation of radically different ways of being that can provide momentum for social change” (p. 9). Driedger (2001) writes, “the problem is that the capitalist system was founded on the productivity of workers. Sick and disabled people, may not be able to produce what “normals” do” (p. 322; also see Lavigne, Burke, & Lemonde, 2001). Meekosha (1999) discusses how beauty, health, and reproduction dominate our society reflecting an able-bodied, and caucasion ethnicity. She further describes how illness can effectively steal a woman’s utility (in such a society), in that her
ability to reproduce is a measuring stick of value. And Meekosha argues further that women are already disadvantaged by their “subordinate status in society” (p. 174).

As in my own experience and from the descriptions of the participants in this study, it is quite likely that health problems tend to create (degrees of) lack of productivity. We are valued in our patriarchal society on our ability to produce. With our able bodies we work, generating income for large corporations. And with our able bodies we create life, ultimately sustaining the future of the human race. Without able bodies, our value decreases. And as (aging) women, loss of production quite likely is experienced both professionally, as we are displaced in our employment, as well as personally as we lose the ability to reproduce physically/sexually. This concept of displacement has potential for further negative impact on our overall health and well being as we ponder in our minds trying to make sense of and find new meanings for our different, dis/abled selves.

**Lifting the Fog**

“But if a woman ‘far from home’ surrenders all power, she will become first a fog, then a vapor, and finally a wisp of her former wildish self... Most of a woman’s depressions, ennuis, and wandering confusions are caused by a severely restricted soul-life in which innovation, impulse, and creation are restricted or forbidden” (Pinolka Estes, 1992, p. 274).

The categorizing of females within society is both interesting and confusing to me. It is my opinion that women are categorized into the simple roles of mothers, wives, or whores. (There are exceptions to this notion, but these women are exceptional). “Gloria Steinem believes that women get more radical with age because they become less valuable—their merits as sex objects are diminished, their function as breeders depleted—as time goes on” (Wurtzel, 1998, p. 29).

“Losing her gender, a girl may well miss the chance to sign up for the ‘unfair gender contract’, in which she provides domestic, sexual, and personal caring for others, particularly a man, in
return for some opportunities to be cared for by others” (Baines, Evans & Neysmith, 1991, p. 127).

Invisible dis/ability makes me think of one the most derogatory statements regarding women that I have heard. I think of the term “useless cunt.” I ponder this from time to time. I am no longer a wife. And I am not a whore. Where do I fit into society’s definition of female person? I used to take some bizarre comfort in the fact that if ever my financial state became completely bleak, I could at least become a prostitute, but that ironic comfort has been stolen from me also…nature of my disability, I couldn’t be a prostitute if I wanted to. It is as though all that I have learned to attribute to being female is lost. Without the “productivity” of my genitals, what is my value as a female? My usefulness as a person, regardless of gender, is void. I have become the epitome of a ‘useless cunt’ despite that I have challenged people in my lifetime that there really is no such thing, I now believe on some level that indeed there is, and I am “it.” (2009, participant interview) I have crossed over to the dark side of my shadow self. Pain and illness have distorted my thoughts. I no longer have control over my body due to the nature of this grotesque disability, and I question my usefulness to society. I am soul-wounded, walking dead, no longer human (2009, participant interview, Hel).

“This experience is a kick in the crotch!…I have become something dirty…like a yeast-infection or douche commercial…I have become unclean” (2009, participant interview, Hel).

“Wash yourself thoroughly down there and spray a bit of my rose petal spray around your penis and shamebag, so it doesn’t smell bad…Menwim have to wash themselves carefully and frequently, because they smell so rank” (Brantenberg, 1985, p. 13).

33 Just to let you know that this paper was written largely in psychic darkness. Thankfully, today I am feeling more connected to the topside world, the lighter, less damning side of my psyche. I didn’t want you to send in the “white coats...”
I have no control over the physicians or the direct the health care I require and receive... I am completely at the mercy of our system, and a body that have none. And the place I find myself in when I wake up is very dark, and not at all how social work is supposed to look...

Yet, upon closer examination of what social work really looks like, perhaps I am not so far from that truth (2009, participant interview, Hel)
CHAPTER THREE
METHODOLOGIES

A Cultural Studies Bricolage

Cultural studies is an emerging body of knowledge in Canada that developed in the UK out of Marxism, structuralism, feminism, and from literary sociological and anthropological domains (Hartley, 2002, p. 49, as cited in Henning, 2006, p. 8). Henning (2006) refers to Barker (1999, p. 114) when she defines cultural studies as “theoretically valuable because it opens doors for critical analysis of North America’s customs, habits, technology, values, ideology and political behavior” (Henning, p. 8). Henning (2006) discusses the importance of cultural studies to female researchers noting that culture and finance do not operate entirely by the same set of rules.

“The French word, bricoleur, describes a handyman or handywoman who makes use of the tools available to complete a task” (Denzin & Lincoln, 2003, p. 252). Kincheloe (2001) offers that “if hermeneutics came to connote the ambiguity and slipperiness of textual meaning, then bricolage can also imply the fictive and imaginative elements of the presentation of all formal research” (p. 680). Transken, (2005) describes cultural studies bricolage as a technique which allows us to use whatever materials accessible to assist us amidst the chaos (p. 15). She also frequently and fondly refers to bricolage as a “dog’s breakfast”.

My research is an examination of the relationships and intersections between gender, class, disability, power, and oppression from a social and cultural context and therefore, I incorporated data analysis from a cultural studies, “bricolage” format (Denzin & Lincoln, 2003; Kincheloe, 2001). Utilizing a variety of methodological approaches enabled me to access multiple analyses from a variety of disciplines, which provided the basis for more complete descriptions of the experiences explored within this paper. I blended together reflexive auto/ethnographic
monologues, in the forms of “messy texts” and poetry, as illustrated in Denzin and Lincoln (2003). Lavigne, Burke & Lemonde (2001) remind us that “the area in the brain called the Bronca’s Centre which affects speech and language is severely inhibited by trauma which can ‘freeze’ us into a state of anxiety” (p. 232). They describe how the process of “writing about traumatic and other important experiences can help us understand and deal cognitively as well as emotionally with these experiences, and move on with the flow of our lives (p. 232; also see Driedger, 2001).

I agree with Denzin (1997) in reference to Richardson (1994b) when he describes the relevance of lyrical poetry in relation to ethnography and lived experience. He suggests that narrative poems often allow us to understand the deeper meanings within the words and stories of the author (Denzin, p. 209). Birney (1953) suggests that poems provide heartfelt insight into the personality of the writer. And Transken (2003) recognizes that poems often describe difficult and complicated feelings, and by providing the author the ability to delve into her subconsciousness, poetry essentially captures the essence of the human condition in a more complete way. By utilizing poetry in ethnographic research, we breathe life into the stories, providing opportunity for the readers to hear the authors’ voices from within the words.

**Twisted Journey Between Goodness & Evil**

Zweig & Abrams (1991) write that “illness and health are mysteriously united in some odd way and that to know one is to know the other and that one cannot have one without having the other” (p. 92). I compare exploring these stories to yet another journey through the entangled paths between lightness (health) and dark (illness) within my own psyche…

‘The Fall,’ the metamorphosis into physical suffering, is preceded by certain premonitions. Nature does not deal as underhandedly with us as it may sometimes seem. Long before the situation becomes serious from a medical point of view, our hearts are tortured with a hate
which haws only our best interests prophylactically ‘at heart.’ Long before any morphological changes are noticed in the spinal column of the hunchback-to-be, he is plagued by feeling of guilt. Long before the first asthmatic episode, nihilistic anxiety obtains, while actual diarrheic crises serve but as the culmination of psychic incontinence in the face of difficulties. In other words, infarcts occur without actual infarcts, hunchbacks are not necessarily misshapen, asthmatics do not have to manifest bronchial congestion, and diarrhea does not depend upon the presence of frequent and loose bowel movements (Zweig & Abrams, 1991, p. 95).

**Disability Studies**

The process of disabled embodiment can be understood only within historical, cultural and class contexts, along with the gendered and/or racialized body. If the body is a site of political struggle, disabled women are involved in multiple contests which may result in unexpected alliances with dispossessed Others (Meekosha, 1999, p.179).

“The rigid dualism of either a socially constructed disability or a disability grounded in biology is being disputed in the subjective discourse—the lived experience” (Charmaz, 1991; Rose, 1995 as cited in Meekosha, 1999, p. 175). “A personal relation to disability then involves a process of simultaneously being and becoming a person with a disability” (Ferguson & Titchkosky in Wagner, Acker, & Mayuzumi, 2008, p. 69). This involves a uniquely complex process with infinite implications. The intersecting cultural and personal factors that give meaning to our lives and shape our identities within the world as we understand it, change when we become sick or disabled. And our experiences within the medical and economic systems will also impact how each of us relates to and is defined by a particular illness (p. 65).

We need an interrogation of feminist theory of the body from a disability perspective as well as a feminist interrogation of disability theory...yet the socially constructed disabled body
does not adequately account for the totality of the trauma and suffering of impairment, the
subjective experience—for example negotiating pain, spasticity, incontinence and the
iatrogenic effects of drugs and appliances (Crow, 1992; French, 1993a as cited in Meekosha,

Charmaz and Rose (1995) discussed the importance of uncovering the subjective contexts
when interpreting the experiences of people living with disability, and they expressed how this
essentially shifts research “into the realm of cultural analysis” in that we are providing the rich
descriptions of “what Rose calls the ‘agon’ of daily life” (as cited in Meekosha, 1999, p. 175).

Hel describes the following:

I have no space that is my own. I have significantly limited income. My poverty and
disability have reduced me to a walking-wounded, exposed soul. I am a free-spirited, open-
spaced, wild animal. My native heritage speaks to me also from the spirit world. I am a
bear, an eagle, a wolf and a bullfrog...all of these are animals who must roam freely. I no
longer am able to roam anywhere. I am strapped to the toilet and to my bed. I feel like I
have been castrated as well as my legs have been broken. I am the eagle in captivity and the
whale whose dorsal fin has flopped over in despair...armless, legless, skinless body left rotting
in the desert eaten by scorpions and blistered by the sun...utterly powerless and without
defense... (2009, participant interview).

Steiger and Lipson (1988) explained that “women from the same ethnic category did not
always share similar cultural meanings about illness, nor did they manage chronic illness the
same way” (vii as cited in Anderson, Blue, & Lau, 1988). They also described that “the process
of restructuring of life is situated within a complex nexus of economic, circumstances; hopes,
aspirations and fears; support or lack of it from friends, family, and employers; relationships with
health professionals, and the like (Anderson, Blue, & Lau, 1998, p. 183). It is impossible to
know how something will affect someone else, as experiences are completely subjective in nature. Many factors must be taken into account, including quality of life in regard to what that means to each individual.

For instance, if an introverted person, with relatively minimal outdoor activity requirements, who enjoyed staying inside, watching television were to acquire an invisible disability/illness that rendered them inactive (or incapable), this could possibly be viewed as not hugely life-altering. Contrarily, if a person whose identity is composed largely of outdoor sports and activities, and this person rarely spent time indoors, this same illness could have tremendous emotionally damaging effects, that might potentially render them suicidal. “I meet and work with women who have become so overwhelmed by their tasks, responsibilities, and lack of supports that they often become depressed, anxious and even suicidal” (Henning, 2006, p. 36).

For some reason yet to be known to me, and despite the multitude of obstacles the Creator has put before me, I am still here. Despite that my pain continues to betray me in my fitful slumber, feeding my dreams with gruesome and morbid images.

*Human beings are healthier when they are sick.* In its purest form, health is unbearable in the long run, for it carries too great a responsibility and too much freedom for us to take it upon ourselves unscathed for any length of time. The ‘undoing’ and its manifestation, illness, are in the final analysis necessary (Zweig & Abrams, 1991, p. 96).

The following poem illustrates collegial violence as it is manifests itself in social work environments:

appetites & apparitions around mentoring prove excess for both of us; frail, damaged, you skulk the edges of relationship possibilities. in contrast, I rumble, hulk, lunge defeat is not possible in the stupid language my heart sings—only detours, efforts at damage control. we now close our doors to each other avoiding eye contact, cleverly planning de-synchronized
schedules & associations, you, motivated in fear; i, in tender manners, i refuse to collude in cowardly conspiracies or attempts to crush spirit. while I spoke of playfulness your curdled tone slipped past my lips—tired to poison my tongue—but in innocent resilience i chew & spit flowers at your feet (Transken, 2008, p. 221).

Typically, when women (social workers) become afflicted with an illness, especially if it is not clearly visible, it is quite common that they are regarded by their colleagues as “complainers”, who are “faking it” and “slacking off” (2009, participant interviews). “As a chronically ill person you may not be able to work like you did before or maybe not at all, or maybe it changes with your health. You have the added stigma of being seen as lazy and unproductive (Driedger, 2003; Lavigne, Burke, Lemonde, 2001).

Meekosha (1999) argues “disability may be rendered invisible, as though the ‘normal’ mind cannot encompass a difference so profoundly embedded in its/our sense of the ‘normal’ and its silenced Others (those who are not part of the taken-for-granted everyday world of the dominant cultures…disabled bodies exist in spaces outside mainstream society (p. 163). This sentiment is also reiterated by Susan Wendall (1996) when she describes that illness is an excuse for society to further accuse and suspect women of dishonesty and laziness, accusing them of exaggerating illness symptoms. Kali describes this: “There was a definite time element to when and how people thought I should be able to one again care for myself” (2009, participant interview). Wendall further argues that this limits women’s full participation in society.

Meekosha (1999) agrees when she writes “injured women are then forced to ‘prove’ that the injuries are ‘really’ physiological, caused by faulty ergonomics and poor work practices—thereby forced into a mind/body and public/private separation (p. 168). And enus describes this:

But worse…was the conversations co-workers and supervisors would have about the way I wanted to be on disability; that I was ‘lazy’ and I was sucking the system for an easy ride…I
became the taunt of many cruel comments... did people really think that I wanted to live on 
50% of my wage, live in poverty... my self-esteem was low and this added to my stress. I 
was humiliated and felt that no one cared. Certainly no one ate my workplace (2009, 
participant interview)

It is also not uncommon that women have described the need to make numerous trips to 
physicians, and hospital emergency rooms to essentially fight to receive medical 
attention/treatment for conditions that if presented by a male, would have been more readily 
received and accepted as valid in nature of the complaint. Meeksosha (1999) writes that 
although it is well documented by lawyers, medical practitioners and the media, that “women 
have been more likely than men to develop symptoms of repetitive strain injury, owing to their 
social and economic positioning in the labour force and their domestic responsibilities in the 
home” (p. 168). However, despite this fact, there remains a stigma which portrays women as 
hypochondriacs, typically suffering from emotional, “womb-based”, rather than physical 
ailments, which are contributed to an “essentially hysterical” character flaw, and “not 
physiological” origin (p. 168).

But social constructionists of disability tend to assume a fixed embodiment—a fixed, static 
disability. This approach raises a number of issues, in particular for women with disabilities, 
who are more likely than men to experience degenerative conditions such as multiple 
sclerosis and arthritis. So, for example, socially constructed disability does not explore a 
changing body image or identity and functioning. Here the disabled woman must 
continually renegotiate the relationship between body, self and socially constructed disability 
(Meeksosha, 1999, p. 175).

Why is it that when an illness/disability is invisible, it is so difficult for people to 
comprehend that the sufferer is sick, and is entitled to the same compassion and care as is
Meeksosha (1999) argues:

...many disabled people search for solutions to improve their bodily functioning to achieve harmony between body and mind in distress. This is not simply because people with acquired disabilities feel alienated from or confined by their bodies. It reflects philosophical inheritances of the constraints of the mind/body opposition (p. 175).

Meeksosha, (1999) also discusses that “disability theorists, following feminism’s rejection of biology as the determining factor in the making of the gendered or racialized body, have similarly rejected biology as the determining factor in the making of the disabled body” (p. 176). Rather, women's perceptions and definitions of body image, beauty, sexuality, issues of dis/ability and overall sense of productivity and value in society are produced socially and it this socially constructed body, that must be critically analyzed and deconstructed in order to significantly reduce the subordination, marginalization and ultimately violence against women. Meeksosha notes that others, for example, Monks and Frankenberg (1995) propose that we must consider both a “socially constructed disability”, without rejecting the medicalized, or “mainstream” description, and that “both meanings attached to disability and the disabled body itself, takes us beyond crude dualisms” (Meeksosha, p. 176). And Wendall (1989) writes also that “utopian technologies should be examined for their liberatory potential as well as exposing their dangers as tools of domination” (p. 117).

Not Without My Health

I ThankYou Dear for the Opportunity to Release .... puke forth and froth .... Relinquish, Reflect and Honor all that shit .... Man, you GaveAway to me and I am very GreatFull .... it so inspired me to KeepWriting, and to see my Process .... Progressive even in desent ... LOL. I am such a Paradox and I dig that about me .... and all my Crew I Run Howl Caw Wail Sing
"If you never Learn to Howl, You will never Find Your Pack..... ClarissaPinkolaEstes... (2009, participant interview, ChaChaCrowBear).

"Through the writing exercise workshops, she encourages women to write as a means of self expression, find their personal voice, become empowered as they share their inner feelings and allow themselves to write about things they might not be able to speak about" (Jaffe, in Lavigne, Burke, Lemond, 2001, p. 227).

The spirit child is la nina milagrosa, a miracle child, who has the ability to hear the call, hear the far-off voice that says it is time to come back, back to oneself. The child is part of our medial nature that compels us, for it can hear the call when it comes. It is the child rising out of sleep, out of bed, out of the house, and out into the wind-filled night and down to the wild sea that causes us to assert, “As God is my witness, I shall proceed in this way,” or “I will endure,” or “I shall not be turned away,” or “I shall find a way to continue” (Pinolka Estes, 1992, p. 273).

These are thoughts that have transpired throughout my thesis journey and in the development of this research proposal. Thompson Highway’s song, “When children Sleep.” (is based on a lullaby that his mother used to sing after his brother, Rene, died from AIDS) supposes that when children sleep, they are spirits, traveling.

...sleep is my escape... frequently, collapsing from the toilet to the bed, drenched with sweat...i welcome sleep where dreams are sometimes dark but I belong in there...the spirit world...I look forward to time there...this longing consumes me...pressure relieved from my rectum in dreams...enveloped by soft, warm blanket, comfort, kindness...from somewhere else, I watch myself smiling, dancing with angels, we ride horses together, and I weep...tears stain my cheeks, and I awaken, too frequently reality...a toilet...wipe the tears from my eyes, impatient to return to the place I was, prior to another painful
interruption...my rectum rudely demanding more attention while doctors have the audacity to tell me, “try not to strain! this terror that has become also my nightmare...dreams now consumed with gore...bulging masses of fecal matter, outhouses appear from nowhere...knives carve into my stomach and anus relieving the pain in my rectum...anus protruding, mass of pink, mucous-oozing, flesh gasping as I press it back inside me...but in sleep, I ride my horses, motorcycles, drive big rigs... pigtail braids blowing, the wind whips my face...inhale it...LIFE...in sleep I am of the other world where I LIVE (2009, participant interview, Hel).

“I’d lie in bed, then get out and kneel to pray to God for some reprieve. No one in my life believed that I could be without hope. Even my hope in God was fading as the darkness filled the once faithful, hopeful place in my life” (2009, participant interview, Kali).

“Wendell further points out that she has to overcome the chronic pain of her body to do anything, like writing an article...” (Driedger, as cited in Lavigne, Burke, & Lemonde, 2001, p. 322).

We discuss guilt and suicide... Kali writes, “I told my friends, I told my family back home, but not my children. I wanted them to be in the dark about my darkness. They needn’t know that life wasn’t worth living quite yet” (2009, participant interview). And Danu writes, “it is hard being alone with thoughts of suicide and thoughts of loss, no hope. I keep trying to reach out to the next thing, the next activity” (2009, participant interview). Hel shares this:

I was an abundance of energy...I have become the epitome of weakness...reduced to having passion only for death... I cry each morning when I realize that I am forced to be here another dreadful day...I pray He gives me back my health or kill me because I cannot continue to un/exist like this...And when my son says, ‘omg. mom, every day I am afraid to wake up and find that you’re not here anymore...I can’t be here without you...but I
understand why it would you want it just to end, and I don’t even know how you’ve lasted this long’ (2009, participant interview).
CHAPTER FOUR
RESEARCH DESIGN/ METHOD

Self-reflexive Auto-Ethnography

"Foucault's work ...laid the foundation for an entire paradigm and practice in qualitative research on studying discourses and experiences" (Saukko, 2003, p. 93). Self-reflexive auto-ethnography, an example of this method, is a concept in which the researcher identifies a particular phenomenon and then describes the lived experiences from a variety of discourses, including her/his own experience within the study (Saukko, 2003, pp. 84-85). This can otherwise be described as a means by which the research is conducted from insider position working in an outward motion rather than the traditional outside-in method.

As Saukko (2003) eludes to, allowing various participant perspectives within the research has the potential to "effectively discredit" the critique, by exposing multiple dichotomies. But conversely this technique also enables the researcher to "flesh out the ambiguity" that lies within the interpretation of the stories, providing richer, fuller descriptions of knowledge. This holds true in that we all are experts in our own rights and it is impossible that we all might experience something in only one way. It is impossible that there is only right or wrong. The notion of the 'organic intellectual' helps us to understand the multiple ways of knowing. We are all learners and teachers and although we might share many experiences, we have many ways of knowing and this knowledge is revealed to us in what I refer to as shades of 'truth'.

Saukko (2003) refers to self-reflexive dialogue "in 'rhizomatic' terms that does not aim to establish a consensus but allows the different experiences to illuminate the empowering and disempowering elements of discourses and to highlight their complexity" (Saukko, 2003, p. 94). In this way we are welcoming and recognizing both the differences and similarities that we encounter throughout the course of the research. We are not searching for one unanimous
answer or truth, but rather we allow the process to unfold, and in this journey, we open
ourselves to the multiplicity of lived experiences. In doing so, we are more able to capture the
essences of the stories, which ultimately provides a more complete description of the
phenomena we are exploring, thereby honouring the participants.

Foucault acknowledges that one can never liberate oneself from discourses or reach a state
of not governing or disciplining one’s behavior in some fashion. Yet Foucault’s technology
of the self reminds us that one can work towards a technique of governing oneself in a
fashion that aims to be more ethical both towards the self and others (Saukko, 2003, p. 86).

van Mannen (1990) suggests that “the method of phenomenology is that there is no
method” and that instead, “the broad field of phenomenological scholarship” might be more
accurately described as a “set of guides and recommendations for a principled form of inquiry
that neither simply rejects or ignores tradition”, (p. 30) to be applied by the hermeneutic
researcher with rigour.

“A phenomenological question must not only be made clear, understood, but also “lived by
the researcher” (van Mannen, 1990, p. 44). My intention was to ask questions that will enlighten
us to women’s experiences of invisible illness/disability. The questions I developed were
designed for their “relevance and clarity” (Dawson, Klass, Guv, & Edgley, 1991, p. 222). The
questions are specific to this study and have not been asked in this manner previously. The
questions have been chosen to elicit the information required for the purpose of the study
(p.222).

Sample

“The starting point of phenomenological research is largely a matter of identifying what it is
that deeply interests you or me and of identifying this interest as a true phenomenon, i.e., as
some experience that human beings live through” (van Mannen, 1990, p. 40). I utilized a
snowball sample to find female social workers who identified as having experienced invisible illness/disability at some point within her career. Coldwell (1999) and Osborne (1990) state that the number of participants in a phenomenological study may vary from as few as one participant to multiple participants and that the sample size may vary based on the researcher's ability to illustrate an in-depth analysis of the phenomenon being studied.

The reasoning behind my choice of a snowball sample is that I am unfamiliar to this geographic area. Essentially, I am a “fish out of water.” I do not have a network of friends and colleagues from which to choose a sample of participants who share the criteria I am interested in studying. Also, due to the constraints and the nature of my own invisible dis/ability, I am unable to venture out in to the community to secure new collegial networks for this purpose. Fortunately, I have managed to discuss my research intentions within the academic setting, and these connections have enabled me to actualize the snowball sample method.

I am largely at the mercy of the people I have met here, in that I relied on them to spread the word of my thesis intent, in order that I was able to find at least five participants who met the criteria for my study. I also continue to be at the mercy of the physical and emotional limitations of my illness which vary on an ongoing ever-changing basis. The challenges are many.

**Data Collection Process**

Creswell, (1994) states that the qualitative researcher is the primary instrument for data collection and analysis. (p. 145). I followed the data collection format according to what I learned reading Neuman (1997). Van Mannen (1990) identified “four existentials” (p. 101). He explains that these existentials are reference points from which we experience and perceive our world, and depending upon subjective criteria these perceptions and experiences may or may not differ from those of another. I interpret van Mannen’s analysis to mean that these can be
utilized as tools to help manage the reflexive process of research, these frameworks then help create a reference point from which I located myself in this research.

These four existentials helped me ask reflexive questions and to determine the crucial components of the data. These include, 1. “Lived space (spaciality)”, which I interpret to mean that since the participants in this study are presently located in (and have moved between) different communities, our access to medical care and services will be experienced differently from the onset of the study. 2. “Lived body (corporeality)”, for the purpose of this research, I interpret to include that our invisible illnesses are varied (and particular illness was not the focus of the study), but the variances in our dis/abilities and how we perceive and locate ourselves might likely affect how each of us maneuvers through the various systems this research is exploring, and our perceptions of (our) illness also potentially impact how each of us interprets and responds to the questions asked in the study. 3. “Lived time (temporality)” I interpret to refer to the way in which each of the participants interprets her own life experiences and how she believes her invisible illness impacts her life and her ability to function (for example, does her illness impede or enhance the aspirations and goals she may have prescribed for herself). 4. “Lived human relation (relationality or communality)”, I interpret as how do the participants relate to and identify with the persons important to them in their own circles of family, friends, colleagues and cohorts. How does the connectedness or lack thereof impact their responses to the research question(s)? It was throughout the research process, while utilizing these existentials, that as I questioned what I was noticing in the data, that I noticed the emerging theme of social connectedness and began to wonder if this was a crucial element in discussions of invisible illness/disability.

In “Journeys of Disorientation & Dislocation: Women/ Invisible Illness/ Dis/Ability In and Out of Social Work: A Transdisciplinary Exploration, the research question itself was borne
from my own desperate need to discover how other women have experienced invisible illness/disability in order to perhaps make sense of the uncomfortable disabled lens from which my own personal world view now gazes. The interview questions were developed from my desire to gain a deeper understanding of the disability and medical processes social workers must negotiate and specifically in relation to the contradictions I have observed throughout my own invisible medical journey. The questions are ultimately a compilation of the conscious and unconscious reflexive processes that shaped my thinking, behaviours, and my motivations for engaging in this particular study. Much of the research has been generated from the ever growing and transforming shadows within my psyche, as my journey of invisible illness/dis/ability continues.

To supplement the auto/ethnographic methods of my study, my original intent was to incorporate the use of a variety of triangulation strategies including a survey in order to acquire additional exploratory data, which would have increased the sample size. However, due to the vast amount of literature and the richness of the participant data, this would have made the thesis more enormous. Therefore, the supplementary survey was reluctantly abandoned for a future research endeavor. I did manage to utilize a variety of “bricolage” and “messy” text techniques as read in Denzin (1997) to help me negotiate through the data, from a “polycentric” (Delaney, Brownlee & Zapf, 1999, p. 13), feminist perspective.

**Participant Interviews**

For purpose of this study, I asked the participants six questions:

1. Please describe to me your experience of invisible illness/dis/ability.
2. Please tell me about your employing agency’s response to your invisible illness/dis/ability.
3. Please tell me about your experience with the medical system in regard to how your invisible illness was handled/managed.
4. Throughout your experience with invisible illness/dis/ability, who supported, nurtured and cared for you?

5. What would you describe as having been the most challenging element of becoming invisibly ill/dis/abled?

6. If you had the money/power/ability to do so, please tell me, what would you change about your experience with invisible illness/dis/ability?

Sometimes people become nervous or uncomfortable when asked to speak about personal, intimate situations. I worried that the participants might freeze up and/or wonder what they should/not discuss. To alleviate these fears, I developed some prompts, which I referred to as “self-monitoring mechanisms”, to assist the process of eliciting information in the event that the sharing derailed in some off-topic, or idle chit-chat direction. van Mannen (1990) suggested “before embarking on a busy interview schedule one needs to be oriented to one’s question or notion in such a strong manner that one does not get easily carried away with interviews that go everywhere and nowhere” (p. 67). I recognize that some of us tend to ramble when we are nervous, or we have no parameters or person to bring us back to task. (I have referred to Dr. Transken as a sheep herder on many occasion. lol). These “self-monitoring mechanisms” act as post-its or marking tools, allowing the interviewer the opportunity to re-visit certain topics later.

van Mannen (1990) describes “the conversational interview turns increasingly into a hermeneutic interview as the researcher can go back and again to the interviewee in order to dialogue with the interviewee about the ongoing record of the interview transcripts. (p. 63).

Because we utilized an online/email method of conducting the interviews, I did not have the immediate opportunity to revisit/clarify specific responses during the interviews. The prompts enabled me to revisit the questions for clarification if necessary. This method proved to be incredibly rewarding and provided much rich back and forth communication that lent itself to
deeper understanding through sharing of the stories and it helped me document the data in a most meaningful way. Through this process, strong bonds were developed and this proved therapeutic in a reciprocal way.

It was imperative to the validity and integrity of the study that I expressed to the participants the importance of free-flow, conversational sharing (sharing as freely as each was willing and comfortable, for each question), in order to provide this study with as much rich data as possible. I encouraged the participants to be as candid as possible within her comfort level, in order that the study is as meaningful as possible. I also emphasized that candid sharing was crucial because this was our opportunity to tell our stories in each of our own words.

The downside of including additional material in the email interview is that there was some risk that the participants might have thought that they had to answer the 6 questions, speak to all the examples provided, and perhaps limit their discussion to only that. This could have potentially, minimized the potential overall validity, purpose and impact of the study. I took steps to reduce this potential hazard by including clear, detailed instructions. As it turned out, each participant answered the questions in a very unique way and this provided a broad scope of data for the research, but provided descriptive accounts to the experiences of each participant for all the questions in the study.

I originally intended to use a face-to-face focus group method. However, due to time constraints and ongoing medical concerns, my thesis supervisor and I agreed that an online/email method would inevitably be most the viable method to use for my study because of the ever-challenging, debilitative and counterproductive symptoms of my own illness. Because I was not likely to ever meet the participants face-to-face, it initially felt awkwardly impersonal to me. This was something I felt compelled to address with the women because I wanted to make sure that they realized how thankful I am that they were willing to partake in this journey with
me. Despite my initial apprehension over the lack of face-to-face communication, there was no discomfort. Rather, this method produced concise and clear data, which perhaps might have been overwhelming had the interviews been in person, tape-recorded then transcribed. In my experience, people are less likely to write more than necessary, versus some of us tend to talk a lot which increases the chances of collecting off-topic data. Also, had I used a focus group there was potential for participants to be more fearful of sharing the poignant and intimate details that were the essence of this study.

Throughout the study and through the various back and forth emails, as noted earlier, bonds were developed and genuine friendships evolved from the back and forth sharing. Kali writes, “You sound so beautiful and lovely and real. The real is my passion, knowing real is such an experience... you don’t feel like a stranger, you feel like a dear friend.... I appreciate your listening ear, your response... good night my new friend” (2009, participant interview). Hel shares, “you are truly an amazing beautiful woman! I am truly blessed to have the good fortune to have you in my life... This has brought such joy to me it makes my heart soar...” (2009, participant interview). And ChaChaCrowBear beckons: “I sooooo damn excited.... we BE going on a Journey, MyGirl!!!!! Can’t ya feel it in yer nostrilzzzzzzzzzzzzzz???? Have an Interesting Amusing Day ... I shook my BuffaloHorn, You were in there” (2009, participant interview).

I am delighted to announce that we cannot wait to meet! Hel writes, “Finding you women has been so powerful in so many ways cuz i learn so much from your stories and experiences that feeds my own starving soul and i am so thankful for that. It has given me renewed strength” (2009, participant interview). And Kali replies, “You are beautiful and amazing, I have found such a light in you. You make my day lighter both physically and emotionally” (2009, participant interview).

34 I think that perhaps this process was similar to online dating (in which I have not partaken) when strangers become connected, sharing intimate details in relatively short timeframes?
I asked each participant to please share with me at the end of her interview, how this process felt for her. Kali responds, “Thank you for this opportunity to express some feelings that have had no audience and have spent their time hidden from the present” (2009, participant interview). I also asked the women prior to commencing, to share any of their own creative work (including letters, journal entries, poems or some other piece of written work) with me for the purpose of this study, if they were so inclined, because, as van Mannen (1990) noted, “literature, poetry, or other story forms serve as a fountain of experiences to which the phenomenologist may turn to increase practical insights” (p. 70) and “a poet can sometimes give linguistic expression to some aspect of human experience that cannot be paraphrased without losing a sense of the vivid truthfulness that the lines of the poem are somehow able to communicate” (p. 71). The powerful poems and rants of the participants have been delightfully woven throughout this thesis. The following is a 'brutifully' written poem, exemplary of our bipolar-aggressive, neither politically correct, nor ladylike manner. I found it awesomely brilliant!

Where do I go when I've burned all my bridges, torn down all my supports, pushed away all that's familiar? How does one explain irrational behaviour, an aggressive aura, self injury by isolation? what was I doing standing on a soap box looking down from above? Running scared from all of it: the landslide of blackness LURKING mud, dirt, catching at my heels finally burried in it, my one eye opened I find one iota of light enough to fix on while the

I made up the word, ‘brutifully’ as a playfully sarcastic extension of the word brute, which describes someone who is perceived as barbaric, aggressive, improper and ill mannered. These negative attributes also tend to lend themselves to the stigma associated with bipolar disorder. Many of us, who suffer from symptoms which fall under the bipolar disorder umbrella have described either feelings of inappropriateness, aggressiveness, outspokenness, or unladylike mannerisms, or have expressed that rather we have been identified by medical professionals and judgmental others as having these negative traits. (Many of also have been advised by counselors or concerned friends, that we need anger management). These descriptions reflect the negative manner in which invisible illness/dis/ability is regarded in North American culture.
filth melts away as a shoot would; I try to grow up from the dark (2009, participant interview, Danu).

Making a quilt/ Qualitative Data Analyses

This is a qualitative, exploratory study, based deeply in hermeneutic phenomenology and feminist scholarly application making quantification neither relevant nor appropriate. van Mannen (1990) refers to Merleau-Ponty (1962) when he writes that “to give a direct description of my experience as it is, without offering causal explanations or interpretive generalizations of my experience” (van Mannen, 1990, p. 54). “The ‘data’ of human science research are human experiences” (p. 63). The data was analyzed by utilizing a cultural studies brioclage method.

Qualitative research contributes to the “enlightenment” of the participants. Many of those studied (the participants) within the fields of healthcare and social sciences live within the margins of oppression so it is of utmost utility that as researchers we optimize the availability of the qualitative paradigm in order to not further contribute to their domination, at least within our research. “It is in and through the words that the shining through (the invisible) becomes visible” (van Mannen, 1990, p. 130).

It is my opinion that because qualitative research holds the greatest value in its ability to lend itself to the un-silencing of those who have remained without voice throughout the reign of the empirical quest for knowledge and power, from its interdisciplinarian framework, that it is important for qualitative researchers find some place of peace, at least within the discipline of qualitative inquiry. We must yet battle many “other” criticisms and challenges, than for us to consume ourselves.

I used content analysis in which “the data from interviews provides a basis for answering the research question and addressing the research hypothesis” (Geisbrecht, 2003, p. 117). This was an exhaustive process by which the frequency of words, manifest (visible meanings) and
latent (underlying meanings) themes (Babbie, 2001, p. 310) were purposefully examined. The data categories in this study were inferred in that the “scheme waits to let content of text determine the category” (Geisbrecht, 2003). This included that the words of the participants were presented in as sensitively and truthful manner as possible. The participants are the experts in this instance. There was no quantitative method used to validate their individual “truths”. The study was brought back to the respondents for verification of accuracy and it was also read by my friends and peers for validation of relevance in the circles of women to whom the information applies.

This research is deductive in nature. As applied to my study, deductive theory (Rubin & Babbie, 1993) holds that I would expect that the presence of the variables, women’s experiences of trauma, abuse, neglect, poverty, and abandonment (oppression and marginalization) prior to a social work career might increase the likelihood that they might have similar experiences within their profession as social workers.

It is interesting to note that in my research I believe I have uncovered a theme wherein it appears that despite the numerous similarities of the methodological approaches, phenomenological research/ers tend to differ with feminist research/ers in the manner in which the public and private domains of lived experiences are regarded. For example, van Mannen (1990) writes this:

My own life experiences are immediately accessible to me in a way that no one else’s are. However the phenomenologist does not want to trouble the reader with purely private, autobiographical facilities of one’s life. The revealing of private sentiments of private happenings are matters to be shared among friends perhaps, or between lovers, or in the gossip columns of life. In drawing up personal descriptions of lived experiences, the
phenomenologist knows that one’s own experiences are also the possible experiences of others (p. 54).

I took offense to van Mannen’s statement (1990, p. 63), “to bring the difference between phenomenology and other so-called qualitative research approaches (such as ethnography, ethnomethodology, symbolic interactionism… etc). I felt the presence of a familiar condescendence and this made me more aware of the necessity for rigour in my own research. Feminist researchers/activists tend to regard the intersection between private troubles/ public issues as a place to promote change. By making the uncomfortable comfortable, we become more empowered and less oppressed. We do this by talking and writing about issues as they impact women specifically, including such things as wage equity, discriminations, rape, and other violence. “…how much information is socially appropriate to share is grounded in culture and class” (Wagner, 2008, p. 95). We are aware of the implications of language and how it determines and/or persuades our perceptions of specific events or situations. And as women become more vocal, we continue to be frequently reprimanded, and chastised if not punitively punished for our aggressive, inappropriate and unladylike behavior. “And the longer I wait without getting properly fixed, the less concerned I become with appropriateness” (2009, participant interview, Hel).

The point of this research study is to share the experiences of women who have become invisibly ill/dis/abled at some point in their careers as social workers. It was imperative to uncover the essence of their words from within the dialogues as their own words were typed within the transcript pages. To honour these brave warrior women who have endured a variety of traumas and violences against their bodies and spirits, it was up to me, the writer of this document to ensure that I made every effort to describe to the readers what they intended to share. “In gathering anecdotes, one needs to be quite rigorous and construct accounts that are
trimmed of all extraneous, possibly interesting but irrelevant aspects of the story” (van Mannen, 1990, p. 69). “...a hermeneutic methodological approach, which aims to gain a ‘thick’ understanding of other people’s experience...” (Saukko, 2003, p. 8).

In keeping with Saukko’s (2003) analysis of the anorexia discourse, similarly, the dominant discourse of illness/disability “shapes our most fundamental sense of our self’, how we define what kind of a self is ‘healthy’ and what kind of a self is ‘disordered’ and “at the same time it gives rise to specific regimes of treatment and lifestyle, becomes part and parcel of popular media imagery, and is mobilized to pathologize or buttress a variety of social and political regimes” (p. 6).

Qualitative research informs education. It guides how research is performed within the social sciences and across the disciplines. Because qualitative studies are utilized in anthropology, sociology, psychology, nursing, history, philosophy, cultural studies and feminist research studies, we can, therefore, “blend purposefully, qualitative methods, with explanation as to why we blended them” (Cutcliffe, 2004).

Qualitative research is essentially the human side of research and in fact, life is qualitative research. By utilizing a qualitative research study, I chose to offset the existing structural power imbalances, refusing to reduce the participants to measurable objectifications—the output of research, in order to satisfy the criteria imposed upon us by a quantitative paradigm in search of “truth”. I made every effort to offer the participants as much equal ownership of the research endeavor as possible. The ability to do so exists within the qualitative research paradigm as it is constructed, and it depends upon the researchers’ comprehension, creativity and dedication how they choose to interpret and implement the utility of this paradigm within the health and social sciences field. I am hopeful that this research provides diverse analysis of the subject, and is

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applicable to the unique nature of humanity as it is to the exquisite diversity of the women in this study.

It was during the first pass through the data “Open Coding” is when the initial concepts began to appear. This first pass through the data was basically a summary of the interviews. This read was completed with no note-taking. During the second pass, “Axial Coding” a more in depth analysis of the research and its purpose began to emerge (p.423). Here I began to noticed ideas and potential underlying meanings within the data. It seems to me that this stage was like a directional phase of the research process and the rest of the research design grew from this stage of data coding.

During the final “Selective Coding” stage was where the making sense of the data occurred. Here is where I questioned the direction the research was taking, based on the work completed in the previous stages, and I decided if it made sense. It was during this stage that the underlying meanings were deciphered. Here is where I determined whether the participants and I were speaking and understanding the same language and (interpretations). I presented summaries of the data to the participants to determine if my understanding was accurate. It was confirmed that the essence of what was shared between us was accurate and acceptable.

Saukko (2003) refers to ‘dialogic validity’ as a hermeneutic approach that asks “how well it manages to capture the lived realities of others” (p. 19). The main criteria of this approach is “respect of other people’s lived worlds and realities” (p. 20). This thesis adheres to the following three criteria for ‘good’ or valid research as outlined in Saukko, 2003. “Truthfulness. Research should do justice to the perspectives of the people being studied…”(p. 20). “Self-reflexivity. awareness of the way they perceive reality and other people…cultural baggage” (p. 20). Polyvocality. “not studying a lived reality but many”… trying to be true to their diversity as well as relations and tensions between them” (p. 20). “Reality changes when we change the
methodological angle or perspective from which we look at it” (Saukko, 2003, p. 25). Angen (2000) writes “the social discourses we are engaged in, through our past and present interactions with the world around us, constantly inform and reformulate our understandings, our interpretations, and our claims to knowing” (p. 386).

Interesting to note, is that the participants of this research study also acknowledged the potential for possible misunderstandings of their words, and they reciprocated immense respectfulness in their correspondence with me. ChaChaCrowBear writes: “I wanna say HappyTrailz, but I don’t know if you’d like that... LOL Thankz for the RambleOn....” (2009, participant interview). I am curious to know if this behavior simple politeness, or is it because social workers are taught to ask permission? Or is it because as women we are more inclined to cater to the needs of those with whom we communicate? Or could it perhaps be due to some socialized permission-seeking behaviour? This is worth exploring further in future research.

Validity and Limitations of the Study

In all research, there is room for misinterpretation of interview questions and as well, one can question both the legitimacy of the respondents’ answers to the questions, and their motivation for participation in the study (p. 242). Can the research be generalized to other populations? Generalization was not the goal of this research study. What type of inferences might be made from this data? Might the responses of females from a northern community be reflective of the responses of females from a more southern context? Did the researcher maintain objectivity and professional distance from the research? “One of the central criteria for validity in research is ‘reliability’, which refers to the idea that if a different scholar conducted the same research, s(he) would come up with the same or similar results” (Saukko, 2003, p. 18).

“legitimacy for knowledge is at least in part a political one and that the methods and products of science are not apolitical or value-free” (Anastas, pp. 5-6). “The tools of traditional research as they are now used demonstrably do not serve well women and people of colour” (McMahon & Allen-Meares, 1992 as cited p. 6).\[37[1]\]

A future step in the research process would be to identify dependent and independent variables which could be manipulated in an experimental, quantitative research design. One might then determine whether the relationship between the variables is significant. (I have already developed a draft survey for this purpose). These results could be utilized as data for future studies examining women’s experiences of oppression and marginalization within the realm of social work. Perhaps someone might also want to perform a test on high-school graduate women that determines if they have experienced trauma, and also perform the same test on graduate social workers and graduate scientists. Are those who have experienced oppression and trauma perhaps seeking to experience more? This exploratory, qualitative research study is a first step in this process.

This study is in accordance with the structures and guidelines applicable to qualitative research. The results were taken to the respondents for validation (and to peers for verification of meaning and relevance). The issue of reflexivity was paramount throughout the study. As a researcher, I located myself within the study, in order to reflect honesty and to display potential bias and subjectivity. “The use of reflexivity during fieldwork can mute the distance and alienation built into conventional notions or ‘objectivity’ or objectifying those who are studied. The research process becomes more mutual, as a strategy to deconstruct the author’s authority” (Finlay, 2002, p. 535).

The very issue of researcher bias which is used to condemn many qualitative (feminist research) studies is frequently invisible, but evident within the literature presented in quantitative studies, where the researchers fail to disclose the privileged positions they hold as scientific researchers. "Qualitative researchers accept the fact that research is ideologically driven. There is no value-free or bias-free design" (Janesick, 2003, p. 57). Fiumara also wrote that "science is not value-free or impartial" (1990, as cited in Angen 2000, p. 388).

Saukko (2003) refers to 'deconstructive validity' as a poststructuralist approach that gauges "how well it unravels problematic social discourses that mediate the way in which we perceive reality and other people" (p. 19). The primary argument of 'deconstructive validity' is that there is no 'unbiased' way of comprehending the world" (p. 21). As researchers we must always acknowledge our own social contexts/agendas (and how we came to those positions) in order that we do not impose our own views.

What quantitative research describes as "systemic error due to researcher bias" (Anastas, 1999, p. 400) is actually addressed and embraced within many qualitative studies, often in reflexive accounts. Schwandt, 2003, wrote, "acting, and thinking, practice and theory, are linked in a continuous process of critical reflection and transformation" (p. 295), and that phenomenological sociologists use reflexivity to help researchers understand the relevant contexts in which language is dependent. What he describes are the social realities and interactions that are constructed within the meanings ascribed within specific cultures. I found what Li (1988) wrote about the "restructuring of life to accommodate a chronic illness does not take place in a vacuum independent of the social context" (as cited in Anderson, Blue, & Lau, 1998, p. 182) to be especially relevant to my study. And "the lack of recognition of the social context of illness conceals unequal class relationships" (p. 182).
Mitroff (1974), defends reflexive positioning when s/he writes, “research into the work of scientists indicates that the idea of a dispassionate scientist is largely a myth and that the very best scientists are the ones who are most passionate about, and committed to, their ideas” (as cited in Ritzer, 2000, p. 43). If all such steps were taken to maximize truthfulness of the research process, then it is likely that a qualitative measurement of significance will speak to the credibility of the data. “Collins asserted that individuals who have lived through the experiences on which they claim to be experts are more credible than those who have merely read or thought about such experiences” (as cited in Swigonski, 1994, p. 391).

It is preposterous that our health care system is designed in such a way that differences in male/female usage of this system are neither reflected in policy, design, or practice. To suggest that women and men experience illness identically is ludicrous. The literature supports that women and men experience illness and use health care resources in a variety of ways. (Anderson, Blue, & Lau, 1998; Anderson 1985; 1987; Sorenson et al. 1985; Verbrugge 1985). Anderson, Blue, & Lau (1998) also discuss the subjective nature of chronic illness and argue that many factors in one’s life including economics, culture, relationships with family and friends, as well as other elements unique to each of us will impact how we experience illness (p. 183).

This said it is equally unrealistic to expect that all the participants in this study would describe her experiences of having an invisible illness/disability in exactly the same words. And it would be both condescending and nothing short of ridiculous for me as a researcher to paint all social workers with invisible illness/disability with the same brush. It is for these reasons that qualitative research is necessary and invaluable. The results provide a more descriptive and relevant picture of the impact of invisible illness and disability on the lived realities (the physical and emotional lives) of these women.
Qualitative research does not subscribe to the notion of one ‘truth, but instead, there is a recognition of multiple truths. Wagner, Acker, & Mayuzumi (2008) refer to Titchkosky (2003) when write that “disability remains the space for the reproduction of dichotomous gendered and colonial relations between bodies and truth” (Wagner, Acker, & Mayuzumi, p. 66). I argue, also that the context of the truth can be altered to fit the teller’s own agenda. In this paper, the multiple and similar truths have been shared through the stories of the participants, all of whom are experts in her own story, and these truthful versions have been confirmed by those experts, individually and collectively.

van Mannen (1990) refers to Merleau-Ponty (1962) when he criticized feminist research’s use of personal experiences within research and he expressed his preference “to give a direct description of my experience as it is, without offering causal explanations or interpretive generalizations of my experience” (van Mannen, p. 54). I argue that we risk becoming un/intentional subordinators if a we take advantage of and/or use creative liberty to omit and/or misinterpret the meanings and the contextual basis of the data, and rather told the stories in our own words, ignoring the actual meanings, as intended by the participants. This would reflect oppressive research. I did not specifically use the “contrast contexts” method of rich data interpretation as developed by max Weber (Neuman, 1997, p. 433). I was conscious of the potential for cultural differences among the participants, and none presented in the data. To uphold the integrity of this research and to respect the stories of the participants, their words were presented verbatim within the thesis, and not taken out of context or misconstrued. The document was presented to the participants for clarification and verification of information prior to its submission.

Reinharz (1992) writes that when we fail to carefully present the research from the appropriate, legitimate context, it “brings it back to scientific gossip” which devalues what was
said by the speaker, thereby devaluing the speaker, who would likely be left feeling dishonoured, unheard, defensive and violated. Essentially researcher failure to bring data back to the respondents for verification of intent and accuracy was described by Reinharz as “real experiences disappearing in translation.” I do not want my research to be exemplary of “scientific gossip” nor do I want it to be yet another piece of statistical firewood. I want my thesis to speak from within the souls of those who risked sharing with me. “Our friends show us what we can do, our enemies teach us what we must do (Zweig & Abrams 1991, p. 194). I refuse to become the “enemy.”

Failure to locate oneself in the research, with reflective accounts and motives etc. contributes to the oppression of those being studied and fails to provide legitimate, accurate portrayals of the topics we explore. Further, the reader is also victimized because if she does not challenge what is presented, and relies solely on what is presented, (the reader does not know the participants, and has no knowledge of author bias) then bad research becomes accepted as historical fact, and herstory therefore, remains silently in the shadows. Wagner (2008) refers to Anne-Louise Brookes (1992) when she describes how women are educated, through the “reinforcement of feelings of fear, inadequacy and contempt” to separate personal and academic contexts and that to do so is “not nice, not scholarly, and certainly not scientific”. She argues that “relations of power work to produce the well-kept secret of violence against women”, and this continues to “silence them” (Wagner, p. 92).

**Triangulation and Crystallization**

Triangulation is a concept that lends itself to the credibility of qualitative studies. Denzin (1978). ‘Triangulation’ can be “interpreted as a pursuit of truth” (Saukko, 2003, p. 23). “Theory triangulation is the use of multiple perspectives to interpret a single set of data and Methodological triangulation is the use of multiple methods to study a single problem” (Janesick,
2003, p. 67). My use of bricolage and interdisciplinary methods to interpret and analyze the research, are both reflective of these two methods of triangulation. Although triangulation is a framework based in positivist methodology that can be useful to combine some approaches, Saukko suggests that it is not entirely useful in combining the three approaches she described. “The strength of these analyses is that, working from the inside out, they provide powerful critiques of how discourse constitutes us. However, this acute critical insight into the self is also the greatest shortcoming of this line of inquiry” (Saukko, 2003, p. 86).

‘Crystallization’, instead, uses the metaphor of “prisms” (Saukko, 2003) to illustrate that “there are endless or multiple truths about the reality” (p. 27). Janesick (2003) also referred to Richardson’s (1994) notion of “crystallization” in that it is subjective and dependent upon a complexity of reference points, including the distribution of light that reflects on/against/through a particular lens at a particular moment (Janesick, p. 67). This lends itself to the idea that the nature of research is in fact subjective, and we must be careful of this, so as not to disregard potential bias from a variety of sources.

Further to the matter of validity and credibility, as is so with many qualitative researchers, I do not subscribe to the positivistic belief that there might only be one “truth”. Therefore, it is plausible that there could be a variance in interpretation of the data from my study. As noted in Janesick (2003) I included “written testimony from my participants” (p. 75). Their words were woven throughout this paper exactly as they were written as a “type of permanent insurrection” (Janesick, 2003).

This research is to satisfy the requirements of a Masters Thesis. For this purpose, I chose to limit my participants to six women. Micro-level theory, as described in Rubin & Babbie (2001), focuses on small slices of time, spaces or numbers of people (p. 49). According to the guidelines of qualitative research, this research will produce rich descriptions and analysis from a variety of
disciplines. Finlay (2002) write that “noting that the validity of research is not only a matter of the methods used” (p. 536). And Finlay refers to Kvale (1996) when identifying the “moral integrity” of the researcher as “critical for evaluation of the quality of scientific knowledge produced” (Finlay, p. 536).

Andermahr, Lovell, & Wolkowitz (2000) describe qualitative research as “interdisciplinary” which differs from multidisciplinary in that it has “the tendency to blur the confines of methodological boundaries within the disciplines” (pp. 135-136). This is particularly beneficial to analysis of women, gender and culture (pp. 135-136). Importantly, this enables social science researchers to dip into their toolboxes and utilize methodologies that would otherwise be off limits within their research.

Confidentiality /Ethical Considerations / Informed Consent

This research project was ethical and in accordance with BCASW, Section 9.3, “the social worker will take reasonable action against the unethical conduct by any other member of the profession” (1984, p.11). It also reflects and adheres to UNBC approvals and REB standards. Brzuzy, Ault, & Segal (1997) wrote, in a study of female trauma survivors, that “victimization and trauma are a significant part of women’s lives” and that we must be careful not to re-victimize the women we interview. As a feminist researcher, I do have to help peel back the layers to get to what is on the inside, but it involves a careful process, so that what is inside does not become further damaged, or left exposed. “We do not want to leave our participants not knowing how to cleanse and heal” (Transken, Seminar, 2003). For this purpose, a list of counselors was included in the informed consent packages sent to the participants, along with the university research ethics form. Also, because of the confidential and sensitive nature of this study, the potential implications were discussed with the participants prior to signing consents.
Also, I utilized reflexivity as a self-protection tool during the interview process. Being aware of my own thoughts, emotions, and possible triggers, helped me to be a more effective listener. Due to my own proximity within this research topic, there was potential for me to experience triggers from witnessing the accounts of my participants and also there was potential for my own biases to contaminate the accounts of the participants. "It is not possible for qualitative researchers to be totally objective, because total objectivity is not humanly possible" (Ahern, 1999, p. 407).

Due to the fact that we exist in relatively small communities there is a remote possibility that particular aspects of references might be recognized by participant colleagues or acquaintances, which could potentially jeopardize anonymity. Also, some aspects of the interview transcripts may have the potential to "expose" agencies, which would have various implications thereby creating the potential for repercussion. For this reason, all names were changed within the writing of the paper. The participants chose (or asked me to choose for them) a "goddess"- pseudonym to be used instead of using our actual names. Also, no communities or agencies were named within the paper to further protect respondent identities. Tremendous care was taken not to reveal any identifying information of the respondents, all of whom were fully aware of the potential risks to this research. My hopes that any risk potential was outweighed by the benefits of participation have been verified by the participants, all of whom have expressed overwhelming personal satisfaction from having participated in this journey.

**Timeframes**

In the earlier stages of this thesis journey, I gave myself exactly one year to complete the research process. I was hopeful that the data would have been transcribed and that the results would have been transferred to my working thesis by December 2004. And it was my intention
to present my thesis by January, 2005 for the first review. "The road to hell is paved with good intentions!" (lol).

I was fortunately blessed throughout this journey, despite much tangled trauma and strife, with scholarship awards which enabled me to pursue and persevere. It is through the generosity of those scholarship programs and the compassion of this university that I managed to make it to this point. My most recently amended goal of defending my thesis December, 2009 have been successful. I am presently writing the revisions with overwhelming joy and satisfaction at having completed what I set out to accomplish...and this has been a tremendously expensive suicide prevention (lol)!

Financial Considerations

I was initially prepared to budget a total of $1000.00 to facilitate the completion of my research.

Photocopying $ 200.00
Phone Calls $ 200.00
Gifts/ Honorariums $ 200.00
Postage $ 200.00
Other Expenses $ 200.00

Total $1000.00

At this time, due to my devastating financial situation, (I have been engaged in a nasty, ongoing battle with the NSL since 2002 and my credit has been completely obliterated) and due to the lengthy duration of my illness and lack of adequate and appropriate medical treatment, I have lost everything. I have absolutely zero dollars with which to budget for completion of this research study, other than the scholarship I was recently blessed with. (I no
longer qualify for student loans as I have apparently met my lifetime maximum limit). I continue to receive my disability income, thankfully, but I live in fear each day that this might be revoked for some reason unbeknownst to and uncontrollable by me. This sense of powerlessness and dependence leaves me in a state of imminent despair. I am ever-grateful for the generosity and helpfulness of my supervisor whose fantastic wisdom and creativity have been utilized to find ways to see this journey to graduation. And I give tremendous thanks to the goddesses and again to the scholarship awards donors and committees as mentioned in the previous section.
CHAPTER FIVE
SO WHAT?

Findings

Most importantly, I have learned from this study that women’s experiences and perceptions of invisible illness and dis/ability are incredibly subjective. But having said this, collectively, isolation, poverty, depression/sadness, shame, fear, powerlessness, and the frustration presented by the invisibility of the illness itself, were overwhelmingly reported in this study as the most devastating challenges these women experienced as they maneuvered through the various medical, employment, and political systems. ChaChaCrowBear writes: “Shame and sorrow were the challenges...to move Thru them was the work. So my getting sick forced me to get well...ironically...paradoxically...twistedly... (2009, participant interview). And Kali writes: “I believe that putting me in the hospital and putting me on heavy sedating medications without any talk therapy, without the coherence to be able to even say what I was feeling or what I may have needed for myself, was devastating for me and for my children” (2009, participant interview).

Challenges included accessing and receiving adequate medical services and treatments, in a timely manner. Venus shares:

The most challenging aspect has been financial...it takes two or three years to recoup and then I am back in the throws of the disease again...Because this illness is invisible and intermittent in the way it debilitates me people, often don’t get the seriousness or degree of my issue...I have learned to ‘give er’ and excel when I can, then ‘go down’ when the disease is rearing its ugly head...very frustrating” (2009, participant interview).

Kali describes this:

...hard to say what is the most challenging but equally hard I would have to say the lack of support from my agency was a very challenging part of the process because I never knew
where I stood with my link to my income and my financial ability to keep afloat... and the children and not having them cared for and not having them understand to this day what went on and my constant questioning my abilities... (2009, participant interview).

Based on what was described by the participants, I found evidence supporting possible correlation (to be further explored in a quantitative study) between personal and social resources, finance, perception (self and others) of illness, and overall individual health. This led me to question might social connectedness also contribute to women’s abilities to maneuver through the various processes, including accessing medical care, dealing with employers, and overall perception of self and illness? Is social connectedness an important indicator into how women might experience invisible illness and dis/ability? For instance, are the experiences of women who are well connected to her family, friends and community versus the experiences of women who are relatively disconnected/isolated from family, friends, community (ie. ‘transplanted’ for employment) dis/similar in regard to invisible illness? This emerging theory was supported in the data provided by the participants in this study. The study developed into an examination of the potential impact of class and wealth in the female experience of invisible illness/dis/ability and is something to be explored in further studies.

Those participants who listed a variety of support systems, for example, spouses, immediate family (specifically mothers, and children), and available close proximal friendships, as well as positive work environments, tended to have the most positive outlooks of their situations.

ChaChaCrawBear writes: “I have Sisters and I have a Circle of WomenFriends who Love me a lot...and I have GrandFathers and GrandMothers....My grandson stayed with me a lot, he loves me...we are tight...my sister let me stay in her basement, my brother-in law...is the only Man who never left me” (2009, participant interview). Venus writes that “women are so amazing to be able to have the depth and insight of character to be able to extend their caring to others during
times of personal distress...I got allot of support from my girlfriends...more so than my family” (2009, participant interview).

Those women who described a combination of solid friendship networks and healthy family supports as well as the financial means with which to access timely medical services/treatment, seemed to not experience the isolation (that is often symptomatically associated with disability) to the same degree as those participants who were not as well grounded or connected to her community. ChaChaCrowBear sings: “...if not for getting by with a little help from my friendzzz” (2009, participant interview). And Venus adds: “I have had girlfriends do housework and help with my son. My husband met me while I was on a disability and was quite willing to get involved with me despite my illness. He really excels when he has to take care of me...I am nurtured by him...he has brought economic stability” (2009, participant interview).

Perhaps women with emotional or geographical disconnect from family, friendships and other social supports might be more inclined to suffer more intense depressing factors of invisible disability, lending itself to the possibility that she be further marginalized by the existing structures within the system that tend to blame and re-victimize women for their situations...thereby reinforcing the cycle of oppression...ChaChaCrowBear sarcastically laughs: “LOL the medical model sucks...the MedicineWheel encompasses ALL...” (2009, participant interview).

One participant identified “excruciating” social isolation and devastating financial loss due to the “debilitative nature” of her illness. She described some of the most profoundly negative, heartbreaking, and hopeless experiences. She presented tremendous loss and grief, similar to someone in mourning 38. She mentioned that the past two years of counseling was helping improve her functioning and overall outlook, compared to a number of previously unsuccessful

38 I am curious to learn if perhaps her suffering might be reduced through positive social connections.
counseling attempts 39 (2009, participant interview, He). And Venus writes: “I always had emotional support but no financial support” (2009, participant interview). Kali offers this:

I didn't however have anyone that was family that was able to come and help take care of my children for any length of time. My oldest sister came to help me for about two weeks but she had family of her own that were still being raised and needed her assistance. I did have friends who stayed with me some nights and slept over at my house to help to relieve some of the pressure as the children became very high needs because of their own fears, and disbelief (2009, participant interview).

It seems that isolation, when combined with poverty, increases the anxiety and stress related to accessing medical treatment and services, and I suspect this would potentially increase any existing physiological and psychological symptoms of the dis/ability. The women who reported less intense financial struggles did report frustration with their invisible illness, but to a lesser degree.

Those participants who expressed having little or no financial difficulty 40 accessing services and who had the ability to travel comfortably to and from communities for necessary specialist appointments/ consultations, surgeries, follow-up care did not describe as much frustration or futility compared to those participants for whom inadequate funds were paramount to perceived poor quality of care. And they did not refer as strongly to experiencing delays or lack of medical treatment.

39 She referred to previous attempts to get help as “abusive, unhelpful, and horribly oppressive largely due to language/ cultural barriers (incidentally, the counselors/psychiatrists she was referred to were older, East Indian males), gender bias, and an inability to communicate issues of trauma, poverty and sexual abuse” (2009, participant interview, He).

40 One participant who later dropped out of the study (for undisclosed reasons) did not report any financial issues because she stated that she and her spouse both had very good extended heath care plans which she was able to access freely. She claimed to manage her illness with “good self-care” and the “support of her spouse” (2009, participant interview, Lis). She expressed gratitude that because both of them were employed and their extended health coverage plans provided dual coverage, she was able to monopolize on this to use a variety of services that would otherwise be unaffordable.
Powerlessness is the common experience described by the participants which includes needing something, (or something is needed of us), but it remains beyond our ability or reach. An overall sense of powerlessness emerged from within the data, (some participants acknowledged this, whereas others implied it). This sense of powerlessness is extends itself to not only the individual experiencing the invisible illness/dis/ability but also those around her. It is also painful and unbearable for loved ones to witness our suffering while they stand by in relative helplessness. “My son has been greatly affected by my illness…but he is a social worker today and I hope that some of that passion came from helping me to successfully live with and indeed overcome my illness” (2009, participant interview, Venus). Hel shares the following:

I die more each day, knowing how much my son misses his ‘old’ mom… his frequent statements such as “I just want my mom back! You’re so puny and weak now I’m always afraid you’re gonna break…you never used to have to ask for help now you can’t do anything” are simply heartbreaking reminders of the tremendous loss my illness has caused.

“We used to wrestle and play-fight, now he has to be so gentle…it scares him still…sometimes he forgets, a playful jab to my arm, challenging me…regret…it is so difficult to witness his grief, which is constant reminder of my own…(2009, participant interview).

Fear was prevalent throughout the data, and it was expressed by one participant that she has no financial means to hire a caregiver when/if she receives intestinal repair surgery, and she is neither nearby close friends nor family. She jokingly referred to herself as “GUD” 41. She has no idea how she is going to tend to her surgical dressings, and due to the intimate nature and debilitating factors of her illness, she would “not feel comfortable asking just anyone” (2009, participant interview, Hel). Venus describes her fear: “I was always aware that as a single mom,

41 geographically undesirable.
if I looked like I couldn’t take care of my son, then they might take him away... I lived with the fear of asking for help (2009, participant interview).

Hel identifies her fear of being cut off disability and her constant frustration in the following passage:

I can’t work one job, let alone, three jobs like I used to just to pay the bills... and if the doctors refuse to complete the forms, (I had a specialist tell me “that’s not my job”) the employer/disability services doesn’t pay the money... so because there is a doctor shortage, therefore I can’t get a doctor in another community, and when I do get an interview, the new doctors are so overwhelmed and troubled by the complexity of my situation, they won’t touch me with a ten foot pole! So I am forced to continue to travel between 3 communities, up to 10 hours driving (one way) between them whenever my appointments are scheduled, and I have little control over the scheduling of these appointments... I have spent a fortune, (and I lost everything including my horses, vehicles, furniture, in the process) because medical travel, moving, and living expenses has left me destitute, but still the government continues to bludgeon me... they steal every penny they can possibly grab... most insulting is that 8 years into this and I’m still not fixed!” (2009, participant interview).

And ChaChaCrowBear describes similar fear of losing her income also: “I was afraid all the time now that I knew how sick I was, anxiety, and depression were constant... I was scared it (long term disability) would not be allowed by my employer... I hated it that I was fearful every month, that my cheque would not come...” (2009, participant interview).

The division between “deserving and undeserving” becomes very visible when we are exploring invisible dis/ability. All the participants expressed that they felt guilty for acquiring an invisible illness, implying a need for validation. This validation came by means of labels from physicians, completion of medical forms, parking permits, medical reports, and disability pay.
However, despite the legitimacy of the diseases, the pain, discomfort, and disruption endured by the participants, most remained (or became) illegitimate and bastardized within their work environments. Davidson (2001) writes “while diagnosis is in no sense equivalent to a cure, feelings of immense relief, of recognition and legitimacy are common among newly diagnosed…” (p. 167) and “having something nameable gives subjects something to work on, and offers new hope that it is also treatable” (Davidson, 2001, p. 168). All the participants express frustration from being accused by their colleagues and employers of illegitimately receiving funds that are supposed to be for people who are “really disabled”. Some express that they were scorned and subjected to verbal assaults, and vicious notes, for using SPARC parking permits when “clearly they could walk”. And a participant describes a heartbreaking situation where she recalls her picture, on the wall at her work, was defamed.

I found evidence that the subjective nature of individual perception of illness/health, and normalization might lend itself to the debilitative/degenerative natures of the actual (self-described) illnesses and to changes/adaptations of participant lifestyle (for those participants who spoke to this), as well as severity of the ailment itself. The participants who described the most isolation (in a variety of ways) and who were the poorest tended to have the least access to services and they described some of the more depressed overall circumstances.

All of the participants reported experiences of feeling ‘unheard’ of being ‘devalued’ and ‘condescended to’, and of being treated like a ‘complainer’ like ‘a child’, and like they ‘had no choice/say in what happened to them’ in regard to the medical system. They all referred to overwhelming feelings of powerlessness.

A few of the participants described positive experiences at their workplaces in regard to their peers, and two participants noted that they would not have been aware of disability benefits programs if a colleague had not intervened. Both would have just left. Hel writes, “I would
have just quit my job, and committed suicide because the doctors were not helping me and I was terrified because of what was happening to my body” (2009, participant interview). Kali describes that she was aware of the benefits that she would be eligible to receive because she “had helped to negotiate them” with her union (2009, participant interview).

All the participants described large caseloads and lack of supervision and direction in their employment. All the participants described workplace isolation and abandonment in regard to job expectations and training. One participant claimed that her work environment was great before she became sick, but this changed when she went on sick leave. Another participant stated that her employing agency was extremely abusive when she became ill. And her experiences in the medical system were horrifically abusive and degrading. She described racism, ageism, and she endured much workplace violence.

As Kali eloquently describes loss and change in the following poem, the profundity of that which we take for granted such as rugs, relationships, financial stability and good health has been a primary theme within this research. Especially how when these are removed or torn from beneath us we falter like a newborn foal...seeking something to cling to, feebly we attempt to balance our once steady stance or narrow grasp of reality:

The rug covered that hall, Persian I believe intertwined, rare and beautiful, marked by age it was pride, as it laid on shiny hard wood the colors so sublime. This rug it was , love and security always there to warm my feet, there every single day, not moving even taken for granted, beautiful. Back and forth, corners turned fringes and tassles pulled and stretched, priceless part of life and part of love this masterpiece in cloth stability, security, aged and rare, colors all in turn I strode across like every day, noticing a slip, pulling steady, balance was a chance quick steps on the rug, the beginning of the dance questioning I watched my step, moving side to side. In a hurry, I didn’t notice then, the rug had slipped, from under
me. I landed on my head, then forward in a crashing way, my knees were red and torn, rug burn from stability was bruised and stretched and gone. Rugs are rugs, beautiful are some, others simple twisted knots, no symmetry, rags and bags conform no matter where they lay, they’re all the same, they cover up the floor. swept under rugs are many things we all try to ignore. I like to stand on stable ground and feel what’s real look face on and see the shifts of energy and pain rugs cause burn, deceit and cover up mud in rain bruised knees heal, so do hearts, nothing heals swept under rug, carrying those scars, the redness goes away at times I think I may have done it to myself, pulled the rug, landed hard, bruised my head and heart only time will tell the end, I stand on stable ground again (2009, participant interview).

Presentation of Results

“Given the entrenched inequities within the system, introducing meaningful change will require challenging the normative practices that currently force women to remain in disadvantaged position” (Wagner, 2008, p. 101). The results of the data will be presented for submission of my thesis to the University of Northern British Columbia for thesis defense/celebration. The finished copy of the thesis will also be presented to those participants of the study who expressed that they wish to receive a copy. I will also be presenting this information to the National Association of Social Workers for their review as it directly speaks to their (2003) statement of non-violence.

Hope, Faith, Spirituality and Forgiveness

“...with Love Acceptance and a great therapist, I unlocked the fuckin block!!!blox...” (2009, participant interview, ChaChaCrowBear). I would like to conclude my thesis with this piece of writing to honour the triumphs that speak to the strength and survival abilities of the women who partook of this study. It is my preference always to give bad news first, then offer the

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42 See appendices/supplement section for Statement of non-violence.
good, as I find this tends to leave people feeling somewhat uplifted, if not hopeful. Therefore, this section includes a composite of the kindneses, nurturings and anecdotes shared by the participants (and from other conversations and learnings) to prevent this research from becoming too negatively saturated.

My goal rather, is for this research to be viewed not only from a bittersweet, provocative, and reality-drenched perspective, but also from a “dark and twisted” 43, neither truly funny nor entirely politically correct scope. It is my intent that the voices from these pages stir in all of us the necessity for action and movement towards change. It will be a sacred section honouring those who have provided us with sustenance, and soul-food throughout our journeys. Hel shares some darkness:

My poverty and disability have reduced me to a walking-wounded, exposed soul. I feel like I have been castrated as well as my legs have been broken. I am the eagle in captivity and the whale whose dorsal fin flops over in sadness. There is no remedy for such despair other than regaining my health. For me, there is no substitute, only death (2009, participant interview).

“The shadow starts to emerge, as the person looks to their inner life more, less taken up by the demands of the external world” (Page, 1999). Throughout this decomposition, my emotional well state has deteriorated immensely, rendering me permanently disabled, scarred for life. Henning (2006) refers to Graves (1990) when she writes “empowerment of people with disabilities occurs through three strategies: people having the information and knowledge they need; people having economic opportunities; and people achieving their civil rights” (Henning, p. 38). And Venus roars, “education is power” (2009, participant interview)!

43 Hel identified a “dark & twisted sense of humour” as her biggest coping mechanism, and similarly, humourous anecdotes were noted in all the transcripts.
The participants question how they might be hopeful in a hopeless system. “Hope is essential to healing” (De Luca, 2001). I question how I am to encourage other women to be strong and to be hopeful, when I am incapable of these tasks myself? Pearlman & Saakvitne, (1995) write, “holding hope with and for our clients is an essential part of their healing. In order to sustain that ability, we need to be aware of subtle shifts in our own capacity for hope” (p. 392). Notable to the concept of hope is that in my own journey, my UNBC wellness centre counselor offered to hold hope for me while I am empty of hope for myself and this has freed me of carrying the burden of guilt for feeling such hopelessness and self-pity. Malmo & Laidlaw (1999) write:

Outwardly, I appeared competent, cheerful, warm. Inwardly, I felt completely in darkness, in a body that was slowly fragmenting, shattering, going numb. I didn’t understand what was happening to me. All I knew was that I was slowly edging toward death. This made me feel very sad and guilty…(, p.108).

Throughout my own journey with invisible illness/dis/ability, I questioned if it is ethical of me (or any social worker or professional) to work with clients, under the pretentious guise of social work values and philosophies when, in fact, we are the “walking wounded?” I have paid a lot of money to be here. Transken (2008) reiterates this sentiment: “being an academic costs me more than I ever imagined” (p. 222). I questioned also if I could write respectfully because if not then it would be neither appropriate nor ethical for me to write this thesis. The profession of social work has already been consumed with hypocrisy and I choose not to contribute to this toxicity.

I have observed that those adults who were unable to fully experience childhood for reasons

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44 I have abundance of hope for others but do to the gross nature of symptoms and suffering, and the intolerable and lengthy wait for medical care for me, I have long since run out of hope for myself.
45 For the record the answer is "yes".
including abuse, neglect and other trauma who have maintained some sense of childlikeness appear to have some innate resilience that enables them to handle somewhat effectively, much of what life throws at them and they seem to have ability to persevere despite tremendous chaos. And it is interesting to note that many of those people have become social workers. I question if this might also have anything to do with one’s spiritual beliefs and coping strategies (or lack there of).

Pearlman & Saakvitne (1995) identified that we “seek spiritual renewal”, and “remain hopeful” and that we “take time to have a personal life” (p. 391). Mayuzumi, & Shahjahan (2008) describe the significance of spirituality in academia as a means by which to alleviate the suffering. They refer to what Asante (2003) calls a ‘victorious consciousness’ (Mayuzumi, & Shahjahan, p. 196). They also discuss the lack of credibility given to spirituality in many academic realms which they describe as a symptom of marginalization.

“I have always been active in my faith and so I had a fairly established social support through this network” (2009, participant interview, Kali). “I have slipped into such a depressed state that I fear that I will not be able to ‘snap out of it.’ This has become very scary for me. I feel hopeless and shame that I have been reduced to this nothing” (2009, participant interview, Hel). If hopefulness truly is what pulls people up from such places, then I have been blessed to have found strong women who were willing to have and hold hope for me while I am unable to do so for myself. Hel shares this:

I find myself in such darkness...my world is rain and mud. There is no light. There is no hope for change or future. My desire to plod onward is depleted and exhausted. I am tired... The wise old woman in me knows it is time to sleep. She is unable to carry me further. She has grown weak, weary from the continuous storm that is my life here. She knows the seed could grow, but she cannot continue to absorb the rain, that has damaged
the fertile soil, making it mud...drowns the nutrients, limiting the potential for growth. We are starving...empty...The shell, outside-skeleton of my wise old woman gazes back at me from the mirror, wishing she could see her alternate reflection, the youthful, vibrant, healthy soul. But instead she sees nothing, for my vibrant self is dead, unable to fight physicians, politicians, employers...not measuring up to standards...obscure abusive reasons, too weak to fight such systems any longer... (2009, participant interview).

Jordan (1997) writes that depressed persons prefer isolation as this creates an illusion of less vulnerability to further abandonment. Baker Miller & Pierce Stiver (1997) similarly discussed that people develop ways of surviving traumatic situations to avoid becoming re-wounded.

...finding the way back to one's rightful psychic order begins with the feeding of or caring for a lonely and/or injured woman, man or beast. That such a child, who will have the ability to traverse two very different worlds, can come from a woman who is in such a skinless state and “married” to something in herself of in the outer world that is so lonely and undeveloped is one of the constant miracles of the psyche (Pinolka Estes, 1992, p. 273).

The division between the conscious and the unconscious can be described as layers, like an onion peel or limestone that represent adult socialization. What this means is that because we all have been socialized by our families of origin, our peers, the media, health care and educational systems, we have prescribed a set of values, rules, and social norms based upon our own learnings. These concepts shape our both our individual and collective/cultural selves. Essentially, we have two sides to our psyches; “a light side and a shadow, or dark side” (Seminar, 2003). Many of us recall this famous line, “Luke, come to the dark side” (Lucas, 1977). Jordan (1997 p. 153) describes that some of the experiences from within our collective our individual psyches cause us to feel shame. ChaChaCrowBear tells it like this:
Being on a disability claim was like being on welfare again kinda...the shift from that was EnergyWork around my relationship with poverty, using it as a negative Self image...was so out of balance for me, I used it often to be Right, to say fuck you to the system, the capitalists, the Imperialists, the ongoing assaultive oppression of someone is ALWAYS killing Aboriginal Women...when secretly I fuckin LOVE money...if I hadda had $ I may have used it to stay in denial, to just focus on looking good on the outside...the power to Change all the racism and judgmental shit has happened...on the inside...it is still often the challenge for me to Remember there are 4 TobaccoBundles hung in the arbour, in the Sweat Lodge... (2009, participant interview).

Bartky (1999) describes how “self destructive expression” is borne from shame and is “profoundly disempowering” (p. 97). She also describes how “secrecy and concealment” within the “shame experience” “isolates the oppressed from one another and in this way works against the emergence of a sense of solidarity” (p. 97). Dann offers this:

I know I always feel shame when asking for time off to look after my mental disability, although that has certainly eased in 25 years it is still there. I think after awhile the stigma gets inside and I know I am always fighting with my head feeling broken, feeling I am not a valued resource because I have this thing wrong with me that you can’t see, that the more I have to try to convince you, the sicker I sound...when I have been terribly ill with my invisible illness becomes visible to those who know me; the symptoms of severe depression, mania and psychosis are unmistakable. It is in the recovery stages from these crises that friends and family get tired of supporting me, forget that my ego is disintegrated, shattered, no longer intact. They don’t understand why I blame myself and feel shame for this psychiatric disability. It may not be my fault but it is always my consequences to live through (2009, participant interview).
I forgive myself for this shame. I forgive myself for being only strong enough to come this far. I forgive myself for being unable to feed my wise old woman at this time, when she has fed me so much. I forgive myself that I am unable to carry her right now. I forgive myself for having to be carried, while the “other me,” a physically strong-backed, strong willed person who carries others, lies without breath, bleeding out, on the black pavement...

...saved my life. ForReal and not for the first time...Dr. (name deleted)...supported me on applying for long term disability. She is a Healer, in the TrueSense of the Word...she validated my tears, anguish, confusion, fears...They Accepted me...I am a SpiritualWoman...I Offer them what I have and they Give me what I am...(2009, participant interview, ChaChaCrowBear).

This study is a “celebration of survival” in keeping with Tuhwai Smith’s (1999) strengths framework. Venus writes: “Women need to know that it is ok to celebrate their differences between each other and between men. Take ownership of your health journey. Be assertive, seek other women to share my story and gain strength form other’s journeys” (2009, participant interview). Danu argues: “Flexibility would go a long way in managing an invisible disability. The forms you fill out and the paper work you go through makes you feel like you are dishonest and trying to scam or get something for nothing; it would be nice to be treated with integrity. More respect for dignity and privacy” (2009, participant interview). And Kali offers this: “I would create a safe place for women, men and the children financially to get through the rough days and places of the journey” (2009, participant interview).

This journey with invisible illness/disability has taught me to recognize how our psyches find creative ways to warn us of potential danger and how it enables us to act out socially inappropriate responses to real events, through the images and actions of our dreams and
through artistic, creative outlets including humour, spirituality, and poetry\textsuperscript{46}, as in the following delightful piece:

As Kali, the Hindu goddess, I have had my ego challenged, stepped on, torn down and killed. I picked up my remaining body parts and stand with the skeletons of the masks of my past that have become my jewelry. I stand as Mother of beautiful children that will have to fight their own demons and I will be there, naked, willing and able to guide them through life’s journey, their pains and their sufferings. I have turned my palms down and given the world back to Christ to carry the weight of the world. I relinquish my position of power and pick up the wisdom, and love of the future (2009, participant interview, \textit{Kali}).

Although my own medical situation increases intensity every day, and I can barely tolerate the amount of incontinence accompanied with the excruciating pain it brings to my pelvic area, and despite the increasing frequency and duration of the yet undiagnosed seizures and despite that I have become very alone and empty with nothing to contribute, other than an ‘insight to insanity’, (and a morbidly twisted sense of humor, lol) I manage somehow to remain pessimistically optimistic because my research contribution might provoke thoughts and discussions about how we have become desensitized to the nature of gender-violence and have condoned and reinforced it within our own structures. From this study and process I am hopeful that we will work towards creating necessary societal, professional, and legislative changes that will improve the quality of life for all women. And I am pessimistically optimistic that the profession of social work will one day step back to reexamine its own internal policies.

\textsuperscript{46} Poetry is a creative energy that is generated from deep within the psyche. I am grateful to Dr. Transken for encouraging and supporting the development and exploration of the creative energies form her students, and for illustrating how poetry can be woven into scholarly, academic work. I thank her also for introducing me to the works of scholars/authors (including her own) who incorporate such inspiring techniques that enrich the research process. I appreciate the opportunity to nurture and channel the development of my own creative energies throughout my ongoing healing and academic journeys.
that have contributed to the ongoing historical marginalization and oppression of those whom
provide social services to others similarly oppressed.

Wagner (2008) writes that when we close our eyes to the violence that women are subjected
to, and when we fail to intervene, we are guilty of limiting women’s full participation in society.
And she argues that when we pretend that violence against women is not the common
experience of most women, we “collude in the silencing” (p. 101).

Despite the fact that women have contributed significantly to the development of humanity
and community, we have been raped, sold, silenced, and subordinated by the masculinized
structures that were designed as a means with which to dominate us. Frankly, the concept of
choice has been merely an illusion created by our captors, in order to punish us further for our
inabilities or refusals to submit. In this way, when women are observed behaving “badly” they
can be persecuted for having made such “poor choices”. This takes away onus from those who
placed her in the position of fighting for survival in the first place.

The concept of male domination over women that I have illustrated throughout this paper
has remained constant and has presented itself as a challenge to feminist women (scholars) in
society both past and present. I believe that I am in small but good company when I leap into
the realm in which I propose that society has contributed to and not always quietly condoned
the marketing of women as a disposable commodity.

Women are, unfortunately, equally guilty of this. For example, many women continue to
view marriage as a proper life choice and that this union between a man and a woman “entitles”
er her to benefits from the relationship. These married women then regard the single mother, the
street prostitute, the escort, the mistress “other” with alarming contempt and distrust. This is a
phenomenon described by Shaw & Lee (2004) as “horizontal hostility” which is “when
individuals direct their resentment and anger onto those of equal or lesser status” (p. 69).
I propose that women become brutally honest with themselves, and acknowledge the painful similarities, as witnessed (and experienced) from a survival lens, rather than from a lens manifested and structurally reinforced by those who would as easily have traded her for something more potentially marketable, and that we collectively refuse to tolerate fear-based existence, vehemently recognizing that we are on the same team. As ChaChaCrowBear gives us in her wisdom: “...my experiences boiled down to...MYOwnBeing...the invisible made me Seeeee and Feel my Way” (2009, participant interview).
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Health and Social Behavior 26: 156-182.
**Succulent Supplement**

**Goddess Names/Biographies**

ChaChaCrowBear is the name bestowed upon this participant by her grandson. “ChaCha is short for Chapan which is GreatGrandParent in Cree, there is no gender diff when you reach that level, both are Chapan ... I am Kokum {GrandMother in Cree} but GrandDaughter shortened it to KoKo ... so I have moved from KoKo to ChaCha ... Kind Wordsy ...” (ChaChaCrowbear, 2009). She wears this name with honour, dignity, pride, and the strength of her grandmothers, sisters and those who walk the path alongside her...sometimes they carry her when her own limbs grow weary, and for this she is grateful. She speaks with much wisdom and her words echo the wind, the beat of drums...her heart pounds ever-strong.

Sidhe (pronounced Shee) is the Irish word for a hill or a mound, in which live the fairy folk, the Tuatha De Danann—the people of the goddess Danu. Danu, or Mother Earth, is a universal mother goddess and the guardian of the earth and the moon. This goddess of plenty is the greatest of all Irish goddesses, the ancestor of all the gods, providing prosperity and concerning herself with all aspects of life, including health, fertility, and comfort. The sidhe remind us that sometimes when you look beneath the surface, you find a goddess to welcome you (1996).

Hel is the ruler of the Norse underworld. Because she symbolizes the dual nature of all things, she appears both monstrous and beautiful, reminding us how life and death are interrelated. The youngest child of the trickster god Loki and the giantess Angrboda, she was kidnapped and cast into Helheim, the realm of death, at the bottom of the universe. This was not a place of punishment (although the Christian hell is named after this goddess), merely where the dead were sent, especially those who died of sickness or old age. Hel rides a horse—a nightmare—foretelling death (1996).

A moon goddess, Isis has the power to give and restore life; she is also the goddess of medicine and wisdom. Isis is the wife of Osiris, king of the gods. Seth, their jealous brother, murdered Osiris, dismembered him, and scattered the remains across Egypt; Isis collected all the pieces and brought Osiris back to life. Horus, the son of Isis and Osiris, later defeated Seth to become the first ruler of Egypt. Isis’s other names include Queen of the Earth, Goddess of Life and Healing, and Protectress of the dead (1981).

Kali Kali’s name literally means “the Black One.” According to a less probable etymology, Kali is the feminine form of Kala, “time.” She represents the aspect of the goddess that is commonly known as the “Destroyer.” She is referred to as “Terrible Mother”, “Black Mother Time”, or the “Black One”. She symbolizes inexorable force of time, which devours and destroys everything in its path. Here black color, suggestive of the darkness that is at the beginning and at the end of life, reminds us of the inevitable confrontation with our own mortality. Instead of colorful jewels that adorn other goddesses, Kali adorns her otherwise naked body with skulls and limbs around her neck and waist. Kali’s image, enhanced with trickles of blood emanating from her fanglike teeth, gaping mouth, and lolling tongue, is reinforced by disheveled hair, 47

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47 The participants chose the goddess name/pseudonym they wished to use for (confidentiality) purposes of this study. I provided a list from Susan Elanor Boulet Trust (2004). Goddess: 2005 Calendar. Petaluma, California: Pomegranate Communications, Inc. If a participant was unable to make a decision, she asked me to please help her choose a name. I helped them with this, based on information they had shared and the strengths I recognized in what they had shared with me. Some participants had names picked out and provided the reference information or details of the name. Reference info for Kali is cited from Agha-Jaffar, T. (2005). (Ed.). Women and goddesses: In myth and sacred text: An anthology. Kansas City, Kansas Community College: Pearson Education Inc
a bloodshot, penetrating stare, and a severed head that she dangles from one of her four hands. She is frequently depicted dancing on the corpse of her "spouse" Siva in what some have interpreted as a sexually explicit gesture denoting—and promoting—female autonomy (Agha-Jaffar, 2005, p. 163). Despite her mask of outwardly frightening persona, Kali has the spirit of a warrior. She is a ferociously protective mother, a tender and nurturing caregiver and she passionately loyal and protective of her loved ones.

The name of Venus is synonymous with female charm and sexual potency. Venus herself is a god striking affirmation of the love of beauty and the pleasures of the senses. This roman goddess presides over motherhood and marriage in her role as Venus Genetrix. Originally a goddess of vegetation who brought bounty to gardens and vineyards, she was later equated with Aphrodite, assuming many of her aspects and history. She achieved even greater importance when influential Roman politicians embraced the cult of Venus; Julius Caesar and the emperor Augustus claimed her as an ancestor of their family (1987).
Succulent Supplement

CASW/ACTS - Statement on non-violence

Press Release
Ottawa, February 20, 2003

Statement on non-violence

Social workers in Canada will celebrate 2003 National Social Work Week under the theme “Social Work for Social Justice”, a reflection of the social work profession’s long-standing commitment to social justice, peace, and non-violence. Such a commitment is very relevant given today’s reality in which people who take control with fists, weapons and other unjust means devastate families and communities. The devastation is evident in the continuing high incidence of poverty, ongoing social injustice, continued reports of child abuse and violent deaths.

The Canadian Association of Social Workers, representing over 18,000 social workers in Canada, advocates for solutions to conflict that are based on principles of justice and compassion for humanity. At this time of turmoil in the world, we join the International Federation of Social Workers (IFSW) and others worldwide to challenge those in power to show their respect for human life and choose non-violent solutions to conflict. The priority must be to avoid the unnecessary suffering of citizens in all countries and especially those where people are already marginalized and disadvantaged as a result of conflict and economic strife.

All countries that claim to be just societies are compelled to continue to seek alternatives to war and conflict and to uphold the dignity of all people.