Correlates of Mental Health Service Use Among Lesbian, Gay, and Bisexual Mothers and Prospective Mothers

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ABSTRACT. Lesbian, gay, and bisexual women undertake parenting in a social context that may be associated with unique risk factors for perinatal depression. This cross-sectional study aimed to describe the mental

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health services used by women in the perinatal period and to identify potential correlates of mental health service use. Sixty-four women who were currently trying to conceive, pregnant, or the parent of a child less than one year of age were included. One-third of women reported some mental health service use within the past year; 30.6% of women reported a perceived unmet need for mental health services in the past year, with 40% of these women citing financial barriers as the reason for their unmet need. Women who were trying to get pregnant or who were less "out" were most likely to have had recent mental health service use. Women who had conceived by having sex with a man or who reported more than three episodes of discrimination were most likely to report unmet needs for mental health services. Providers may benefit from additional knowledge about the LBG social context that is relevant to perinatal health, and from identifying a strong referral network of skilled and affordable counsellors. doi: 10.1080/03630240802134225

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INTRODUCTION

Lesbian, gay and bisexual (LGB) women undertake parenting in a social context that may be associated with unique risk factors for perinatal stress and depression; yet little evidence is available to guide the provision of appropriate mental health services to this community. Using conservative prevalence estimates of lesbian, gay and bisexual sexual orientation (1.6%) (Statistics Canada, 2004a) and applying them to the American population of women (US Census Bureau, 2005), an estimated over 800,000 American women are LGB women of childbearing age (20-44 years). About 300,000 of these women have or plan to have children (Moran, 1996). The present study attempted to fill a knowledge gap by examining patterns and correlates of mental health service use and unmet need in a population of LGB women in the perinatal period.

Approximately 13% of women experience significant symptoms of depression following childbirth, that is, postpartum depression (O'Hara & Swain, 1996). The consequences of postpartum depression include impaired cognitive, behavioural and social development for the children

and recurrent depressive episodes for the mother, making this a serious mental health issue for women and their families (Grace, Evindar, & Stewart, 2003; Bell, Land, Milne, & Hassanyeh, 1994). Emerging research is beginning to estimate the prevalence of and risk factors for postpartum depression in LGB communities. Ross, Steele, Goldfinger, and Strike (2007) found that while LGB mothers report psychological states in the healthy range, they had higher depression scores than did heterosexual women.

Andersen's socio-behavioral model of health service utilization provides a framework for approaching the study of perinatal mental health service use in the LGB population (Andersen, 1995). Andersen posits that patterns of health service use can be understood as a function of the combined influences of environmental factors, personal characteristics, need factors (including both objective need and perceived need), and enabling resources. Within this model, the mental service needs and use of LGB women in the perinatal period might differ from other women, since their social context is distinct from heterosexual women.

First, the family structure for LGB couples is different from that of heterosexual couples. One or both women may potentially have a child. The social roles and expectations of the non-biological parent are less clearly defined or socially accepted. As well, an LGB couple may choose to enter into a "co-parenting" arrangement with the biological father of the child. This additional family relationship comes with another set of unique benefits and complications (Ross, 2005).

Second, the process of availing themselves of the means of conception differs from most heterosexual couples. While some LGB women have sex with a man to become pregnant, the majority choose alternatives including insemination using the semen of a known donor (e.g., a friend or an acquaintance), or insemination using frozen semen from an anonymous donor (Steele & Stratmann, 2006). These methods of conception also come with unique risks and benefits that most fertile heterosexual couples need not consider (Steele & Straatman, 2006).

Third, for many LGB women, "coming out" to health providers is a source of stress and a significant barrier to health services use (van Dam, Koh, & Dibble, 2001). Women must decide if and when to disclose their sexual orientation and/or family structure during visits for pregnancy, childbirth and/or parenting. While good evidence exists that disclosure of sexual orientation improves quality of care and reduces delays in seeking care, disclosure can still be emotionally difficult and fraught with uncertainty about the response from the health care provider (Steele,

Tinmouth, & Lu, 2006; Klitzman & Greenberg, 2002; van Dam et al., 2001).

Finally, LGB women face exposure to discrimination based on their sexual orientation. Heterosexism (a bias toward heterosexual people based on cultural norms) and homophobia (a prejudice against homosexual people) in the health system continue to be an added source of stress and a barrier to seeking care for women belonging to sexual minorities (Ross, 2005).

We hypothesized that the social context of the LGB women in our study including their role as caregivers, process of conceiving, openness about their sexual orientation, previous exposure to discrimination and mental health morbidity, could be associated with their use of, and likelihood to report an unmet need for mental health services. Research on mental health service use by LGB women has shown higher levels of service use than women in general (Cochran & Mays 2000; Cochran, Mays, & Sullivan, 2003). However, no existing research on mental health services relates specifically to issues in the perinatal period. The aims of this cross-sectional study were to describe the mental health services used by LGB women in the perinatal period and to identify potential relationships between parenting role, mode of conception, outness and perceived discrimination in relation to mental health service use in LGB women.

METHODS

Participants

Between July 2004 and December 2005, we recruited LGB women using e-mail and paper flyers distributed through service providers and listservs for the LGB and parenting communities. Eligible women self-identified their sexual orientation as other than heterosexual (including lesbian, gay, bisexual, transgender, transsexual, two-spirit and queer) and belonged to one of four family role groups: (1) women in the process of trying to conceive a child; (2) women who were currently pregnant; (3) biological mothers of children less than one year of age; and (4) non-biological mothers of children less than one year of age. These groups were selected as the foci for the study on the basis of pilot data indicating unique perceived determinants of perinatal mental health among these women, relative to determinants that have been established

for heterosexual women (Ross, Steele, & Sapiro, 2005). Since the study also included face-to-face interviews for a subsample of participants (results reported elsewhere), women were required to live within 250 km of Toronto, Canada.

In total 150 individuals responded to recruitment advertisements 73 (49%) were eligible to participate. The most frequent reasons for ineligibility included residing outside the geographic area (45 women) and having a youngest child older than 1 year of age (12 women). Of the 72 surveys distributed, 64 (89%) were returned and form the basis for the present analysis.

Instruments

We developed the questionnaire using results from a pilot study conducted with LGB mothers and prospective mothers (Ross, Steele, & Sapiro, 2005). The self-administered mail survey included standardized questionnaires related to depression level (Cox et al., 1987), anxiety level (Spielberger, Gorsuch, & Lushene, 1970), health-related quality of life (Ware & Sherbourne, 1992), social support (Sherbourne & Stewart, 1991), internalized homophobia (Symanski & Chung, 2001) outness (Steele et al., 2006), perceived discrimination (Forman, Williams, & Jackson, 1997) and mental health service use (Statistics Canada, 2002). All participants gave written informed consent to participate, and the local Institutional Review Board approved the research.

Outcome Measures

Our primary outcome measures were past-year mental health service use and perceived unmet need for mental health services. We defined past-year service use as those individuals who endorsed speaking to a professional about emotions, mental health or use of any alcohol or illicit drugs within the past 12 months. Possible sources of care included: psychiatrists; family doctors or general practitioners; OB/GYNs, midwifes, other providers of obstetrical care; psychologists; nurses; and social workers, counsellors, psychotherapists, religious, or spiritual advisors. We identified a perceived unmet need for mental health services when individuals answered yes to the question "During the past 12 months, was there ever a time when you felt that you needed help for your emotions mental health or use of alcohol or drugs but you didn't receive it?"

Predictors

Family Role

All participants belonged to one of four family role categories as previously described.

Mode of Conception

We determined mode of conception by the response to the question "What has been your source of inseminations" for women in the process of conceiving or "How did you or your partner conceive" for pregnant women and biological and non-biological mothers. We aggregated responses into three categories: (1) sperm bank/fertility clinic, (2) known sperm donor, or (3) male partner or casual sex with a man. Two participants who gave responses belonging to more than one category were removed from this analysis.

Degree of Being "Out"

We calculated participants' level of being out by scoring one point for every category of relationship to which a participant endorsed having disclosed her sexual orientation and dividing the sum of these points by the number of applicable categories. This resulted in an "outness" score that ranged from 0 to 1. We defined disclosure as agreement with the statement that "I know for a fact that he/she knows [about my sexual orientation] and we have talked about it." For example, we asked about relationships with mothers, fathers, heterosexual friends, school or work colleagues, etc. This measure of "outness" has been validated (Steele et al., 2006). For bivariate analyses we created a binary "outness" variable, which defined high "outness" level as a score above the median (0.81) and low "outness" level as a score below the median.

Perceived Discrimination Scale

The Perceived Discrimination Scale (PDS) queries whether possible experiences of discrimination have occurred (e.g., unfairly denied a promotion), as well as the frequency of unfair treatment in everyday life (e.g., being hassled by the police) (Forman, Williams & Jackson, 1997). Participants who endorsed any items were asked to indicate why they were discriminated against (e.g., on the basis of my sex, my sexual

orientation, something else about me). The authors of the PDS report a reliability coefficient of 0.88. The total number of discriminatory events reported was calculated by summing positive (i.e., "yes") responses to major events with the number of daily hassles reported occurring either "fairly often" or "very often." We created a binary variable that identified participants who endorsed having experienced at least three episodes of discrimination related to sexual orientation. This cut-off was chosen because we found it to be significantly correlated with depression levels in our sample.

Depression

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item self-report screening tool for perinatal depression. Scores range from 0 to 30, with higher scores indicating greater severity of depression. A cut-off score of 12/13 has been previously validated to indicate probable clinical depression with a sensitivity of 86% and a specificity of 78% (Cox, Holden, & Sagovsky, 1987) and has been validated for use during pregnancy (Murray & Cox, 1990) in fathers (Matthey, Barnett, Kavanagh, & Howie, 2001), and in a number of ethno-cultural communities (O'Hara, 1994).

Data Analysis

We had sufficient statistical power to calculate single proportions with a precision of $\pm 12\%$. For bivariate analyses between two equal groups, assuming a two-sided alpha of 0.05 and a beta of 0.20, we could detect between group differences of 30%.

We computed univariate frequencies with 95% confidence intervals and used chi-squared tests to assess the bivariate relationship between family role, mode of conception, outness score, perceived discrimination and past-year mental health service use and perceived unmet need for mental health services. Multiple logistic regression models were developed to examine factors related to these two outcomes, adjusting for age, income, education level and EPDS score. We forced these variables into each model, regardless of significance level, since age, socio-economic status and severity of depression have all been shown to be significant predictors of mental health service use in Canada in other research (Lin et al., 1996). We used the chi-square test of goodness of fit to assess the models' fit for all regression analyses; a non-significant

test indicated adequate fit. All tests were conducted using the statistical package SPSS version 14.0 for windows (SPSS, 2006).

RESULTS

Among the 64 women, most were urban, educated, partnered and Caucasian (Table 1). The mean age was 34.2 (SD = 5) years and the mean EPDS score was 6.83 (SD = 4.29), well below the cut-off of 12 for clinical depression.

Mental Health Service Use and Sources of Care

While only 23.8% (95% CI: 15.0% to 35.7%) of participants reported that their providers had inquired about their sexual orientation, 90.5% (95% CI: 90.7% to 95.5%) of women disclosed their sexual orientation to the doctor that they had seen most often. Almost a quarter of women (23.8%, 95% CI: 15.0% to 35.7%) reported that their providers had assumed that they were heterosexual.

The majority (73.0%) of participants had seen a professional for mental health services at some time, and one-third of the sample (33.3%) reported some mental health service use within the past year (Table 2). Almost all of the participants (92.3%) who had received services reported being either satisfied or very satisfied with treatment. The source of care was most frequently from the allied mental health professionals; however, for those who reported some mental health service use within the past year, 20.7% (95% CI: 9.9% to 38.6%) identified their obstetrical care provider as the source of this care.

Unmet Need

Almost one-third of participants (30.6%) reported a perceived unmet need for mental health services in the past year (Table 3). Of women with a perceived unmet need for mental health services, 47.4% of women also reported mental health service use in the past year. Women most often identified an unmet need for therapy or counselling (57.9%) and for help with relationships (47.4%). The most frequently reported reasons for not seeking care were a preference to manage the problem themselves (47.4%) and financial barriers (42.1%).

TABLE 1. Selected Demographic Characteristics of Participants

Variable	Mean (SD) or Percentage (95% C.I.) (n = 64)
Age	34.2 (SD = 5.0) (Range = 22 to 48)
Sexual orientation	
Lesbian	64.1% (95% CI: 51.8 to 74.7)
Bisexual	21.9% (95% CI: 13.5 to 33.5)
Two-spirit	4.7% (95% CI: 1.7 to 12.9)
Other	9.4% (95% CI: 4.4 to 19.0)
Geographic region*	
Large urban center	64.1% (95% CI: 51.8 to 74.7)
Rural/town	35.9% (95% CI: 25.3 to 48.2)
Income level	
< 30,000	13.1% (95% CI: 6.9 to 23.9)
30,000-60,000	16.4% (95% CI: 9.2 to 27.7)
> 60,000	70.5% (95% CI: 58.1 to 80.4)
Education level	
High school or community college	24.2% (95% CI: 15.3 to 36.2)
Bachelor's degree	32.3% (95% CI: 22.0 to 44.7)
Master's or PhD	43.5% (95% CI: 31.9 to 56.0)
Ethno-cultural background	
Caucasian	89.1% (95% CI: 79.1 to 94.5)
Middle Eastern	1.6% (95% CI: 0.4 to 8.3)
Black	6.3% (95% CI: 2.5 to 15.0)
Aboriginal	3.1% (95% CI: 1.0 to 10.7)
Relationship status	
Partnered	95.3% (95% CI: 87.1 to 98.3)
Single	4.7% (95% CI: 1.7 to 12.9)
Family role	
Biological	28.1% (95% CI: 18.6 to 40.2)
Non-biological	23.4% (95% CI: 14.8 to 35.2)
Preconception	23.4% (95% CI: 14.8 to 35.2)
Pregnancy	25.0% (95% CI: 16.0 to 36.9)
Mode of conception	
Sperm bank	56.4% (95% CI: 44.0 to 68.0)
Known donor	32.2% (95% CI: 22.0 to 44.7)
Sex with man	11.3% (95% CI: 5.6 to 21.6)
Mean outness score	0.74 (SD: 0.27)
% with 3 or more episodes of perceived discrimination	18.8% (95% CI: 11.1 to 30.0)

*Large urban center population > 250,000; rural/town population < 250,000.

TABLE 2. Mental Health Service Use, Sources of Care and Satisfaction

% of sample who had seen a professional for mental health services	
Ever used	73.0% (95% CI: 60.9 to 82.4)
Past year use	33.3% (95% CI: 22.9 to 45.7)
Current use	23.8% (95% CI: 15.0 to 35.7)
% of sample who had used self-help/support group/telephone helpline etc.	
Ever used	23.8% (95% CI: 15.0 to 35.7)
Past year use	11.1% (95% CI: 5.6 to 21.2)
% of sample with a past psychiatric hospitalization	
Ever hospitalized	7.8% (95% CI: 3.5 to 17.3)
Past year	1.6% (95% CI: 0.4 to 8.4)
% of sample who had ever used mental health service users by sources of care	
Psychiatrist	37.0% (95% CI: 21.5 to 51.5)
FP/GP	58.7% (95% CI: 44.3 to 71.7)
Obstetrical care provider	21.7% (95% CI: 12.3 to 35.7)
Psychologist/nurse/counsellor/social worker/ psychotherapist	89.1% (95% CI: 76.9 to 95.2)
Religious/spiritual advisor	17.4% (95% CI: 9.1 to 30.8)
% of past-year users by sources of care	
Psychiatrist	3.4% (95% CI: 0.8 to 17.2)
FP/GP	13.8% (95% CI: 5.6 to 30.7)
Obstetrical care provider	20.7% (95% CI: 9.9 to 38.6)
Psychologist/nurse/counsellor/social worker/ psychotherapist	51.7% (95% CI: 34.3 to 68.7)
Religious/spiritual advisor	3.4% (95% CI: 0.8 to 17.2)
% satisfied or very satisfied with treatment:	92.3% (95% CI: 75.7 to 97.6)
How much would you say they helped you?	
Not at all	3.8% (95% CI: 0.9 to 19.0)
A little	15.0% (95% CI: 6.3 to 33.7)
Some	26.9% (95% CI: 13.8 to 46.3)
A lot	53.8% (95% CI: 35.3 to 71.3)

Family Role

Non-biological parents were the least likely to have used mental health services, while women who were trying to conceive were the most likely to have used mental health services in the past year (Table 4). After adjusting for age, income, education level, and depression score this difference remained statistically significant (non-biological parents relative

TABLE 3. Unmet Need, Type of Unmet Need and Reason

% Who in the past year felt [she] needed help but didn't receive it	30.6% (95% CI: 20.6 to 43.0)
Type of help needed (may check as many as apply)	
Information about availability of services	15.8% (95% CI: 5.79 to 37.9)
Therapy/Counselling	57.9% (95% CI: 36.1 to 76.9)
Help with financial problems	15.8% (95% CI: 5.7 to 37.9)
Housing problems	10.5% (95% CI: 3.2 to 31.7)
Help with personal relationships	47.4% (95% CI: 27.2 to 68.5)
Help with employment status/work situation	15.8% (95% CI: 5.7 to 37.9)
Other	15.8% (95% CI: 5.7 to 37.9)
Reasons for unmet need (may check as many as apply)	
Preferred to manage myself	47.4% (95% CI: 27.2 to 68.5)
Didn't think anything could help	10.5% (95% CI: 3.2 to 31.7)
Didn't know how to get help	26.3% (95% CI: 11.9 to 49.1)
Afraid to ask for help/Afraid of what others would think	21.1% (95% CI: 8.7 to 43.7)
Couldn't afford to pay	42.1% (95% CI: 23.1 to 63.9)
Problems with transportation/childcare/scheduling	15.8% (95% CI: 5.7 to 37.9)
Waiting time too long	10.5% (95% CI: 3.2 to 31.7)
Didn't get around to it/didn't bother	31.6% (95% CI: 15.4 to 54.2)
Personal/family responsibilities	21.1% (95% CI: 8.7 to 43.7)
Other	15.8% (95% CI: 5.7 to 37.9)

to pre-conception group: OR 0.12 (95% CI: 0.01 to 0.89), p = .038). No significant differences were observed in perceived unmet need for mental health services by family role.

Mode of Conception

No significant differences were observed in rates of past-year mental health service use by mode of conception, but significant differences were observed in perceived unmet need for mental health services. Participants who had conceived by having sex with a man reported the highest rates of unmet need, and participants who conceived via sperm banks reported the lowest rates of unmet need for mental health services (Table 4). Only seven participants in our study conceived by having sex with a man, and this sample size precluded regression modelling to adjust for potential confounders.

TABLE 4. Past-Year Mental Health Service Use and Perceived Unmet Need for Mental Health Services by Group (Unadjusted Analysis)

	Past Year Mental Health Service Use (%)	Unmet Need for Mental Health Services (%)
Family role		
Biological	**27.8**	38.9
Non-biological	**13.3**	6.7
Preconception	**66.7**	42.9
Pregnancy	**31.2**	31.2
Mode of conception		
Sperm bank	37.1	**17.6****
Known donor	15.0	**25.0****
Sex with man	57.1	**35.3****
Mean outness score		
Below median	**50.0**	37.5
Above median	**18.5**	26.9
> 3 episodes of perceived discrimination		
No	30.8	**23.5**
Yes	50.0	**58.3**

Note: Bolded results significant at $p < 0.05$.
**Between groups difference significant $p < .005$.

Outness

Participants with low "outness" scores were significantly more likely to report past year mental health service use (Table 4). These differences did not remain significant after adjusting for age, income, education level and depression score. No significant differences were observed in reported unmet need by "outness" level.

Perceived Discrimination

Almost one-fifth of participants (18.8%) reported more than three episodes of perceived discrimination. The most frequently endorsed event was "being unfairly fired or denied promotion," with 12 women reporting this event. No significant differences were observed in rates of past-year mental health service use by levels of perceived discrimination. However, participants who reported more than three episodes of perceived discrimination were more likely to report an unmet need for

mental health services than other participants (Table 4). After adjusting for age, income, educational level, and depression score, this association was no longer statistically significant.

DISCUSSION

Among perinatal LGB women, our results showed high rates of mental health service use, most often with allied health professionals such as psychologists or psychotherapists. A significant portion of past-year service users identified their obstetrical care provider as their major source of mental health care. Although the median income of our sample was high, and the study was conducted in a region with universal medical care insurance, many women who reported an unmet need for mental health services cited financial barriers to receiving these services. Women who were tying to get pregnant and women who were less "out" were most likely to have had recent mental health service use. Women who had conceived by having sex with a man and women who reported more than three episodes of discrimination were most likely to report unmet needs for mental health services.

To our knowledge, this is the first published study to examine correlates of mental health service use outcomes among LGB mothers and prospective mothers. Compared to Canadian women age 25-64 years old, our participants were much more likely to report past-year mental health service use (33% vs. 13.9%) (Statistics Canada, 2004b) and much more likely to report an unmet need for mental health service use (31% vs. 5.3%) (Statistics Canada, 2004c). Forty-two percent of our participants with an unmet need for care reported financial barriers compared to 13.8% of Canadian women aged 25-64 with an unmet need for care who reported accessibility barriers including cost of care (Statistics Canada, 2004d). This may be because LGB women were much more likely than Canadians in general to receive mental health care from non-physician providers who are not covered by provincial health insurance plans (Steele et al., 2007).

Few studies have quantitatively assessed the importance of social context in determining mental health service use by LGB women, and none have looked specifically at the perinatal period. Our analyses are not confounded by health insurance status as the survey was conducted in Ontario, which provides universal health care coverage to its residents including mental health services from physicians.

As is often the case with research on marginalized populations, our study was limited by the volunteer nature of the sample. As well, the sample was small and mostly Caucasian, partnered and educated and thus is not likely to be representative of the LGB population in general. This is a common problem for researchers who study LGB health issues. Questions about sexual orientation have recently been added into several large population health survey; thus, the generalizability of research on LGB health is likely to improve with the inclusion of these topics on health surveys. However, most of these large community surveys do not ask detailed questions about one's social context related to sexual orientation nor are they large enough to sample specific subgroups of the LGB population such as women in the perinatal period. So, for these detailed questions and sub-populations, convenience sampling remains the most feasible option.

Despite the homogeneity of our sample in terms of race and education, we observed variability in the social context variables within the sample. Still, it is possible that the relationships we have demonstrated between the correlates of mental health service use and unmet need would be different in the general population of LGB women who might be on average less out and less likely to use formal care for their specific perinatal needs.

Another significant limitation of our study was the relatively small sample size. The sample size for this study was determined based on the requirement for saturation of themes in a related qualitative analysis. While we had sufficient statistical power to show significant differences in most of our bivariate analyses, we lacked sufficient power to confirm these differences after adjustment. The broad confidence intervals around the odds ratios imply that the non-significant results for our adjusted analyses were more likely a function of inadequate statistical power than a sign of lack of relationships of the independent and dependent variables after controlling for confounding. Additional research with a larger sample is required to confirm that the associations we have demonstrated are still present after adjustment for potential confounders.

Finally, our sample did not include LGB partners of women who were in the process of trying to conceive or pregnant, nor did we include LGB women in the process of adopting a child. The limited available research on these populations suggests that these women, too, may require mental health services during the transition to parenthood (Bennett, 2003; Goldberg & Sayer, 2006). Additional research including all LGB parents is required in order to develop a broader understanding of mental health service needs during the perinatal period.

LGB women in the perinatal period are active consumers of mental health services. While these women seek services primarily from non-physician sources, obstetrical care providers are important resources for emotional support. Despite a high rate of service use, a significant level of unmet need was also reported. Women are thus looking for relevant counselling and therapy but face financial barriers to these services. Women who had sex with men to conceive and women who have faced discrimination were particularly likely to report unmet need for services. This is consistent with previous research on sexual minority women, which have found that low levels of "outness," experiences of discrimination, and bisexuality are important determinants of mental health (Ross et al., 2005).

For program planners and clinicians our results provide guidance to develop fertility and perinatal services in conjunction with mental health services that are sensitive to the needs of the LGB community. These women have a perceived need for affordable, appropriate counselling services during the perinatal period. Obstetrical providers who currently provide such support may benefit from additional knowledge about the LBG social context and from developing a strong referral network for affordable counsellors.

Rates of service use and unmet need for services, while informative, do not address the issue of the quality and effectiveness of services offered. Future research would be helpful to identify the components of mental health services that LGB women find particularly useful and examine the effectiveness of these services in improving the mental health and well-being of the recipients of such care.

NOTE

1. Definitions (Adapted from: Barbara, A. M. 2004. *Asking the Right Questions 2: Talking with Clients About Sexual Orientation and Gender Identity in Mental Health, Counselling and Addiction Settings*. Toronto: Centre for Addiction and Mental Health):

> *Lesbian/gay:* Terms to describe individuals whose primary sexual orientation is toward members of the same sex. The term "gay" can refer to men or women, although many women prefer the term "lesbian."
>
> *Bisexual:* A word describing a person whose sexual orientation is directed toward men and women.
>
> *Queer:* Traditionally, a derogatory and offensive term for sexual minority people. Many members of the sexual minority communities have reclaimed "queer," using it as an umbrella term to refer to all non-heterosexual orientations.

Transsexual: A term for people who have an intense, long-term experience of being the sex opposite to their birth-assigned sex, and who typically pursue a medical and legal transformation to become the other sex.

Transgender: A term for people who do not conform to society's gender norms of masculine/feminine, but may choose not to modify their bodies medically.

Two-spirited: An English word used by some Aboriginal peoples to describe those who are gay, lesbian, transgender, transsexual, or have multiple gender identities.

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