A Qualitative Narrative Inquiry of the Experience of Accessing Community Supports Among Women Who Have Experienced Trauma

by

Riaz Akseer

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Supervisor: Susan Arai, Ph.D.

Faculty of Applied Health Sciences
Brock University
St. Catharines, Ontario

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Abstract

Abuse related trauma can have serious consequences on individuals’ health and their state of well-being and may result in decreased access to different determinants of health. The purpose of this qualitative narrative inquiry using secondary data was to explore the experience of accessing community supports among eight women who had experienced abuse-related trauma. A conceptual framework drawn from the literature on social inclusion and social exclusion and a narrative inquiry method were used to explore epiphanies, customs, routines, images, and everyday experiences (Clandinin & Connelly, 2000) among the women. A Three-Dimensional Space Narrative Structure was used to explore the participants’ personal or internal conditions, feelings, hopes and reaction as well as their social experiences in interaction with others in community. The participants described experiencing the impact of trauma in their past and present circumstances, a lack of accommodation of difference, challenges in maintaining a sense of self in a world of assumption and labels, impact of trauma on the determinants of health, and uncertainty about the future. The findings from the study demonstrate experiences of social exclusion among the participants in the past, further isolation and social exclusion in the present when personal life issues were ignored by community support services, and uncertainty about what the future will bring for them. The findings indicate close relationships between the women’s personal lives and their social connections which need to be considered to mitigate social exclusion and enhance social inclusion.
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student, whose sudden death was traumatic and left deep pain in the hearts of those left
behind. It is also dedicated to my parents who have supported me all the way since the
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CHAPTER ONE: INTRODUCTION

The last two decades have witnessed increasing rates of violence against women and consequently, a rise in women’s experiences of trauma (Canadian Mental Health Association, 2006; Goodheart, 2006; Hilbert & Krishnan, 2000; Public Health Agency of Canada, 2005). There has also been an increase in welfare dependency (Reid & Golden, 2005) and the experience of social exclusion among women (Raphael, 2004; Wesely, 2006). Individuals often experience social exclusion when they are not part of mainstream society and lack a social support network (family, friends, community, and employment) (Shookner, 2002). Health is widely impacted by the experience of social exclusion, particularly among individuals who have experienced marginalization (World Health Organization (WHO), 2005). Similarly, social exclusion, a lack of participation in the decision making process concerning issues that effect the individual’s health and quality of life, and a lack of access to the social determinants of health, are the major contributors to premature morbidity and mortality from chronic illnesses, such as heart disease, stroke and diabetes (Wilkinson & Marmot, 1998).

Despite attempts to tackle the challenges of social exclusion, poverty and health disparities (WHO, 2006), as well as to increase access to social determinants of health (Galabuzi, 2002; Raphael, 2004), there is a fundamental need for the development of more specific interventions and community support services (e.g., housing, welfare, education etceteras) for women who have experienced trauma (Mullender & Hague, 2001). Most studies conducted on women who have experienced trauma focus on statistics and surveys (see for example: Commonwealth Fund’s Surveys of Women’s Health, 1998; Family Violence in Canada, 2005; General Social Survey 2004; National Violence Against Women
Therefore, qualitative research is needed to explore the context, dynamics, consequences, life experiences and the worldview of individuals’ experiences of trauma (Baker & Cunningham, 2005). As Freiler (2002) states, since social inclusion is conceptually grounded in the real life experiences of individuals, focusing on the concept is therefore important in exploring social and health inequalities among people as well as the negative impacts of social exclusion on health.

The purpose of this qualitative narrative inquiry was to explore the experience of accessing community support services among women who have experienced abuse-related trauma. The aim of this research was to identify the challenges and benefits experienced by women who have experienced trauma. The conceptual framework for this study was drawn from the literature on social inclusion and social exclusion and used to understand the experience of accessing supports among women who have experienced trauma. Researchers emphasize the need for social inclusion research that incorporates the voices of people belonging to marginalized groups (Stanley & Wise, 1997). Experiences of social inclusion and social exclusion were the issues that were explored through secondary data analysis of interviews conducted with women who have experienced abuse-related trauma and who were on social assistance. Structural and social factors in the society are linked to health, as people’s health may be affected by illness, poverty or social exclusion (Eriksson, 2000). To improve the health status and quality of life among women, there is a need to explore empowering interventions which includes the integration of economic, educational and political areas (WHO, 2006).

The conceptual framework for this study is introduced in Chapter One, including the concepts of trauma, social inclusion and social exclusion. It is followed by the problem
A comprehensive analysis of the impact of climate change on coastal ecosystems, particularly coral reefs, is presented. The study highlights the critical role that these ecosystems play in maintaining biodiversity and protecting coastal communities from the effects of storms and sea-level rise.

In order to mitigate the effects of climate change, it is essential to understand the underlying mechanisms that drive changes in these ecosystems. The research conducted indicates that coral reefs are particularly vulnerable to rising temperatures and acidity, which can lead to coral bleaching and loss of symbiotic algae. This, in turn, results in reduced coral growth and increased susceptibility to disease.

To address these challenges, the study suggests a range of interventions, including the implementation of effective management strategies, the promotion of sustainable fishing practices, and the restoration of degraded coral reefs. These efforts are crucial in ensuring the long-term survival of coral reefs and the coastal communities that depend on them.

The findings of the study underscore the urgent need for global action to reduce greenhouse gas emissions and mitigate the impacts of climate change. Collaboration among scientists, policymakers, and stakeholders is essential to develop and implement effective strategies for protecting and preserving the world's coral reefs.
statement which identifies the social concerns to which this research responds. Additionally, this chapter also introduces the research questions and purpose of the study.

**Conceptual Framework**

Social inclusion provides a guiding framework for the study. Social inclusion focuses on participation and inclusiveness for all people in the community. Social inclusion also emphasizes social cohesion, the rights and responsibilities of individuals and government, the quality of services and people’s ability to access them, and maximizing participation to ensure continued opportunity and equality for all people (Manor, 2004; Richmond & Saloojee, 2005; Saloojee, 2005). According to Shookner (2002), social inclusion is used to address poverty and social exclusion (unemployment, low income, inadequate health services, lack of education, lack social assets, poor political and civic engagement, and power issues). As Saloojee (2005) indicates:

social inclusion is about social cohesion plus, it is about citizenship plus, it is about the removal of barriers plus, it is anti-essentialist plus, it is about rights and responsibilities plus, it is about accommodation of differences plus, it is about democracy plus, and it is about a new way of thinking about the problems of injustice, inequalities, and exclusion plus. It is the combination of the various pluses that make the discourses on social inclusion so incredibly exciting. (p. 198)

Similarly, social inclusion covers the broader meaning of the term policy tensions and it suggests bringing marginalized groups of people into the mainstream (Frazee, 2003). Individuals living in poverty or those who are discriminated against due to their gender, race, or disability are more vulnerable to experience social exclusion and are at greater risk of experiencing poor health status, lack of housing, and drug abuse (Shookner, 2002; Wilkinson & Marmot, 2003). Therefore, these individuals may have decreased opportunities for participation in their communities and are vulnerable to experience social exclusion (National Strategy for Neighbourhood Renewal, 2000; Shookner, 2002). A focus on social
inclusion may be a useful concept to increase individuals’ access to different determinants of health, especially individuals who fear exclusion from society (Galabuzi, 2002). In addition, social inclusion includes dynamic participation by people, equality of opportunities, and basic levels of well-being (Frazee, 2003; Guildford, 2000; Sen, 2000), so that people despite their race, colour, employment, educational or health status can develop based on their needs, collective power and resources (Askonas & Stewart, 2000; Canadian Mental Health Association, 2006; Minkler, 1997).

**Problem Statement**

To understand the experience of social inclusion and social exclusion among women who have experienced abuse-related trauma, there are three main areas that need to be understood: (1) the magnitude of violence among women and the abuse-related nature of the trauma; (2) the connection between trauma and poor health outcomes and increased social exclusion; and (3) the lack of access to community support services, and the further experiences of social exclusion and traumatic re-enactment that may occur through other community support services.

First, the increased violence against women is considered a persistent and serious problem in North American society (Hilbert & Krishnan, 2000; Public Health Agency Canada, 2005). In Canada, at least 51% of women over 16 years of age have experienced physical or sexual violence (Statistics Canada, 1993). According to Statistics Canada (2001) the common types of violence against women include abuse related trauma (86%), criminal harassment (78%) and kidnapping/hostage taking (67%). Reports indicate that in 2001, 77% of women who had experienced violent crimes were mistreated by someone they knew (Statistics Canada, 2001). Further, in comparison to men, women had higher reports of
incidence in categories of abuse-related trauma, negative changes in life circumstances, death of a loved one, and witness of injury or death. In contrast to women, men have tended to report higher incidence in motor vehicle accidents, natural disaster and unexpected medical or psychological conditions (Freeman et al., 2002).

Second, there is a connection between trauma and poor health outcomes, and increased risks of social exclusion. Abuse related trauma can have serious consequences on women's health and their state of well-being. A survey done on Canadian women found that nine out of ten incidents of violence against women have an emotional effect on their health and quality of life (Status of Women Canada, 2004). Similarly, women who experience social exclusion due to their race and disability have greater risks of being in debt, and on social assistance, as well as having health problems, and often a history of mental health issues. Rates of abuse related trauma have increased in the last few years among individuals who are the recipients of community support services (Canadian Women’s Foundation, 2000), particularly female clients of Ontario Works and Ontario Disability Support Program (Purdon, 2003). In addition, women who have experienced trauma have higher risks of eating disorders, self-harm and suicidal thoughts (CMHA, 2003). Individuals who have experienced trauma are at a higher risk of social exclusion due to difficulties seeking and maintaining employment, stigma and discrimination (Abrams et al., 2005). Further, according to the Canadian Psychiatric Association (2001) social support is an important variable in determining traumatic responses. The research on women’s health indicates that women, who have gone through experiences of gender discrimination and have a poor social support network, also have poorer health status (Adams, 1995).
Third, according to Hilbert and Krishnan (2000) there is a need to examine existing community support services for women who have experienced abuse related trauma to tackle the challenges of social exclusion among them. Well built social support services contribute to women’s personal and social empowerment (Worell, 2006) and increase chances of social inclusion (Freiler, 2002; Galabuzi, 2004; Richmond & Saloojee, 2005). Women who have experienced trauma have had difficulty accessing community support services and therefore they are more vulnerable to experience social exclusion. As Hilbert and Krishnan (2000) indicate, barriers created by community support service providers and organizations contribute to experiences of social exclusion (see the discussion on barriers to social inclusion in Chapter Two), and decrease access to community support services among women who have experienced trauma. Further, where women are able to participate and access community support services, they often experience further social exclusion and traumatic re-enactment may occur. Purdon (2003) explored the experiences of women in accessing Ontario Works, and found that women who have experienced abuse related trauma often experience further trauma and isolation while accessing community support services. As Mosher, Evans and Little (2004) indicate, the requirements of the community support organizations are being applied in ways that often do not take into account individuals’ experience of abuse related trauma. A large number of women who have experienced abuse related trauma are using social assistance; however, their state of well-being, equal participation in society, independency and safety can be negatively affected by the regulations and conditions of the social assistance programs (Raphael, 2000).
Research Problem and Purpose of the Study

The research problem addressed by this study was the lack of empirical literature on the experiences of accessing community support services among women who have experienced trauma in relation to social inclusion and social exclusion. For example, most of the literature on population health (Public Health Agency of Canada, 2005), broader determinants of health (Raphael, 2004; WHO, 2005) and health care studies are based on quantitative measures of social exclusion. Although there has been some research to date which has focused on the experience of social inclusion for individuals with disabilities (Edwards et al., 2001; Morris, 2005), there have been few studies focused on women who have experienced trauma in relation to social inclusion. Qualitative research was needed to explore the detailed picture and worldview of individuals’ experience of social inclusion and social exclusion. This study provided a deeper explanation of the struggles for social inclusion among women who had experienced trauma by looking at their experiences in one community.

The purpose of this qualitative narrative inquiry was to explore the experience of accessing community support services among women who have experienced abuse-related trauma. The conceptual framework for this study was drawn from the literature on social inclusion and social exclusion and a narrative inquiry method will be used to explore the women’s epiphanies, customs, routines, images, and everyday experiences (Clandinin & Connelly, 2000). Clandinin and Connelly’s (2000) Three-Dimensional Space Narrative Structure was used to perform a narrative analysis of the participants’ personal or internal conditions, feelings, hopes and reaction as well as their social experience in interaction with others in community. The research questions that guided the study were as follows:
1. How are the personal and social experiences of social inclusion different or similar among women who have experienced trauma?
2. What experiences of social exclusion have been encountered in the past, and, what type of struggles are presently encountered by women who have experienced trauma?
3. What are the women’s perceptions of changes needed to community support services to increase their social inclusion?

This study used a sub-sample from a larger research study conducted by Arai, Reid and Mair (2006) entitled “Building inclusive governance structures in rural Ontario: Assessing the capacities of the people who are socially marginalized” in which the experiences of people living in poverty and accessing community social support services were explored.

**Goal Statement**

The primary goal of this study was to shed light on the experiences of women who experienced trauma in their quest for social inclusion and in doing so, to contribute to the literature on trauma. In applying social inclusion and social exclusion as a conceptual lens a secondary goal was met in that a clearer understanding of the women’s experiences of these concepts was achieved and a model of social inclusion and social exclusion resulted.

**Summary**

The purpose of this qualitative narrative inquiry was to explore the experience of accessing community support services among women who have experienced abuse-related trauma. The conceptual framework for this study was drawn from the literature on social inclusion and social exclusion. Using secondary data analysis, a narrative inquiry method was used to explore the experience of the study participants. Chapter Two contains a review of the relevant literature including the literature on trauma, social inclusion and social exclusion. Chapter Two briefly outlines the ways these ideas are used, defined and
conceptualized in the literature. The reason for including the specific literature on trauma, social inclusion and exclusion was due to the intertwined nature of these concepts. As indicated in literature, individuals who have experienced trauma are at a higher risk of social exclusion due to difficulties seeking and maintaining employment, stigma and discrimination (Abrams et al., 2005; Status of Women Canada, 2004). Social inclusion and social exclusion were used as a framework for exploring the participants’ experiences and how they struggle for participation in community life, whereas social exclusion was used to explore the challenges and barriers experienced by the participants.

Chapter Three provides an overview of the research methodology and procedures. Included in Chapter Three is a description of narrative inquiry, a method used to explore the experiences of women who have experienced trauma. Chapter Three also contains a description of the approaches to data collection, and secondary data analysis using a three dimensional space narrative structure, with the assistance of computer software NVivo 7 to aid in the process of data analysis. Finally, a discussion of the ethical considerations pertaining to this study, reflexivity and trustworthiness are included in Chapter Three.

In the final two chapters the Findings, Discussion and Conclusions are presented. Chapter Four provides narratives of the women who have experienced trauma and their voices in accessing community support services. A three dimensional analytical approach as suggested by Clandinin and Connelly (2000) was used to describe aspects of the participants’ experiences in accessing community support services including the personal and social aspects of their experiences. The narratives also provide insight into the past, present and future structure of the participants experiences.
Chapter Five presents five themes that emerged from the narrative structures including: the impact of the past on participants’ present circumstances; lack of accommodation of difference; maintaining a sense of self in a world of assumption and labels; impact of trauma on the determinants of health, and what the future will bring. These themes are discussed in conjunction with the literature and a conceptual diagram of social inclusion and social exclusion for women who have experienced trauma is presented. The chapter concludes with conclusions, a discussion of implications, strengths and limitations, and suggestions for future research.
CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter reviews the body of literature on trauma, social inclusion and social exclusion as the main concepts related to this study. The first part of Chapter Two focuses on literature related to trauma and women’s experience of trauma. To understand the participants’ experience in relation to social inclusion and exclusion, it is important to know more about trauma, its impacts on individuals’ health and quality of life, and the impacts on the broader determinants of health. This literature review on trauma provides a broad picture of individuals’ experiences of trauma (physical, emotional, psychological). In addition, different traumatic events (e.g., abuse related trauma, war, natural disaster) that might have different impacts on the process of healing from trauma are discussed.

The second part of the literature review focuses on the concepts of social inclusion and social exclusion. The concept of social inclusion is interrelated with health (Raphael, 2004); therefore, a detailed understanding of the concept will be useful in exploring individuals’ experience of trauma and struggles for social inclusion. Health can be negatively affected by social and health inequalities, it is therefore important to know more about the concept of social inclusion. In addition, this study will contribute to understanding how different aspects of the social inclusion (i.e., social cohesion, access to services and support, skills and capacity, diversity, citizenship and participatory democracy, and barriers to social inclusion) are being addressed through each participant’s life experience.

Social inclusion cannot be understood without understanding social exclusion (Sullivan, 2002). Social exclusion can be used to describe different barriers to social inclusion experienced by individuals. A general summary of the literature on the
interrelationship between social inclusion and social exclusion is provided at the end of
Chapter Two.

**Literature on Trauma**

Trauma has been known for more than 4,000 years (Sanchez-Hucles & Gamble, 2006), however, it has been approximately two decades that, "sexual, physical, emotional, and psychological abuse of women and children have been recognized as another significant source of trauma" (Sanchez-Hucles & Gamble, 2006, p. 105). Trauma and its impacts on women's health and their state of well-being have begun to be viewed as important issues in different fields of health, psychology, and social sciences since the late 1970s (Alisen, 2003; Russell, 1999; Sanchez-Hucles & Gamble, 2006). Various factors are associated with the causes and effects on individuals who have experienced trauma, and how trauma should be defined. Traumatic events range from short duration events such as a rape or earthquake, to unexpectedly occurring prolonged events such as being kidnapped and held captive (Carlson, 2005). Some traumatic events such as combat and experiences of abuse during childhood are repetitive and anticipated. Extreme trauma occurs when an individual experiences or witnesses life threatening or physically harmful events (Yule, 2001).

**Defining Trauma**

Definitions of trauma differ in their emphasis on mental health (psychiatric), physical health, and psychological well-being. A traumatic event is an event, or number of events, which cause moderate to severe stress reactions. These events are most often characterized by a sense of helplessness and horror, resulting after serious injury, or the threat of serious injury or death (The World Federation for Mental Health, 2002). A traumatic event is also defined as something that is threatening to the self or someone close, accompanied by intense
fear, horror, or helplessness (Bremmer, 2002). A typical example of a traumatic event is a child experiencing abuse from an adult (Alisen, 2003; Bernet, 2000). Trauma in the psychoanalytic sense occurs when the subject comes into contact with something totally foreign and irremediable. Allen (1995) illustrates that psychological trauma is to experience abuse at least once in one’s life. According to the same author, psychologically, trauma is an “overwhelming emotion and a feeling of utter helplessness” (p. 14); it does not always cause physical injury, but may lead to long term mental health effects.

Several authors discuss trauma in the context of trauma theory (Hartman, 2003; Saakvitne et al., 1998). Trauma theory often deals more with the effects of trauma than its causes (shift of attention from aetiology to effects). Emphasis is placed on the power of the effects of trauma. For example, when one speaks of the nightmare sufferings of war related trauma, these extra-ordinary determinants of trauma are different from ordinary ones. Whether they are thoughtless phrases, or intentional insults, or more aggressive excitation, they all inflict psychic damage (Hartman, 2003).

The questionable consequences of the shift to effect is that it establishes an equivalence between such disparate, although at times overlapping determinants: that is, given the existence of the phenomenon called trauma, the variability of human sensitiveness, and diversity of cultural contexts influencing what is traumatic, it has so far been easier to describe the symptoms or general structure of trauma than to connect cause and effect in a predicable way (Hartman, 2003, p. 260).

Saakvitne et al. (1998) explained that, it is unusually hard to formulate and measure the complexities of an individual’s response to a traumatic event, series of events, or circumstance, at a particular time, place, and social and cultural milieu, and in developmental context. The countless intra-psychic, behavioural, somatic, interpersonal and subjective
responses create both conceptual and methodological quandaries. In addition, trauma and one’s response to trauma are implanted in socio-cultural contexts often with political and moral overtones (Saakvitne et al., 1998).

**Gender Differences in the Experience of Trauma**

The literature indicates that physical, sexual, emotional abuse and violence towards women are not rare events. These events are often perpetrated by partners rather than strangers and can occur in both marital and non-marital relationships, including same-sex relationships (Carlson, 2005). Many studies reflect on gender differences in the impact of traumatic events (Baker & Cunningham, 2005; Freeman, Gluck & Tuval-Mashiach, 2002; Sanchez-Hucles & Gamble, 2006). Through the review of literature it was found that men have higher risks of experiencing trauma resulting from combat, while rates of abuse related trauma are higher among women (Freeman et al., 2002). Statistics Canada (1996) identifies that women outnumber men 9:1 in experiencing abuse related trauma. Additional reports’ state high incidences of physical assault, negative change in life circumstances, death of a loved one, and witness of injury or death among women. In addition, compared to men, women were more likely to report their abuse, require more medical attention, had a higher rate of depression or anxiety and lower self-esteem. Women are also more likely to be denied access to family income and have a higher risk of isolation from family and friends (Public Health Agency of Canada, 2005; WHO, 2002a).

In general, risks from the impacts of trauma are often higher among women and they are twice as likely to develop health problems following the experience of trauma. Even though developing the signs and symptoms of Post Traumatic Stress Disorder is very individualized (CDC, 2003: Alisen, 2003; van der Kolk, 1996), women who have
experienced trauma are at greater risks for developing PTSD (twice likely to be diagnosed with PTSD), depression, anxiety, as well as physical injuries (CDC, 2004; Freeman et al., 2002; Sanchez-Hucles & Gamble, 2006; van der Kolk, 1996).

Partner abuse (abusive behaviour by a partner or spouse) often includes physical (maltreatment using physical force for example, by pushing down, slapping, or punching), sexual (maltreatment that refers to forced sexual contact such as, rape or incest), emotional (mistreatment of another person's feelings through actions such as insults, or taunts about being useless), and psychological forms of violence (Baker & Cunningham, 2005; Sanchez-Hucles & Gamble, 2006). Psychological abuse consists of explicit and implicit threats of harm, extreme controlling behaviours, pathological jealousy, denigration, and isolation behaviours (Allen, 1995; Morewitz, 2004). Domestic violence takes into consideration the abuse (be it sexual, emotional, physical and or economic) of at least one family member or an ex-family member onto another member within the home or larger domestic context. Women and children have higher risks of domestic violence, which is usually associated with growing entrapment, medical complaints, injury, psychosocial problems and occasionally unsuccessful help seeking (Baker & Cunningham, 2005; Smith, 2004).

**The Impacts of Trauma**

An individuals’ exposure to overwhelming terror can lead to troubling memories, arousal, and avoidance (van der Kolk et al., 1996). The effect of traumatic experiences on individuals can alter their psychological (Allen, 1995), biological, and social equilibrium (Sanchez-Hucles & Gamble, 2006). For instance the memory of one particular traumatic event taints all other experiences including spoiling appreciation of the present to a very dramatic degree (van der Kolk et al., 1996). Individuals might develop intense fear, panic, or
a sense of helplessness (Allen, 1995; Yule, 2001). The trauma causes stress, which can affect one’s mental, emotional and physical well-being. According to the Canadian Health Network (2003) reactions to trauma are different depending on the event. Reactions may range from a general sadness to a serious long-term reaction. In certain cases, long-term trauma can lead to the development of Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD) (Alisen, 2003; CDC, 2003). Not all individuals who experience trauma will be diagnosed with PTSD (van der Kolk et al., 1996), unless the symptoms of trauma last for more than a month. For those who develop PTSD the symptoms of trauma will appear within 3 months after exposure to the traumatic event. Recovery may occur within 6 months, yet in some cases the symptoms will last much longer and become chronic (National Institute of Mental Health, 2004). People who have experienced trauma usually experience a number of traumatic symptoms without actually experiencing the effects of PTSD; however, these lesser symptoms may interfere with individual and family coping following the traumatic event. For instance, after having experienced a serious or catastrophic loss such as the death of a loved one, a diagnosis of PTSD may not result and yet the long-term effects of having experienced such a loss is similar to those of other traumatic events that can be diagnosed as PTSD (Canadian Health Network, 2003). PTSD is further described later in Chapter Two.

Abuse related trauma during childhood will cause pain and tissue injury that can be healed in time, however the psychological and medical consequences will remain throughout adulthood (Allen, 1995; Johnson, 2004; Russell, 1999). For example, women with an abuse related background will grow up expecting that others will hurt and violate them, and as a result they have trouble developing trust. A woman with a history of abuse related trauma will also have trouble maintaining relationships, and may confuse sex with love and care
getting or care giving (Center For Addition and Mental Health; 2004). Cumulative trauma from childhood to adulthood can drastically affect overall health in adulthood (Russell, 1999). Adults who experienced abuse related trauma in childhood may still remember the memories of abuse, even if they did not understand it as a child (CAMH, 2004). There is also some indication in the literature that experiencing adulthood trauma has more significant impacts on individual health than trauma experienced during childhood (American Psychological Association (APA), 2005). According to the APA, exposures to traumatic events between the ages of 18 to 30 and 31 to 64 years have the greatest impacts on an individuals’ health. Atkinson and Goldberg (2004) illustrate the effects of trauma by comparing trauma to a dragon that comes in the dark and floods us with helplessness. For individuals who experience it there are very limited ways to respond to this dragon. If their loved ones are able to stand beside them, the dragon seems smaller, the dark is less terrifying, and the people who experienced trauma can fight for their life. If alone in the dark, the trauma will likely overwhelm an individual who has experienced it and the will of the dragon increases. Physically, we do not seem to be designed to face trauma and overwhelming fear alone; often we must withdraw and numb out until another person stands beside us. Therefore, the effects of trauma are increased with the lack of a safe and supportive environment (Atkinson & Goldberg, 2004). The seriousness of the symptoms depends on a variety of factors including: personal life experience before trauma, resiliency and coping ability; severity of traumatic event, and support and help from family, friends, and community services after the trauma (Carlson & Ruzek 2004; CDC, 2004). According to the WHO (2005), individual responses to trauma will depend on the social, economic, and physical environment, as well as
individual characteristics and behaviours. The factors that play an important role in individual coping include:

- income and social status - individuals with a higher income and social status are healthier as compared to those with a lower income and social status
- education - individuals with a low level of education are more stressed and have low self-confidence
- physical environment - individuals' access to safe houses, water and air contribute to their overall health and quality of life
- social support network - good levels of support provided by family members, friends and other community resources also play an important role in individual health
- Genetics - inheritance also plays an important role in an individual’s behaviour and coping skills in response to stressful events
- health Services - individuals’ access to services that are required to prevent and treat the disease can influence their health (WHO, 2005).

Abuse related trauma can have serious consequences on women's health and their state of well-being. A survey of Canadian women found that nine out of ten incidents of violence against women have an emotional impact. Women who experience abuse related trauma may feel anger, fear, become more alert and less trusting (Status of Women Canada, 2004). In the sections that follow, more specific impacts of trauma on an individual’s health and well-being are explored. Individuals with a previous history of exposure to trauma, particularly rape, sexual abuse, and/or physical abuse are usually at high risk for life-threatening disorders and illnesses (Yule, 2001) including physical injuries such as gynaecological problems and complications in pregnancy and child birth (Alisen, 2003: CDC, 2004). Others impacts include accidents related to risk taking and drug and alcohol abuse, cancers associated with smoking, early sexual activity, mental illness, and suicide (Morewitz, 2004). Women who have experienced trauma are at a much greater risk than other women for depression, anxiety, and PTSD.
The impact of trauma on personal health practices and coping skills.

Sexual violence by an intimate partner aggravates the effects of physical violence on mental health. According to a WHO study conducted in 2002, 33% of women with a positive history of sexual abuse, 15% of women with a history of physical violence by an intimate partner, and 6% of women with a negative history of experiencing physical violence appeared to have the symptoms or signs suggestive of a psychiatric disorder. In addition, women who have experienced abuse related trauma have greater risks of serious mental health disorders and harmful drug and alcohol abuse than women who have not experienced abuse related trauma (Morewitz, 2004).

Negative psychological effects are known to persist for one year after an experience of abuse related trauma among individuals with a lack of trauma counselling, while physical health problems and symptoms tend to decrease. Symptoms of stress will continue to be experienced by 50% of women despite receiving counselling services (Mennonite Central Committee, 2005; WHO, 2002b). During a trauma, individuals often become overwhelmed with fear. Soon after the traumatic experience, the individuals may re-experience the trauma mentally and physically, which can often be uncomfortable and painful. These occur in the form of thinking about the trauma, seeing images of the event, feeling restless, and having physical sensations similar to those that occurred during the trauma (Carlson & Ruzek, 2004).

Mentally re-experiencing the trauma can include images or thoughts about the trauma, flashbacks, nightmares, becoming upset when reminded about the trauma, anxiety, anger or aggressive feelings, difficulty in controlling emotions, difficulty in concentrating, and physical reactions (e.g., trouble falling asleep, being nervous, getting very troubled by loud noise, trembling and perspiring) (Carlson & Ruzek, 2004). According to Morewitz
mothers who filed restraining orders against current boyfriends or husbands (intimate partners) have a higher chance of having poor physical health, severe psychological distress, and are more likely to develop symptoms of PTSD than those who did not file restraining orders. Further, Wilson et al (1997) note that:

[w]omen who have described exposure to high-magnitude events, such as a physical assault, criminal victimization and sexual assault, have reported poor health. Reports of stressor exposure and health status have documented a relationship of poor global health perceptions or increased reports of physical symptoms in traumatized women in comparison to normal control subjects (p. 1051).

Psychiatric outcomes of exposure to traumatic events are not always consistent (Bremmer, 2002). Rather, they range from depression, PTSD, dissociation, somatic disorders, and alcohol and substance abuse. The more common outcomes of trauma are depression and PTSD. It is unclear as to why certain individuals develop depression while others develop PTSD following exposure to similar stressors. One suggestion as Bremmer (2002) indicates may be that depression is a milder response to trauma, while more extreme cases of trauma may lead to PTSD or dissociative disorder. In this case as Bremmer (2002) illustrates, the depression seen in conjunction with PTSD is not the same as typical depression seen in patients who do not necessarily have a history of trauma. Depression may be caused by exposure to any of the biological, social and psychological factors such as abuse, neglect, alcohol abuse, and traumatic events. Also, other psychiatric disorders may result in depression, such as attention deficit disorder or adolescent conduct disorder (Gillam, 2004). Trauma impacts individuals' behaviour in different ways, such as:

- inflicting self-injury (e.g., cutting, burning)
- addictive behaviours (e.g., starvation, binge-eating, drug/alcohol misuse)
- looking for or avoiding sexual relationships
- being abusive towards others
- preference of loneliness and isolation
- lack of trust in others
• fear of angering others, always willing to please
• disrespect towards one’s own feelings and emotions.
(CAMH, 2004; CDC, 2003; Royal College of Psychiatry, 2004)

The impact of trauma on social support.

Social support, as suggested by several authors, is an important variable in determining traumatic responses. A well-built social support network may be a protective factor for coping with abusive experiences (Canadian Psychiatric Association, 2001). At the community and societal level information and access to resources is needed as support for individuals who experienced trauma after disclosure (CAMH, 2004). For individuals who have experienced abuse related trauma, intimate relationships are difficult to create and maintain due to fear of rejection. They have high rates of divorce as well. The effects of trauma on relationships and the ability to access social supports include:

• not knowing how to trust
• difficulty in socializing with people
• problems in sexual relationships
• fear of others
• isolation and withdrawal
• not recognizing a risky situation
• not knowing how to keep relationships, unable to commit to future relationships
• constantly searching for security
• feelings of being spaced out
• difficulty in connecting feelings of anger and fear
• losing trust in others.
(CAMH, 2004; CDC, 2003; Royal College of Psychiatry, 2004).

The impact of trauma on working conditions, income and education.

Experiencing abuse related trauma may negatively impact the individuals’ work, career and personal and social relationships (CAMH, 2006; Russell, 1999). Individuals with a positive history of abuse related trauma may encounter problems at work such as a lack of ability to fully function (Alisen, 2003) which might result in work slowdowns and termination from work (Brown, 2001). According to the Canadian Public Health Association
people with more control over their work conditions, fewer stress-related demands on the job and greater workplace social supports are generally healthier. The development of life skills through education and training increases: opportunities for income and job security, life management potential, the ability to cope with change, and a sense of control over life circumstances (Canadian Public Health Association, 1997).

In adulthood, the average income of individuals who experienced abuse related trauma in childhood is lower than for individuals who have not (Alisen, 2003). Macmillan (1999) argues that since educational attainment is a vital determinant of occupational status, the experience of trauma would lower occupational status. Macmillan (1999) reported a negative impact on the level of income among individuals who had experienced trauma (hourly earnings were one dollar lower). Macmillan (1999) concluded that individuals who have experienced sexual assault also had an income deficit of about $6000 per year. Furthermore, there are additional costs associated with a need for health care and community support programs such as shelters, lower rates of employment and less productivity in the workplace (Alisen, 2003).

Reyome (1993) studied the school performance of individuals who experienced abuse related trauma. The findings from her study were compared to individuals who have not experienced abuse trauma, drawing from two types of family groups (families on public assistance and families from the lower middle class). Information was gathered on the cognitive achievement of all the participants. The results indicated that when school based measures were used, individuals with experiences of abuse related trauma were more likely to receive lower grades in subjects such as mathematics and spelling, than the control groups. Additionally, nearly half of the participants with a history of trauma had repeated a grade, in
comparison to less than one-third of the matched public assistance individuals, and one-sixth of the matched lower middle class students (Reyome, 1993).

*Healing From Trauma*

The impact of a traumatic event will vary from person to person. Some will be traumatized by the event while others will be psychologically scathed. The trauma will have less devastating impacts if the individual can integrate it into conscious self-awareness, thus the severity of trauma is determined by the meaning the individual attaches to it (Classen, 1993). The meaning is determined by the extent to which the individual sees it as a threat to himself or herself. With younger persons, the capacity for integrating information is low; therefore the psychological damage is greater (Classen, 1993). The seriousness of the symptoms that results depend on a variety of factors including: personal life experience before trauma; resiliency and coping ability; severity of traumatic event; and support and help from family, friends, and community services after the trauma (Carlson & Ruzek 2004; CDC, 2004).

According to Saakvitne, Tennen and Affleck (1998) responses to trauma can be complex:

It is widely accepted that trauma is transformative and that in the aftermath of a traumatic event nothing is again the same. We are most familiar with negative aspects of this change; grief and traumatic loss, emotional fragmentation, and psychic devastation. Yet personal narratives, clinical lore, and a growing research base suggest that trauma also leads to other transformations, including the reconstruction of meaning; that renewal of faith, trust, hope, and connection; and the redefinition of self, self-in-relation, and sense of community (Saakvitne et al., 1998, p. 281).

With respect to adolescents and young adults, the outcomes of trauma may be largely preventable, as Wilson et al. (1997) indicate both alarm and hope should be raised. Efforts can be targeted at the individuals who have experienced trauma to prevent cancers and other
physical illnesses, mental illness and disorders, and perhaps even suicide. With an emphasis on hope, Atkinson and Goldberg (2004) identified that the creation of a more secure attachment helps an individual who experienced trauma with increased resiliency and coping skills. Also, the creation of a more secure bond with a partner or loved one creates a safe haven that helps individuals regulate their grief, anger, and fear in a positive self-enhancing way.

The recovery process from trauma will take some time. The healing process includes two stages. In the immediate stage after the traumatic event the person cannot understand the traumatic event. The traumatic event in this stage can cause feelings of shock, confusion, as well as fear and anger. In the long term coping stage after the event, the person may re-experience the traumatic memory and attempt to avoid the associated feelings. Many people at this stage may experience sleep disorders, physical pains, depression, anxiety and sometimes isolation (Israel Center for the Treatment of Psychotrauma, 2005). Levine and Fredrick (1997) state that the process of healing trauma requires:

having a 'felt sense' because trauma is an innately mediated process. It cannot be effectively dealt with through verbal or by emotional expression alone. Rather the instinctual language of bodily sensing is what allows the fixated moment to sequence and move along in time. In this way, traumatic fixation opens to flow and transformation. (Levine & Frederick, 1997)

Another critical factor in the process of healing from trauma includes creating a democratic living learning environment that is physically, psychologically, socially, and morally, safe for individuals who have experienced trauma and the service providers (Rivard et al., 2003; The Royal College of Psychiatry, 2004). Problem solving is encouraged on personal, interpersonal, and community levels. Talking treatments including counselling,
psychotherapy, and cognitive-behaviour therapy are often suggested to individuals who have experienced trauma (Royal College of Psychiatry, 2004).

**Trauma and Social Inclusion**

Individuals who have experienced trauma are at greater risk of experiencing mental health problems and social exclusion due to difficulties seeking and maintaining employment, stigma and discrimination (Abrams et al., 2005). A lack of emphasis on social inclusion by mental health services, and barriers to engaging in community such as a lack of adequate transportation and housing, also force individuals to become excluded from a ‘normal’ functioning society and may result in social exclusion (Abrams et al., 2005).

Social inclusion occurs when individuals in a society have equal participation and have rights to make decisions about issues that affect their lives despite their race, colour, employment status, educational status or health status (Askonas & Stewart, 2000). When socially included, an individual feels connected to others either through formal (e.g., work) or informal (e.g., neighbourhood) networks (Butterworth & Berry, 2004). Social inclusion challenges community support programs to focus on how an individual’s own network of people and interests can help them heal by removing barriers and factors which lead to exclusion (Butterworth & Berry, 2004). Community support services may be designed for women who are in search of relationships or groups within which they can seek inclusion and belongingness. The sense of belongingness will allow individuals to restore their self-esteem and self-confidence so that they can continue a normal life by being in control and creating a positive social identity (Abrams et al., 2005). In addition community support services may be increased to enable women to come together, to value and respect each other by working together, to care, to understand and to embrace all of its members (Abrams et al., 2005;
[Image 0x0 to 541x773]
According to Butterworth and Berry (2004), identifying and affiliating with other individuals in similar situations is an important coping response to trauma based exclusion. The individuals' position within a group is more strongly related to personal self-esteem than the group's position in society as a whole (Abrams et al., 2005). In addition, being and feeling excluded is damaging psychologically and materially not only for women who have experienced trauma but also for the community (neighbourhood) in which they live, resulting in a conflicting environment which enhances mistrust and inequality (Abrams et al., 2005). Therefore, it is very important to design programs where people who have experienced exclusion can receive the help they deserve and have greater participation in decision making processes which affect their lives. Greater participation will enable individuals to improve their living standards and overall well-being (Abrams et al., 2005). According to Labonte (2004) rights and the redistribution of power are just the surface of combating exclusion within families, communities and societies. Further programmes and interventions are needed to challenge economic rules and political powers regarding excluded groups and conditions.

**Social Inclusion and Social Exclusion**

Social inclusion and social exclusion have an inextricable link (Sullivan, 2002). This section provides a review of social inclusion and social exclusion as presented in the literature and aims to provide awareness and understanding of the concepts social inclusion and social exclusion and their main components (social cohesion, citizenship and participatory democracy, barriers to social inclusion, rights and responsibilities, differences, skills and capacity, social justice, and equality). This section also provides an understanding of the development of ideas on social inclusion and social exclusion within the literature, a
history of the origins of the concepts, and common indicators of social inclusion and social exclusion.

**Concepts of Social Inclusion and Social Exclusion**

The concepts of social inclusion and social exclusion have expanded as strong principles for policy development in recent years. These concepts have earned central positions in goals for achieving and promoting an inclusive society (shared social experience, active participation, equality of opportunities, and state of well-being for all citizens) (Edwards et al., 2001). Social inclusion emphasises improvements in individuals' quality of life and access to community resources (Saloojee, 2005). Social exclusion then “offends against human dignity, denies people their fundamental human rights and leads, in conjunction with social and economic instability, to marginalization and deepening inequalities, which threaten the stability of democracy” (Edwards et al., 2001, p.417).

Social inclusion has been used in different ways in literature. The idea of social inclusion is used to address poverty, and also used as an answer to social exclusion (unemployment, low income, inadequate health services, lack of education, lack of social assets, poor political and civic engagement, and power issues). In addition, Saloojee (2005) illustrates “[t]he intersection of an anti-oppression discourse with social inclusion as a process and outcome is an incredibly powerful impetus to social change and political solidarity” (p.201). Furthermore, social inclusion is also used to describe social cohesion around rights and responsibilities of individuals and government. In general, one can say that social inclusion is about improving the quality of all services, maximizing participation, and ensuring continued opportunity and equality for all people (Richmond & Saloojee, 2005).
Origins and Uses of the Concepts of Social Inclusion and Social Exclusion

Social exclusion was first used in 1960s France as a foundation for policy geared toward inclusion for all, or to address the problem of marginalization among individuals in society (Beall, 2002; Burchardt et al., 2002). According to Frazee (2003) social exclusion also emerged as a response to social division emerging from issues in the labour market, and a lack of social support networks to address the needs of a more diverse population. Later, in the 1980s, social inclusion emerged in Europe as an important concept. The term ‘social inclusion’ was popularized by the social theorist René Lenoir (1974) and it was originally used in French public policy (Beall, 2002). In the early 1980s the concept of social inclusion was also used in the field of education to encourage the integration of students with physical, learning and developmental disabilities within the education system (Wotherspoon, 2002).

In Canada, social inclusion became the focus of attention among individuals concerned with the negative effects of poverty on people (Richmond & Saloojee, 2005). Social inclusion is also viewed as a solution for social exclusion (Shakir, 2005; Sullivan, 2002). Social inclusion and social exclusion are oppositional terms (notion of proximity and distance) and the role of public policy is to fill the gap between the two (Shakir, 2005). Public policies attempt to reduce economic, social and cultural inequities such as economic disparities, racism, and age or gender discrimination within the population (Shakir, 2005; Sullivan, 2002).

Social exclusion has been used as a multi-dimensional term referring to people who have experienced a combination of problems that are linked to each other; such as unemployment (National Strategy for Neighbourhood Renewal, 2000), a lack of skills (poor education), poor or insufficient income, deprivations in housing (Hanvey, 2003), increased
violence and health inequalities (Raphael, 2005), as well as a fear of differences and racism that limit full participation of people in their communities (Hanvey, 2003; Saloojee, 2003). Attempts to alleviate social exclusion include the removal of: discrimination (Saloojee, 2003; Williams, 2004), inequality, lack of opportunity and injustice (Williams, 2004), and addressing the problems of poverty and unemployment (Atkinson, 1998; Levitas, 1998; Lister, 1998; Saraceno, 2001).

**Defining Social Inclusion and Social Exclusion**

This section focuses on different definitions of social inclusion and social exclusion. Definitions of these concepts have referred to different concerns, yet there are common elements that all definitions share, such as: health and quality of life, access to resources, relationships, structural and institutional barriers, social justice, participation in social and economical levels, morality, skills and capacity, social values and social control.

Social inclusion often appears as a positive term that relates to bringing improvements in individuals’ quality of life, participation and role in community, and access to community resources, particularly among those who experience a combination of problems (e.g., unemployment, poor skills, poverty, poor housing, and high crime rates, disability, ageism and racism). Social inclusion covers a wide range of policies that target resources on relatively disadvantaged groups or places.

This study uses the definition of social inclusion provided by Saloojee (2005) as a conceptual framework. For Saloojee (2003), the focus of social inclusion is on the valued recognition and full participation of individuals in the community, so that they can benefit from and contribute to society.

...social inclusion is about social cohesion *plus*, it is about citizenship *plus*, it is about the removal of barriers *plus*, it is anti-essentialist *plus*, it is about rights and
responsibilities plus, it is about accommodation of differences plus, it is about democracy plus, and it is about a new way of thinking about the problems of injustice, inequalities, and exclusion plus (p. 198).

Social inclusion occurs when individuals feel connected to others either through formal (e.g., employment) or informal (e.g., neighbourhood) networks (Butterworth & Berry, 2004). For Guildford (2000), the term ‘inclusion’ is about being accepted and being able to participate fully within the context of family, community and society. In social inclusion, the idea of participation of individuals as valued, respected, and contributing members of society is ensured, thus it is a values based concept (Frazee, 2003). In addition, it is indicated that social inclusion occurs when everyone in a society has equal participation and has rights to make decisions based on issues that affect their lives despite their race, colour, employment, educational or health status (Askonas & Stewart, 2000). According to a recent definition provided by the Canadian Mental Health Association (CMHA, 2006) social inclusion is a normative concept aimed at re-establishing a civil society, one that values, recognizes and provides room for everyone to participate, and which aims to reduce the distance between all members of society (CMHA, 2006).

Saloojee (2003) illustrates that gaining success in social inclusion will depend on the extent to which the issue of social exclusion is successfully addressed and social cohesion is promoted in society. In comparison to social inclusion, the term social exclusion often reflects on the state of deprivation. According to Raphael (2005) the definition of social exclusion covers all different aspects of unemployment, low income, housing, educational opportunities, discrimination, citizenship, and a variety of other conditions that are recognized as social determinants of health. Societies with increased incidence of income inequality and poverty have a lack of social infrastructure; therefore, such societies are at
high risk of social exclusion. Galabuzi (2004) defines social exclusion in the Canadian context as the:

inability of certain subgroups to participate fully in Canadian life due to structural inequalities in access to social, economic, political, and cultural resources arising out of the often interesting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, immigrant status, and the like. Along with the socio-economic and political inequalities, social exclusion is also characterized by processes of group or individual isolation within and from such key Canadian societal institutions as the school system, the criminal justice system and the health care system, as well as spatial isolation or neighborhood segregation (p. 238).

**Components of Social Inclusion**

Literature on social inclusion and social exclusion indicate there are links between different components of social inclusion and social exclusion. However, these links are complex and non-comparable (Athkinson, 2002; Cantillon, 2001) (See Figure 1). Figure 1 presents a conceptual diagram which reflects Saloojee’s (2005) definition and outlines the components of social inclusion and social exclusion. These components are then described in the following sections.
Psychological
• Psychiatric disorder, depression, PTSD

Social
• Lack of social support, poor coping skills, lack of access to resources

Economic
• Problems in perusing employment and career
• Increased drug use and criminal activities
• Lower wage

Impact of Trauma on Health

Social Inclusion

Citizenship and Participatory Democracy
• Participation in political activities and decision making (Saloojee, 2005).
• Equality treatment.
• Access to legal rights (social, civil and political) (Marshall, 1950).

Skills and Capacity
• Facilitate access to employment
• Capacity building, education and skill development
• Promote individuals talents, skills capacities and choices (Galabuzi, 2004)

Social cohesion
• Social belonging
• Shared values, and equal opportunity (Jenson, 1998).

Diversity
• Recognition of diversity and substantive equality
• Individual & Community (Freiler, 2002; Saloojee, 2005).

Access to Services and Supports
• Improving quality of all services (Saloojee, 2005).
• Access to social, economic and cultural resources (Galabuzi, 2002; Williams, 2004).

Social Exclusion

Barriers to Citizenship and Participatory Democracy
• Lack of transparency in decision making
• Denial of human rights (Raphael, 2001; Shookner, 2002).

Barriers to Skills and Capacity (Economic Barriers)
• Unemployment, living in poverty, inadequate income
• Lack of education,
• Lack of supportive environment
• Lack of opportunity for personal development (Morris, 2004).

Barriers to Social Cohesion
• Poor sense of belonging,
• Social segregation and distancing (Freiler, 2002; Shookner, 2002).

Barriers to Diversity
• Diversity and identity, lack of recognition and tolerance, language
• Structural Barriers
• Discrimination against race, sex, and homophobic (Omidvar & Richmond, 2003; Shookner, 2002).

Barriers to Services and Supports
• Lack of access to community support services (Shookner, 2002)
• Marginalization, institutional dependency
• Limited choice (Raphael, 2004; Shookner, 2002).

Physical barriers

Figure 1. A Conceptual Diagram of Trauma in Relation to Social Inclusion/Social Exclusion.
Citizenship and participatory democracy.

Citizenship is about the full, active and democratic participation of individuals in institutions and society (Saloojee, 2005). Participatory democracy is about the sharing and participation of individuals (citizens) in public life and political issues. It is also about achieving collective goals, and engaging citizens within the local community (Putnam, 2000). This part of the study contains a short discussion on citizenship and participatory democracy as important elements to social inclusion.

Citizenship, from social inclusion perspectives, is not just about being entitled to certain rights that are typically associated with democracy, such as the right to vote, freedom of religion and freedom of association. It focuses on addressing the challenges of exclusion, discrimination and inequality. In democratic citizenship an individual’s identity, participation and sense of belonging is respected (Saloojee, 2005). Crick (2005) reflects on citizenship as a process of encouraging individuals to take direct or indirect part in public debate, political process and decision making. The basis of citizenship in a community is cultural solidarity amongst individuals which creates social stability, and community identity (Etzioni, 1995; Wylie, 2004). Crick (2005) argues that democracy is often claimed by individuals, institutions and governments who use the phrase to refer to individuals’ power and legal rights, but few or no one can fully achieve it or practice it. Citizenship and social exclusion are linked to each other by the degree to which visible minorities and marginalized communities experience structural and systemic barriers and restriction from participating in society (Saloojee, 2003). (See discussion on barriers to social inclusion). Participatory democracy allows citizens to actively participate in social, political, economic, and ecological life, so that they have power over issues that affect their lives and they are able to
make decisions in ways that reflect their values, needs and interests, while also having a voice and sharing power in a fair and equitable way (Hemingway, 1999).

All citizens of a society should recognize their rights and responsibilities as citizens of that society, and know whether or not their rights are protected, their experiences are being valued and their contribution to society is respected and promoted (Saloojee, 2005). Marshall (1950) explains the rights and responsibilities of individuals in the community by looking at it from a citizenship (status given to individuals as becoming full members of a community) perspective. Marshall (1950) identified three types of rights:

- social rights-economic welfare and security rights and rights to a fully shared social heritage and to live according to current standards within society
- civil rights-rights necessary for individual freedoms that include the freedom of speech, thought and faith, the right to own property and access the justice system
- political rights-right to participate and take part in political power both as a voter and as an elector.

In addition, Citizenship and Immigration Canada (2005) indicate the rights and responsibilities of all citizens based on the practice of democracy and human dignity. Accordingly, all citizens are entitled to equality rights (lawful treatment, equal protection and benefit), democratic rights (participation in political activities, and decision making), legal rights (access to a lawyer, interpreter in court, reputed innocent unless proven guilty by law), mobility rights (choice of living and moving within the country or living outside the country), language rights (access to the official languages, French or English in dealing with Canada’s federal and provincial governments), and minority language education rights (right to be educated in one’s own languages). The government respects fundamental freedoms of religion, thought, expression, peaceful assembly and association. Responsibilities associated with citizenship include obeying and understanding the law, participation in the political system, voting in elections, respecting individuals’ rights of freedom, and protecting and
appreciating multicultural heritage. Similarly, Saloojee (2005) illustrates that “…citizens should be equally entitled to certain rights typically associated with democracy” (p. 167). According to Mitchell and Shillington (1998) for individuals to participate and be included in all different dimensions of society, they need to have sufficient resources, capacity and rights. Citizenship depends on individuals’ legal status, rights and access to social and economic resources. A sense of belonging and solidarity is connected to equal distribution of resources in society; conversely, experiences of social exclusion due to poverty and inequality lead to decreased social cohesion and increased social exclusion (Schneider, 2000).

In summary, social inclusion promotes equal access to opportunities for all and gives individuals the choice of being able to exercise their rights and responsibilities, irrespective of their ethnicity, faith, culture, sexuality or gender. Individuals should be able to engage in the development of their communities, and their opinions and ideas should be heard (Government Office for the West Midlands, 2006; Saloojee, 2003).

**Skills and capacity.**

Improving individuals’ skills and capacity facilitates their access to employment, maximizes economic productivity and institutional strength, and strengthens democracy (Bates & Davis, 2004). Another way to promote social inclusion is through improving individuals’ skills and capacity, and alleviating social exclusion and poverty (Social Exclusion Unit, 2002). This section will provide an overview of the importance of individuals’ skills and capacity in achieving employment and the reduction of social exclusion. Although the definition of social inclusion provided by Saloojee (2005) does not indicate skills and capacity as a main component of social inclusion; a review of the literature
(for example, Inclusive Cities Canada) states that skills and capacity are also important aspects of social inclusion. Therefore, a discussion of skills and capacity has been added to this paper along with the ideas mentioned in Saloojee’s (2005) definition of social inclusion.

Through individual and community capacity building, which includes education and skills development, real benefits to communities can be achieved (Freiler, 2002; Social Exclusion Unit, 2002). In addition, by developing individuals’ skills and capacity, issues related to social exclusion (unemployment, poor skills, low income, and poor health status) might be tackled and may contribute toward key social inclusion outcomes (cultural, economic, participatory, physical, political, structural, and relational) (Saloojee, 2003; Shookner, 2002). Individuals with disabilities, individuals from disadvantaged groups, recent immigrants, individuals living in poverty, and older adults require improved skills and capacity to find employment and tackle stereotyping (Galabuzi, 2004; Social Exclusion Unit, 2002; Toye & Infanti, 2004). In addition, human development that promotes individuals’ talents, skills, capacities, and choices of life, such as providing learning and development opportunities for individuals, child care programs, leisure and recreational activities are important elements for creating inclusive society (Freiler, 2002). Individuals’ skills and capacity can increase the chances for achieving inclusive society. Some examples of approaches include:

- parents’ involvement in, controlling and organizing services for youth inputs for school curricula, and making decisions affecting their children
- individuals’ engagement in municipal policy development, decision making and political participation
- having material resources to allow children and parents to participate fully in the community. This includes having access to safe and secure housing and employment opportunities (Galabuzi, 2004; Social Exclusion Unit, 2002; Toye & Infanti, 2004).
According to Galabuzi (2004) individual skills and capacity are associated with education, employment and income status. According to Health Canada (2002), employment has a direct effect on individuals’ physical, mental and social health as:

Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth...[u]nemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job. Conditions at work (both physical and psychosocial) can have a profound effect on people’s health and emotional well-being.

Individuals with high incomes have more control over their lives. They experience good health conditions, increased coping skills, access to safe housing, good and nutritious food, and access to community support services (Health Canada, 2002). Evans and Repper (2000), indicate that employment can decrease risks of social exclusion, while “[u]nemployment is clearly linked to mental health problems; also overall employment can improve quality of life, mental health, social networks and social inclusion” (p. 15).

In summary, developing individual skills and capacity are important to decreasing social exclusion among individuals. It further supports the importance of skills and capacity in poverty reduction and social inclusion outcomes.

Social cohesion.

Social cohesion has long been studied in fields of sociology and psychology (Hogg, 1992; Levine & Moreland, 1990), and has recently earned more attention in the social and political sciences (Council of Europe, 2001). This section of Chapter Two provides a conceptual analysis of social cohesion. It begins with a brief history of social cohesion and definitions of the concept. It further focuses on the main dimensions of the concept that include: social belonging, individuals’ participation in local community, recognition of individuals’ diversity, and legitimacy.
As cited by Atkinson (1998) the term social cohesion was first used in the Single European Act (1987) at the insistence of the poorer states. The term originally referred to regional inequality, only subsequently acquiring its connection to the problems within existing societies. In addition, social cohesion—a characteristic of a society that deals with connections and relationships between individuals, groups and associations in a society—was first used by sociologist Emile Durkheim. According to Durkheim social cohesion was defined as the interdependence between the members of the society, shared loyalties and solidarity (Jenson, 1998). Social cohesion has been variously defined in the literature; however, contemporary theorists view it as a multi-dimensional phenomenon (Bollen & Hoyle, 1990). According to the Social Cohesion Network, Policy Research Initiative (2003) social cohesion represents the process of developing shared community values, shared challenges and equal opportunities for all individuals based on trust and reciprocity. The main threats to social cohesion include unemployment, poverty, income inequality and social exclusion. Jenson (1998) describes social cohesion as a societal concept in comparison to social inclusion, which focuses on ensuring individuals rights. According to The Council of Europe (2001), social cohesion is defined as, “a concept that includes values and principles which aim to ensure that all citizens, without discrimination and on an equal footing, have access to fundamental social and economic rights” (p. 5). Additionally, in a cohesive society citizens share the same values and feel a sense of belonging towards the community. Jenson (1998) described social belonging as a dimension of social cohesion that reflects individuals’ feelings of belonging to community and share of similar values, and equal opportunity (Dominelli, 2005; Friedkin, 2004; Jenson, 1998). For example, access to housing in a cohesive community is the most essential condition because homeless people experience
isolation from cohesive community and thus have a poor sense of belonging to the community (Jenson, 1998; Williams, 2004).

Social cohesion encourages equality in access for everyone in different social, economic and cultural fields. Being socially included and having equal opportunities for everyone in the community means no one is isolated from the community (Jenson, 1998; Williams, 2004). Social cohesion requires individuals’ active involvement and participation. Individuals’ democratic participation at the local level is considered very crucial in producing social cohesion (Collins, 2003; Jenson, 1998; Mitchell & Shillington, 2002). Voluntary associations have an important role in increasing individuals’ participation in their communities (Jenson, 1998). A cohesive society gives recognition to diversity and pluralism of individuals, so that people of different races, ages and backgrounds are respected and appreciated (Friedkin, 2004; Jenson, 1998).

According to Forrest and Kearns (1999) social cohesion is about the need for a shared sense of morality and common purpose that include aspects of social control and social order, levels of social interaction within communities and families and sense of belonging. Social cohesion focuses on two opposite dimensions that include the reduction of disparities, inequalities, social exclusion and increasing and encouraging social relations, interactions, and ties between individuals in a society.

**Diversity.**

In an inclusive society the diversity of people’s different backgrounds and circumstances are appreciated and positively valued. Social inclusion also encourages equal opportunities for individuals from diverse backgrounds and promotes positive relationships between individuals’ in workplaces, schools and neighbourhoods (Mitchell & Shillington,
A lack of recognition of diversity often leads to the social exclusion of individuals of diverse background and ethnic groups.

According to Freiler (2002), the cornerstone of social inclusion includes valued recognition, whereby individual or group identity is validated. It is therefore, necessary to develop a strategy that can deal with the challenges of individuals’ recognition in society, which affect individuals’ employment, income capacity, and rising mobility (Saloojee, 2005). According to Sennett (2000) inclusion at both the individual and community levels requires mutual recognition, “people must signal that they are aware of each other as legitimately involved together in a common enterprise” (p. 278). For Sennett (2000) mutual recognition is about giving individuals the feeling that their presence is being noticed and their voices are heard and socially honoured. Social inclusion encourages individuals to nurture paths of mutual recognition and fills the distant gap between people in society in ways that bring respect and value for the differences that defines them (Bach, 2002). Bach further illustrates that the, “issue of recognition by others and who is included among those obtaining valued recognition and who is not are central issues in recent jurisprudence in Canada concerned with interpreting constitutionally protected equality rights” (p. 7). In a multicultural society, ethno-racial communities are struggling to gain recognition of their identity similar to the dominant culture. As Day (2000) explains, multicultural policy just recognizes racialized communities by their existence, not their value and equality. In comparison social inclusion, emphasizes democracy, citizenship, accountability, public policies, increased representation and participation by marginalized groups and the development of skills and capacities, recognizing and respecting differences (Saloojee, 2003). According to Davey (2003) and Raphael (2004) social exclusion is encouraged by diversity in urban areas as policy and
practices are set to represent the perceived majority—not diverse groups living in urban areas. Mullaly (2002) specifies six main factors which contribute to diversity in urban areas, these factors include gender, race, ethnicity, sexual orientation, age and disability.

**Access to Services and Supports.**

According to Williams (2004), to achieve social inclusion there is a need for integration of different issues including social justice, and issues of equality together with other cross cutting issues such as rural affairs, education, transportation and housing. Many people experience barriers to accessing opportunities offered by society. These barriers are often limited to particular groups, families, and individuals who receive pensions and individuals who are more vulnerable to poverty, and experience discrimination because of their gender, race or disability. Other barriers that are more personal are often experienced by individuals with poor health, poor housing, and drug addiction (Shookner, 2002; Social Exclusion Unit, 2001).

The discussion of barriers to social inclusion is the focus of Shookner’s (2002) research paper “An Inclusion Lens”. Shookner identified several dimensions including cultural, economic, physical, relational and structural dimensions that are considered barriers to social inclusion and promoting factors to social exclusion.

Some barriers to social inclusion—including unemployment, poverty, drug addiction, lack of housing, exclusion from political empowerment, and limited access to public services—are often experienced by individuals living in poverty and those who are discriminated against for different reasons (e.g., gender, race, or disability) (Shookner, 2002; Toye & Infanti, 2004). Shookner (2002) suggests that the barriers to social inclusion result in social exclusion. The following is a discussion of these barriers.
Ignoring individuals’ contributions to society, lack of recognition and fear of individual differences, a lack of tolerance and gender stereotyping are considered cultural barriers often experienced by disadvantaged groups (Monk et al., 1999; Omidvar & Richmond, 2003; Shookner, 2002). In addition, cultural barriers decrease individuals’ access to health services and enhance social exclusion and segregation of racialized groups from society (Health Canada, 2001).

Language can be used in ways which exclude or discriminate against particular social groups and may label people based on socio-economic and ethnic differences in a negative or derogatory sense (Gans, 1995) and may result in exclusion and poor feelings of belonging to society (Pickering, 2001). According to Corker (2000), language can bring positive and negative changes in life. An example of negative change includes the experience of racism among individuals in everyday life (stereotypical views by some professionals, lack of cultural sensitivity, lack of access to community health services, and barriers in access to utilization) (Galabuzi, 2002). Regular and ritualized practices of racism cause damage, oppression, and results in the social exclusion of racial and ethnic groups from the society in both individual and institutional levels. Social exclusion and language barriers, as well as cultural attitudes to seeking healthcare, often make the biomedical risks even greater as Carballo and Nerukar (2001) describe:

Language also plays an important role in mental health, and barriers to good communication compound feelings of isolation and being ‘unwanted’. The capacity to communicate can influence healthcare-seeking behavior, underreporting, poor explanation of health problems and symptoms, inappropriate diagnoses and the capacity of immigrants to comply with treatment regimens. (p. 558)

Similarly Novac (1999) indicates that individuals, particularly women, experience housing difficulties due to their poor language skills, lack of knowledge about their rights,
and lack of advocates in the housing community. According to Health Canada (2001) the following four groups face language barriers in Canada: Aboriginals, immigrants, people with disabilities, and people who do not speak one of the official languages in Canada (English or French). In addition, resistance to racialized individuals’ participation in society results from language problems and reinforcement of stereotypes and prejudice by a superior racial group (Basok, 2004; Carballo & Nerukar, 2001).

In brief, cultural and language barriers limit individuals’ participation in society and result in discrimination and isolation from society. Further, cultural and language barriers may also increase experiences of exclusion and rejection, reinforce stereotypes and prejudice by a superior racial group, increase health problems, and limit individuals’ participation in community.

**Economic barriers** which lead to social exclusion include: poor skills and capacity, lack of participation in society, poverty, unemployment, inadequate income, poor access to resources, deprivation, lack of education and a lack of a supportive environment (National Strategy for Neighbourhood Renewal, 2000; Shookner, 2002; WHO, 2005). Arundel (2003) notes that for individuals to participate in community, sustain good health, form a stable base, and access adequate food and shelter, it is important to have an adequate income. The author further adds that an individual’s poor access to community resources and low participation in community results from their low income, which often results in isolation from the community. For example, individuals with low incomes are not able to afford transportation and are prevented from participating in community life.

Individuals’ poor health, nutrition, hygiene, behaviour, mental health problems, poor housing standards, limited employment opportunities, low academic achievements and lower
economic standing are associated with poverty (Canadian Council on Social Development, 2000; Silver, 2000). Accordingly, the effects of poverty create economic barriers to social inclusion (Toye & Infanti, 2004). Racial inequality and discrimination result from power imbalances and structural constraints in society. These structural constraints are often experienced by more racial minorities as they access the labour market and seek to gain progress within organizations (Saloojee, 2003). Due to difficulties in gaining full access to the labour market, racialized individuals or visible minorities experience discrimination and unfair treatment in the workplace (Galabuzi, 2002). In addition, Morris (2005) reflects on the experience of direct and indirect discrimination among people with disabilities which include: unequal access to educational and training opportunities, having higher rates of unemployment, and economic inactivity.

**Physical barriers** include the restriction of access to public places, such as libraries and parks, and a lack of transportation facilities. These barriers are often experienced by people with disabilities in their access to education, employment, leisure and other activities (Monk et al., 1999; Shookner, 2002). Physical barriers also include the geographic location of neighbourhoods in relation to community resources. Wilkinson and Marmot (2003) illustrate that people living in disadvantaged areas with poor access to community resources have higher health risks including: risks of divorce, separation, disability, addiction, social isolation, cardiovascular diseases and other social and psychological issues.

**Relational barriers** influence individuals’ living in isolation or individuals who are segregated from mainstream society. Relational barriers include the experience of violence, abuse and having low self-esteem, poor sense of belonging, social segregation and distancing (Freiler, 2002; Shookner, 2002). Structural barriers to relationships include discrimination
against individuals’ based on race, sex and homophobia that were described previously under cultural barriers. Structural barriers also include a lack of access to community programs, governmental jurisdictions and restrictive communication and lack of flexibility (Social Exclusion Unit, 2001; Shookner, 2002). At a structural level, relational barriers translate into the denial of human rights, and the lack of protection for vulnerable groups in the community (individuals with disabilities, chronic illness, and mental health problems). Limiting policies and legislation create political barriers and lead to social exclusion of individuals in a society (Raphael, 2001; Shookner, 2002).

Economic, cultural, physical, relational and structural barriers are described as dimensions for exclusion by Shookner (2002). Social inclusion ensures equal and barrier free access to resources for all members of society to participate with an equal sense of belonging (i.e., no marginalization) in society. It further supports individuals’ right to equality and their right to be free from discrimination (Saloojee, 2003). Increasing the flow of resources to individuals, and building their capacity to become more powerful, organized and self confident will help them fight against barriers to social inclusion (Galabuzi, 2002). In addition, social inclusion does not only focus on the removal of barriers for individuals, but also the individual’s full participation and validation (Freiler, 2002).

Chapter Summary

The aim of Chapter Two was to provide a discussion of trauma, social inclusion and social exclusion within the literature. The review of literature on trauma provided information concerning the impacts of trauma on individual health and access to the determinants of health. Individuals with a history of abuse related trauma may have less control over their work, difficulties finding employment, poor career achievements and have
difficulties in their personal and social relationships; in short, they are at a higher risk of experiencing social exclusion. The impacts of trauma can be unique among individuals, and it is often related to individuals’ history and exposure to traumatic events, and other factors such as psychological, social and economic conditions. Reactions to trauma can range from impacts on memory and isolation from society, to the development of severe mental health problems such as depression, somatization, anxiety, eating disorders, sleep disorders, dissociative disorders, and PTSD. In comparison to men, women are at a greater risk for developing PTSD, depression, anxiety, as well as physical injuries following the experience of trauma. Risks are greater among women who have experienced abused related trauma as children. Individuals with access to the social determinants of health and social inclusion, generally have improved coping skills and resiliency to trauma.

The discussion of social inclusion and social exclusion highlighted the history and origins of the concepts. Social inclusion supports participation and inclusiveness for all people in the community (Manor, 2004; Richmond & Saloojee, 2005; Saloojee, 2005). The components of social inclusion were discussed, including: citizenship and participatory democracy, skills and capacity, social cohesion, diversity access to services and supports, as well as the barriers to these components.

In contrast to social inclusion, social exclusion referred to the process of deprivation associated with an inability to fully participate in social, economic, political, institutional and civil life. This includes a lack of participation in the processes of decision making and policy making. People experience exclusion when they are not part of the mainstream society, have poor sense of belonging, experience social marginalization, and have poor access to
null
community support services and social supports (family, friends, community, and employment).

Chapter Three outlines the methods for this study including a discussion of narrative inquiry, the data collection methods and ethical considerations. This is followed by a description of the approach to qualitative analysis used and a discussion of reflexivity and trustworthiness. In Chapter Four, the findings from the study are reported. This Chapter commences with a brief description of the eight participants followed by each participant’s Three Dimensional Narrative Structure. Chapter Five presents a discussion of the themes which emerged from the participants’ narratives, followed by a detailed examination of these themes within the context of the literature. Chapter Five ends with a discussion of the implications, strengths, limitations of the study and suggestions for future research.
CHAPTER THREE: METHODOLOGY

The purpose of this qualitative narrative inquiry was to explore the experience of accessing community support services among women who have experienced abuse-related trauma. The conceptual framework for this study was drawn from the literature on social inclusion and social exclusion. The conceptual framework was used to explore the relations between trauma and the experiences of social inclusion and social exclusion in accessing community support services among the participants. This study provided a deeper picture of the experiences of women on social assistance who have experienced trauma, in relation to social inclusion and social exclusion by looking at the personal and social aspects of their experiences. The research questions that guided the study were as follows:

1. How are the personal and social experiences of social inclusion different or similar among women who have experienced trauma?
2. What experiences of social exclusion have been encountered in the past, and, what type of struggles are presently encountered by women who have experienced trauma?
3. What are the women’s perceptions of changes needed to community support services to increase their social inclusion?

Answering these research questions yielded insight into the participants’ experience of social inclusion and social exclusion and contributed to the literature on social inclusion with regard to women who experienced trauma and were on social assistance.

This qualitative narrative inquiry used a sub-sample from a larger research study conducted by Arai et al. (2006) entitled *Building inclusive governance structures in rural Ontario: Assessing the capacities of people who are socially marginalized*. The study explored the experience of women in relation to social welfare supports and the challenges encountered. The study by Arai et al., (2006) addressed the following questions:

- How do individuals who are socially marginalized experience social welfare supports?
null
• How do individuals who are socially marginalized construct their lives?
• What challenges are experienced by individuals who are socially marginalized?
• What is the worldview and sense of self held by individuals who are socially marginalized?
• How can individuals who are socially marginalized become more involved in governance?

The original research study by Arai et al. (2006) was designed to provide policymakers with insight into the particular needs and abilities of individuals who have experienced social marginalization. The goal was to design governance frameworks engendering more inclusive decision-making processes and civic engagement for these populations. The study gained a detailed picture of the experiences of women who have experienced marginalization. It also explored the experience of women in relation to social welfare supports, the encountered challenges, and the world views of women who have experienced marginalization. The study was reviewed and received ethics clearance by the Brock University Research Ethics Board (File # 05-032 - ARAI).

Considering some advantages of secondary data analysis and the effect of gender in the process of data collection (see the discussion on secondary data analysis), the intent was to use the data collected by Arai et al. (2006). Participants in the original study (n=27) included women over the age of 18 years who received or were receiving social assistance at the time of the study. However, for the purpose of the research reported in this thesis a sub-sample of eight women who had experienced abuse-related trauma was used to explore the experience of social inclusion and social exclusion among the selected participants. The findings from this study may be used by community organizations that are providing support services for women who have experienced trauma.
Narrative Inquiry

Generally every individual has unique, important and valuable knowledge and experiences, when their knowledge is recognized, valued and used, individuals feel their views are significant and can help others understand their thinking, actions, and reactions (Ricoeur, 1990). A narrative inquiry method was used to explore the experiences of accessing community supports among women who experienced trauma and were on social assistance. Narrative inquiry has gained popularity in the field of social sciences over the past 20 years (Lieblich et al., 1998). The term ‘narrative’ refers to a more comprehensive unit of actions that include not only the story telling of individuals’ experience, but also the participants’ evaluation of the reported events (Ochs, 1997). Murray (2003) defines narrative inquiry as an organized interpretation of a sequence of events. Similarly, it is a type of qualitative research, which captures a participant’s story as both its raw data and its product (Bleakley, 2005). According to the same author, narrative inquiry is a unique type of qualitative research, which can enlighten soft data to hard realities and give dramatic insight into the lives and experience of the study participants. Bleakley (2005) further adds that, “narrative inquiry often seeks not only to personalize, but also to engage proactively with its research population through deliberate intervention, as research with, not on, people” (p. 535). According to Clandinin and Connelly (2000) narrative inquiry is about the study of epiphanies, custom, routines, images, and everyday experiences.

Bruner (1991) argues that scientific and narrative ways of knowing are fundamentally different. While, science concerns itself with the establishment of truth, narrative’s concern is to endow experience with meaning. Narrative means to know, and storytelling engages the production of knowledge as well as the shaping of experience (Chambers, 1999).
According to Polkinghorne (1995), narrative inquiry includes three different kinds of research data: numerical, short form and narrative. In addition it is an appropriate method for researching experiences through time, such as chronic illness (Bleakley, 2005). Chase (2005) sees narrative inquiry as an, “amalgam of interdisciplinary lenses, diverse disciplinary approaches, and both traditional and innovative methods—all revolving around an interest in biographical particulars as narrated by the one who lives them” (p. 651).

Lieblich et al., (1998) suggest two dimensions for narrative inquiry that includes holistic versus categorical and content versus form. In a holistic approach a story is taken as a whole and contextualized in a culture, history, and attempt to cover the general pattern or leading descriptions. While in a categorical approach, particular episodes are dissected, that may be drawn inductively from the raw narratives to provide manageable data for further investigation. The content is how events happen in a narrative and the form is the way events happen (Lieblich et al., 1998). As Bruner (1991), indicates that, “we organize our experience and our memory of human happenings mainly in the form of narrative – stories, excuses, myths, reasons for doing and not doing, and so on” (p. 4). The author further adds that a key resource in every day talk is also narrative in form, the “canonical narratives” of a culture. In addition, Denzin and Lincoln (2005) indicate that, “narratives are socially constrained forms of action, socially situated performances, ways of acting in and making sense of the world” (p. 641). The authors further add that narrative inquiry can be used to develop a social change agenda, which can encourage individuals with similar experience to tell their stories. The narrative inquiry method will help women who have experienced social exclusion, particularly marginalization to create a public space for them and to be heard as valued citizens (Denzin & Lincoln, 2005). As suggested by Fulford (1999), by using narrative
inquiry method, not only the history of individuals’ experiences (women’s experience of trauma in relation to social inclusion and social exclusion) will be explored, but also, the meaningfulness of these experiences will be sought.

Conle (2000) identified two limitations to narrative inquiry. First, there is not one fact about the individual’s past that if explored might completely conclude the results of the inquiry. Second the focus of narrative inquiry is about re-producing and retelling the stories of the participants and not establishing verifications of the actions. Based on these limitations of the narrative inquiry the readers might be cautioned about recognizing the narrow focus of the current study when transferring the results to other situations.

A narrative inquiry was used to retell the stories of the participants in rich thick descriptive information which Clandinin and Connelly (2000) refer to as “the four directions of inquiry”. The first direction (inward) reflects on feelings, hopes, aesthetic and moral reaction. The second direction (outward) includes existing conditions and environment. The third and fourth direction (backward/forward) includes the past, present and future. These directions of inquiry are discussed further in the section on data analysis in this chapter.

Data Collection

Site and Sampling

The site in which the original research study occurred was Niagara Region and is populated by over 410,000 people (Information Niagara, 2006). The Region includes: St Catharines, Niagara Falls, Welland, Fort Erie, Port Colborne, Grimsby, Thorold, Niagara-on-the-Lake, Lincoln, Pelham, West Lincoln and Wainfleet (Information Niagara, 2006). The Principal Investigator Dr. Susan Arai worked with the YWCA Job Route Reference Group in the development of the study. This reference group consisted of representatives from a
number of local community service organizations who assisted the Principal Investigator with recruitment for the study. Potential participants of the study were identified and later recruited by members of the local organizations based on the following criteria:

- participants must be on social assistance (including Ontario Works, ODSP, housing supports etceteras) for a minimum of one year before participating in this study.

Staff members of these organizations approached the potential participants, explaining the study, as well as providing them with a copy of a letter of introduction. Participants were then contacted by the Principal Investigator to arrange an interview. All of the participants in the original study voluntarily agreed to participate. Each participant took part in an interview that lasted approximately an hour and a half. The interviews were conducted by the Principal Investigator in different locations within Niagara Region from November 2005 to January 2006.

A purposeful sampling method was utilized, which involves selecting subjects to complement the goals of the study (Schloss & Smith, 1999). Purposeful sampling uses special knowledge and expertise about a group to select participants who represent that population (Berg, 2004). According to Patton (1990) purposeful sampling selects information rich cases for in depth study. Specifically, the sampling method used here was criterion sampling which involved the selection of participants who met some criterion. These participants in the original study met the following criteria:

- female
- over the age of 18 years
- currently receiving some form of social assistance (including Ontario Works, ODSP, housing supports etc.) for a minimum of one year before participating in this study
- living in Niagara Region.
From the original sample in the study by Arai et al. (2006) the criteria for the sub-sample drawn for this research project is as follows:

- participant disclosed an experience of abuse-related trauma during the interview.

Using this criterion sampling method, eight women who have experienced abuse-related trauma were selected from a total of 27 research participants who participated in the original study conducted by the Principal Investigator. Abuse related trauma refers to a specific category of trauma that includes sexual, physical and emotional abuse (CAMH, 2004), other forms such as trauma related to war, natural disaster and accidental trauma do not fall in this category.

**Interviews**

In qualitative research the purpose is to understand some part of the human experience, and one of the most common methods of qualitative data collection is through interviewing (Donalek, 2005). According to Patton (2002) qualitative interviewing begins with the assumption that the perspective of others is important, understandable, and able to be made clarified. In qualitative research the most frequently used method is known as the in-depth, semi-structured, exploratory or open-ended interview (Holloway & Jefferson, 1997). In-depth interviews with stakeholders involve open-ended questions asked by a researcher to an individual. An interview guide is used by the interviewer; however, it does not rely on a structured question set (Holloway & Jefferson, 1997).

In the original study a semi-structured open-ended interviewing method was used to interview the participants and determine their perceptions, opinions and facts about their life experiences. All interviews were tape-recorded and later transcribed verbatim. Interview questions focused on: the complexity of participants' lives, participants' experiences of social
welfare, their goals and hopes for paid employment, the challenges they experienced in seeking employment, the impacts of social assistance and community support services along, and the women’s worldview and sense of self (see Appendix A, Interview Guide).

**Ethical Considerations**

All of the participants’ voluntarily agreed to participate in the original study. To improve the credibility of the interview (Guba & Lincoln, 1985) an audit of the transcripts was conducted. Each participant received a copy of their interview transcript along with a member-check letter asking for the participant’s feedback about the transcript quality and accuracy based on their memory of the interview. To ensure confidentiality, all participants were assigned pseudonyms. In the letter of introduction for the recruitment of participants, the idea of confidentiality was clearly discussed. When the potential participants contacted the Principal Investigator, it was ensured they were fully aware of the purpose of the study and confidentiality. Confidentiality was maintained during the primary data collection phase by Arai et al. (2006). The written transcripts were labelled by the interviewer using pseudonyms. A master list of the participants’ names with related pseudonyms was stored in a secure location in a locked drawer in the office of Dr. Arai. All paper records that linked participants’ actual names to pseudonyms were destroyed upon completion of the study.

During secondary analysis of data all required steps to ensure confidentiality were followed. Anonymity was guaranteed as the researcher conducting the secondary data analysis was not face to face with the participants. The assigned pseudonyms were used in reporting the findings. All identifiers (i.e., references to specific individuals) were stripped from the transcripts and verbatim quotes used in the reporting of the study. Participants’ names did not appear in the written and oral dissemination of the study. Where necessary
(such as in the use of direct quotes) pseudonyms were used. The direct quotes were scrutinized to ensure that the participants were not able to be identified.

**Secondary Data Analysis**

Secondary data analysis has been differently defined in literature (Turner, 1997). The main components discussed in all definitions include: analysis of data collected by a different researcher, addressing new research questions and may use a different method than the original research (Cnossen 1997; Turner, 1997). The situation is best characterised by the fact that the researcher going to analyse the data is not familiar with (all) the phases of data collection for the respective data set (Cnossen, 1997). Data gathered for one purpose can be used for other research, which is often called secondary data (Riedel, 2000) and may be used to generate new knowledge, new hypotheses and theories (Hinds, Vogel & Clarke-Steffen 1997).

Secondary data is easy to access, is low in cost and requires little time (Riedel, 2000). In addition, secondary data analysis may be important in situations where the gender of the researcher may impact the study. Collecting data from participants who are from a different gender may carry some challenges (Egharevba, 2001; Vincent & Warren, 2001). Egharevba (2001) argues that factors such as gender and establishing credibility and rapport may effect the type and level of information shared by the interviewer and the participant. In addition Finch (1993) suggests that similarity in gender may facilitate the process of sharing information between the researcher and participant. Further, it has been argued that having the same gender can be an important factor in interviewing the respondents and establishing rapport (Archer, 2002; Egharevba, 2001; Finch, 1993; Vincent & Warren, 2001). Women
who have experienced trauma may prefer to talk to a female support provider about their experiences of trauma (CAMH, 2006).

Despite the advantages of using secondary data analysis, particularly from different gender perspectives, a challenge posed for the current study was the inability to carry out member checks and examine emerging themes within the specific scope of the study.

Qualitative Data Analysis

Data analysis is the process of systematically organizing data, bringing meaning to theme so that they tell a coherent story, and communicating that story to others (Glesne, 1999). In this process of data analysis I took the role of an active learner. As Connelly and Clandinin (1990) describe, a researcher in a narrative inquiry focuses on learning about both the personal experience and social experience of the participants. According to Creswell (1998) acquaintance with data should be ensured in the process of data analysis. I began by familiarizing myself with interview transcripts, and read each transcript thoroughly numerous times to ensure familiarity with the data. Data was analysed using a Three Dimensional Space Narrative approach. Following this, themes which emerged during Three Dimensional Space Narrative approach were further developed and analysed.

Phase I Data Analysis: Three Dimensional Space Narrative

A three-dimensional space approach to narrative inquiry allows a holistic lens of the participants’ experiences, ideas, and views on advocacy (Clandinin & Connelly, 2000). As Clandinin and Connelly, (2000) explain, the terms interaction, continuity and situation generate:

- a metaphorical three dimensional narrative inquiry space, with temporality along one dimension, the personal and social along a second dimension, and place along a third. Using this set of terms, any particular inquiry is defined by this three dimensional space: studies have temporal dimensions and address temporal matters;
they focus on the personal and the social in a balance appropriate to the inquiry; and they occur in specific places or sequence of places (p. 50).

In retelling participants' stories, the three dimensional analytical approach as suggested by Clandinin & Connelly (2000) was used to record aspects of participants' experiences and understand the links and interplay between the personal, social, spatial and temporal factors. The approach included: interaction, continuity and situation. Clandinin & Connelly's (2000) three-dimensional narrative approach highlighted the importance of storytelling as a means to the narrative quality of experience through time and cultural expression. Each transcript was analyzed for each participant's personal and social experiences as well as her interaction with other people (Ollerenshaw & Creswell, 2002).

The data were analyzed for the personal experience as well as for the interaction of individuals with other people who had different viewpoints on a certain topic of the story (Clandinin & Connelly, 2000). In exploring participants' personal conditions, their hopes, feelings, desires and moral dispositions were described while exploring their social conditions, their context and present conditions, as well as environmental factors (community, policy, administration and others). In pursuing an understanding of the participants' stories, valuable interactions were retrieved which highlighted participants' understanding and perception through personal and social experiences. In continuity, the transcripts were analyzed to find information on past and present experiences that in some cases illustrated actions or future events (Clandinin & Connelly, 2000). The approach positioned the interpretation of each participant's current experience within a broader past, present and future context. Finally, specific situations such as physical places or landscapes were reflected upon during data analyzing (Clandinin & Connelly, 2000). The physical settings and places related to the participants' experiences were identified (see figure 1.
Three-Dimensional Space Narrative Structure. The structure of the table came from Clandinin and Connelly (2000) and was later adapted by Ollerenshaw and Creswell (2002).

Table 1

The Three-Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Continuity</th>
<th>Situation/Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>Social</td>
<td>Past</td>
</tr>
<tr>
<td>Looking inward to</td>
<td>Look outward to</td>
<td>Look at context, time, and place situated in a physical landscape or setting with</td>
</tr>
<tr>
<td>internal conditions,</td>
<td>existential</td>
<td>implied and possible experiences and plot lines.</td>
</tr>
<tr>
<td>feelings,</td>
<td>conditions in the</td>
<td></td>
</tr>
<tr>
<td>hopes,</td>
<td>environment</td>
<td></td>
</tr>
<tr>
<td>aesthetic</td>
<td>with other people</td>
<td></td>
</tr>
<tr>
<td>reactions,</td>
<td>and their</td>
<td></td>
</tr>
<tr>
<td>moral dispositions.</td>
<td>intentions, purposes, assumptions, and points of view.</td>
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<tr>
<td></td>
<td>Look backward to</td>
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<td></td>
<td>remembered</td>
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</tr>
<tr>
<td></td>
<td>experiences, feelings, and stories from earlier times.</td>
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<tr>
<td></td>
<td>Look at current</td>
<td></td>
</tr>
<tr>
<td></td>
<td>experiences, feelings, and stories relating to actions of an event.</td>
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<td></td>
<td>Look forward to</td>
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<td></td>
<td>implied and possible</td>
<td></td>
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<td></td>
<td>experiences and plot lines.</td>
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</table>

Adapted from Ollerenshaw & Creswell (2002).

The transcripts were read numerous times, considering participants’ interaction, continuity and situation. Further, participants’ perspectives and their practical knowledge in terms of aesthetic, moral and affective elements and the construction of the language used in explaining their experiences were explored (Clandinin & Connelly, 2000). Following the Three Dimensional Narrative Structure, tables were created for each participant to capture the participants’ experiences of accessing community supports. These tables reflect on their experiences of interaction and continuity. To add more detail to the participants’ description of experiences, additional text is presented in each narrative.
Phase II of Data Analysis: Development of themes and pattern

Upon completing the Three Dimensional Narrative Space Structure it became apparent that several themes were consistently arising from the narratives of the participants. Consequently an additional phase of data analysis, following the tradition of grounded theory, was used to help further explore these emergent themes. According to Patton (2002) the first step in data analysis is classifying the data into manageable scheme or coding. Open coding was used to label and summarize data into meaningful units. Data were examined for similarities and differences during the process of coding (Patton, 2002). Data were coded into categories and each category was given a name. To make comparisons between categories and yield fresh insights into the data collected, creativity was considered. Open coding helped to explore the data in a detailed way by identifying and conceptualizing the data. Axial coding helped to connect different categories and include situations and phenomena in discovering the relationships between different statements. Selective coding was used to confirm the relationships between different categories (Patton, 2002). In addition, in this step big units of information were identified which became the basis for defining different categories that emerged from the data. From the themes which emerged during the Three Dimensional Narrative Space Structure as many rich and useful pieces of information as possible were identified. Participants’ experiences of accessing supports were retold based on the narrative elements covering their past and present experiences as well as their future hopes and goals (Ollerenshaw & Creswell, 2002).

The transcripts were approached as a single body of data and analyzed for patterns within and across the transcripts. The themes identified include: the impact of the past on participants’ present circumstances, lack of accommodation of difference, maintaining a
sense of self in a world of assumption and labels, impact of trauma on the determinants of health, and what will the future bring? These themes will be described in more detail in Chapter Four.

Use of Analytic Memos and Qualitative Software

Since all qualitative research studies are unique they demand unique strategies for analysis (Patton, 2002). Memos were written during the analysing process (Glesne, 1999) as this helped in understanding participants’ experience of social inclusion. Throughout the analysis, memos were recorded to clarify creative bounds. Furthermore, memos helped in linking emerging categories and recording emerging theoretical reflections. Analyzing the data (transcripts, documents, field notes) required more than description and thematic development of the data (Ollerenshaw & Creswell, 2002), the central focus was to understand the participants’ experiences and the retelling of stories.

Although I was not directly involved with data collection for the original project, I was part of the research team during transcribing, primary data analysis, coding and interpretation of data. I was granted access to the original data, including tapes and field notes through the Principal investigator (Dr. Arai). In re-examining the data with the new focus in mind I consulted with the Principal investigator to contextualise the material (rather than rely on field notes alone).

NVivo 7 (qualitative research software) was used in the process of data analysis. Richards (1999) illustrates that computerized software such as NVivo is a useful tool to manage large amounts of unstructured data including, coding, locating, and retrieving the key and target words and phrases, as well as sorting categories and creating memos. It is particularly designed to facilitate the building of relational networks identifying the content
and structure of respondents’ views and ideas (Richards, 1999; 2000). The emergent themes from the participants’ narratives (Three Dimensional Narrative Structure) were used to label the nodes in Nvivo7, during the second phase of data analysis.

Reflexivity

According to Hertz (1996) the concept of reflexivity arose from a modification in the consideration of data and its gathering. A reflexive study does not just report ‘facts’ or ‘truths’ but actively constructs interpretations of researcher’s experience in the field. Reflexivity is also the reaction of participants resulting from being studied or observed (Howard, 1985). Other qualitative researchers define reflexivity as the process by which researchers review and challenge the bases for their thought and decision making throughout data gathering and theory building (Hertz, 1996). While reflecting on the data, researchers also reflect upon the ways they create the assumptive framework upon which they construct their understandings of the data (Berg & Smith, 1985). Furthermore reflexivity can be defined as an awareness of the impact of the research process on the participants of the research investigation (Calhoun, 2002). According to Patton (2002) as a researcher one should be attentive and conscious of intellectual, political, communal, linguistic and ideological origins of one’s own view and voice as well as the perceptions and voices of those who are being interviewed and to those the researcher reports to.

As a foreign medically trained doctor in a war-torn country (Afghanistan), and working in the surgical ward, my understanding of trauma was that it was an external force that caused injuries. The picture of trauma in my mind was mostly of the intensive care unit and emergency room where patients with accidental trauma, war injuries, and other forms of physical trauma were referred. Most patients exhibited fractures in upper and lower
extremities, spinal cord and skull injury, abdominal and thoracic injury and disseminated injuries of skin (friction, incision, laceration/tearing, puncture, or blunt impact trauma). In general, it was the entire physical trauma, and rarely PTSD as a consequence of exposure to different types of trauma, which I observed. Consequently, I was less aware of psychological trauma and the psychological aspects that emerge from traumatic events, as well as the challenges encountered by individuals who have experienced trauma and the impacts on social inclusion. I now understand that trauma includes a combination of physical, emotional, biochemical, psychological, genetic and social factors.

In September 2005, I completed a qualitative case study of a community support organization ‘Design For A New Tomorrow’ as part of fulfilling the requirements for entry into a Master of Arts program. This community support organization provided counselling support services for women who had experienced trauma. I learned about the struggles of women who experienced trauma in accessing community support services, as well as their experience of further marginalization in accessing these services. This experience increased my interest in conducting qualitative research and created further questions about the experiences of women who experienced trauma. I was provoked by these curiosities to further explore the bigger picture of the experiences of women with trauma in terms of social inclusion and their participation within a community.

In this study, I incorporated reflexivity by constantly questioning my assumptions about what I thought was happening. I sought to maintain a responsive sense of awareness of the biases that I brought to the study and maintained this awareness when adding contextual data and also when writing journal entries. A journal was kept to note memos and field notes throughout the research. Following Holloway and Wheeler (2002), to ensure the credibility
and dependability of the study, as a main tool of research I reflected on my role, feelings and experiences as a researcher during the study. The active voice was used for better communication and understanding of inquiry as suggested by Patton (2002). I used a journal with wide margins on the left-hand side to enable myself to highlight particular events of interest and create specific notes. A journal is used to remind oneself to investigate an event in more depth (Berg, 2004). It also helped me to note participants’ deepest thoughts about their experiences.

**Trustworthiness**

According to Glaser and Strauss (1967), trustworthiness is the extent to which one can believe in the research findings. According to Lincoln and Guba (1985) a researcher needs to bring together into temporary categories those pieces of data that actually relate to the same content. It is then important to:

devise rules that describe category properties and that can, ultimately, be used to justify the inclusion of each data bit that remains assigned to the category as well as to provide a basis for later tests of replicability (p. 347).

In addition, Lincoln and Guba (1985) illustrate that in qualitative research methods the terms credibility, confirmability (neutrality), dependability, and transferability are the essential criteria for quality. According to Patton (2002) a detailed and truthful report and document of the process of data analysis and research findings adds to the credibility of the research.

To address the issue of trustworthiness of analytical interpretations the following points were considered as suggested by Hollway & Jefferson (2000). There is a need for reflecting on my subjectivity in terms of observing, listening, and engaging in reflexivity. I
[Text content]
thought of the research process as a whole and I tried to maintain a responsive sense of awareness of personal knowledge of the topic.

_Credibility_

According to Lincoln and Guba (1985) one of the criteria for assessing trustworthiness is credibility, which is the assessment of whether or not the research findings represent a ‘credible’ theoretical interpretation of the data drawn from the participants’ original data (Lincoln & Guba, 1985). In addition, the changing conditions of the phenomenon under study can be ensured through dependability. According to Lincoln and Guba (1985) the basic question addressed by the idea of trustworthiness, is simple: “How can an inquirer persuade his or her audiences (including self) that the research findings of an inquiry are worth paying attention to, worth taking account of?” (p. 290). A key issue for qualitative research is developing a shared understanding of appropriate procedures for assessing its credibility or trustworthiness that refers to the truth or believability of the findings recognized by the researchers (Morse, 1994). Improving the credibility of the study involves the use of multiple comparison groups, and sharing with each participant the verbatim transcript of the individual interviews and drafts of the emerging concepts and categories (Glaser & Strauss, 1967). Similarly, Patton (2002) adds that participants’ reflections, conveyed in their own words (verbatim quotes) strengthens the credibility and validity of the research (Patton, 2002).

The Principal Investigator was consulted for cross-checking the results of the secondary analysis. In addition, as suggested by Jayaratne (1983), I strictly adhered to the rules of a good design and norms of correct interpretation to avoid gender bias. In addition, I reflected on my field notes throughout the research. Further, to add to the dependability and
credibility of the study from a different gender perspective, all phases of data analysis and reporting were done under close supervision of the Principal Investigator.

**Transferability**

Transferability is the degree to which the findings of an inquiry can pertain or transfer beyond the boundaries of the project. It involves collecting enough data so that external judgments may be made about the data (Guba & Lincoln, 1989). Lincoln and Guba (1985) suggest thick description as an important aspect for transferability of a qualitative study. The transferability of the data is a practical question which cannot be answered only by the researcher (Lincoln & Guba, 1985). The context of interest should be compared to the research context to identify similarities. The degree of transferability depends on the similarities found between the two contexts. It is also called ‘fittingness’ which is the degree of similarity between sending and receiving contexts (Guba & Lincoln, 1985). In addition, the degree of transferability depends on similarities between the two contexts being studied; the researcher collects rich information with detailed description of data in context and presents them with sufficient details and accuracy that can allow the judgments of readers on transferability. The readers can then apply the research findings when they find sufficient similarities between the two contexts (Holloway & Wheeler, 2002).

**Dependability**

Dependability can be established through the development of an audit trial (Guba & Lincoln, 1985). To check dependability, the study was carefully audited using NVivo 7 (QSR, 2005). NVivo enabled researchers to verify different steps in the process of data analysis/interpretation as well as the logic and chronology of the research process. By utilizing NVivo 7, analysis was supported through an audit trail which showed explicitly how
the data was analyzed (Richards, 2000). NVivo facilitated the creation of the audit trial, for example, automatically tracking the day and time that nodes were created, as well as keeping the records of the research methods, analysis and findings. Keeping detailed notes on decisions made throughout the process added to the research auditability and, therefore, reliability (Holloway & Wheeler, 2002). The NVivo qualitative software can enhance the reliability of data by applying the rules built into the program (for example, the line by line numbering of interview transcripts) as well as keeping a record of coding and writing (Richards, 2000). The logic used for selecting participants to interview and include in the study should be clearly presented in order to make the results more dependable (Guba & Lincoln, 1985). The context of the study was described in detail, and the findings of the study were reported consistently and accurately to achieve some measure of dependability (Holloway & Wheeler, 2002).

**Confirmability**

Confirmability is a measure of how well the inquiry’s results are supported by the data collected (Lincoln & Guba, 1985). To reinforce the confirmability of themes, verbatim quotes were included in the report (Wuest et al., 2001). Confirmability may be ensured by using the NVivo software as the research findings can be matched to the data by having another researcher review the research notes, transcripts, the codes and the decision trails so that the research process can be clearly followed.

The results of the study were referenced to literature and findings by other authors to confirm the interpretations and strengthen the confirmability of the study (Guba & Lincoln, 1989). To comprehend the details of constructed themes and their interpretations, the details about the researcher and background feelings of the researcher were reflected upon. In
addition, to show confirmability, a record of the inquiry process was provided (Lincoln & Guba, 1985). The methods used in the study were described as concisely as possible to provide an audit trail. All the successive steps in the study were clearly stated and undertaken with conscientious concentration to detail.

**Summary**

The research used narrative inquiry and grounded theory to engage in secondary data analysis of data collected by Arai et al. (2006). Eight participants were selected based on criterion sampling from a total of twenty seven participants who took part in the original study. A Three Dimensional Space Approach to narrative inquiry provided a holistic lens to examine the participants’ experiences, ideas, and views (Clandinin & Connelly, 200). Themes that emerged during the Three Dimensional Narrative Approach were further developed using open and axial coding. Ethical considerations such as confidentiality and anonymity were addressed. Throughout the research process a journal was kept to note memos.
CHAPTER FOUR: FINDINGS

This chapter provides narratives of the 8 women who have experienced trauma and their voices in accessing community support services. A Three Dimensional Analytical approach as suggested by Clandinin and Connelly (2000) was used to describe aspects of the participants’ experiences in accessing community support services including the personal aspects (e.g., thoughts, hopes, feelings, images, moral reactions and perceptions) and social aspects (i.e., existential conditions in the environment with other people and their intentions, purposes, assumptions, and points of view) of their lived experiences. In addition, these narratives provided insight into the past, present and future structure of their social experiences.

This chapter begins with a brief history and background of the eight participants, including their age, education, work experience, current place of residence, personal and social experiences of accessing social supports (both positive and negative), experience of abuse-related trauma, and the challenges and barriers they experienced. This is followed by a Three Dimensional Narrative Structure of each participant based on their personal, social, past, present, future, and situational circumstance in accessing community supports (Clandinin & Connelly, 2000). Within these narratives the women’s experiences shed light on the research questions that guided this study, including:

1. How are the personal and social experiences of social inclusion different or similar among women who have experienced trauma?
2. What experiences of social exclusion have been encountered in the past, and, what type of struggles are presently encountered by women who have experienced trauma?
3. What are the women’s perceptions of changes needed to community support services to increase their social inclusion?
The narratives provide important insight into the experiences of the women. In each of the following sections the stories reflect the uniqueness of the women’s lives and their personal journeys. Verbatim quotes are used to enable the women to speak in their own voices and are captured in Tables 2 through 9. Pseudonyms are used throughout the findings to ensure confidentiality. Following this, a summary of the 8 participants’ narratives appears in Table 10. From the narratives a number of common themes that arose are explored in more detail in the Discussion found in Chapter Five including: the impact of the past on participants’ present circumstances; lack of accommodation of difference; maintaining a sense of self in a world of assumption and labels; impact of trauma on the determinants of health; and what will the future bring?

*About the Participants in the Study*

The women who participated in this study (8) all lived in Niagara Region, all received some form of social assistance, and had past experiences of abuse. Six of the eight participants were receiving Ontario Works (OW) at the time of the study. The biggest struggle for almost all the participants in terms of social assistance was covering the cost of housing. The duration of traumatic experiences was different among each participant. Some of the women had previous experiences of spousal abuse (Julia, Linda, Christine, Mandy, and Xantha); one woman was assaulted in the work place (Connie). Connie had also experienced trauma and a resulting physical disability from a car accident. One woman had experienced childhood abuse (Wendy). In total, six participants (the exception being Christine and Julia) lived with some form of disability. Additionally, four participants (Xantha, Wendy, Mandy and Linda) with disabilities also experienced mental health issues. Most of the participants...
(six) are on welfare and described a shared experience of low self esteem from accessing welfare supports.

Almost all of the participants were single mothers with one or two children. Wendy and Leeanne were the only women in the study without children. Most of the participants were between 45 and 53 years of age. One participant was in her twenties. Almost all participants talked about returning to paid work in the future. Two women (Julia and Christine) were enthusiastic about returning to paid work. Six women (Leeanne, Linda, Connie, Xantha, Mandy and Wendy) expressed their concerns about returning to paid work in the future, and discussed limitations in the employment opportunities available in their local communities. These six participants wanted to focus on their immediate life challenges such as housing and health related issues. Among the last six women, three (Mandy, Linda and Leeanne) talked about their interest in doing volunteer work.

Despite the similarities among the women in their experiences of abuse-related trauma and receiving government transfer payments (OW and ODSP), each woman’s personal (age, education, work experience, place of residence etceteras) and social story (positive and negative experiences, social interaction, support network) and her experiences in accessing community supports differed. The participants accessed different community-based support services including: employment supports (e.g., Human Resources Development Center); housing supports (e.g., Niagara Regional Housing), education supports (e.g., Independent Learning Center); counseling for women who have experienced abuse related trauma (e.g., NOVA house, CARSA (Niagara Region Sexual Assault Center), Design For A New Tomorrow); physical and mental health support programs (e.g., Canadian Mental Health Association, Public Health, St. Catharines General Hospital, Distress Center);
family support programs (Family and Children Services, Family Responsibility Services), and supports for women (Women’s Resource Center). The participants’ current place of residence played a major role in their access to community support services as most of the participants reported transportation as a major barrier in accessing community support services. Niagara Region is comprised of 12 municipalities and many Regional, Provincial and Federal supports are offered on a Regionalized approach with the majority of community support services located in St. Catharines (Information Niagara, 2006). However, there is no Region-wide transit system. Separate municipal transit bus services are available in each of the municipalities in Niagara Region with the exception of Beamsville which does not have public transit. In the communities with public transportation the hours of operation all differed at the time of the study. For example St.Catharines was the only city that had public transit service during each day of the week (including Saturdays and Sunday) (Information Niagara, 2006). In addition, bus services operated between communities but required that a separate ticket be purchased from each bus company.

Consequently, almost all participants described experiencing some challenges in accessing supports within and outside of their local municipalities. For example, Julia, Christine and Wendy lived in Niagara Falls but to access supports, Julia and Wendy had to travel to St. Catharines. Wendy did not have a vehicle. To get to St. Catharines she had to purchase tickets on three different bus systems. Even though Christine used services that were available locally in Niagara Falls, she still experienced challenges (including not having a driver’s license, having physical health issues which created barriers to using public transportation, affording bus fare for her children). Mandy and Xantha lived in St. Catharines, where most of the support services were located. However, Mandy had to travel
to Beamsville to receive support services from the only Women’s Resource Center in the Region. Xantha described experiencing financial barriers to accessing supports in St. Catharines. Connie lived in Fort Erie and accessed local supports. Leeanne lived in Thorold and Linda was in Beamsville, they both travelled to St. Catharines to access supports services.

Three Dimensional Narratives: Women’s Experiences with Community Support Services

Following Clandinin and Connelly (2000) the following narratives contain an analysis of each woman’s personal or internal conditions, feelings, hopes and reactions, as well as her experience of social interaction in the community. Further, the participant’s past and present experiences in relation to her future actions and perspectives are described in the narrative structure.

Julia

At the time of the study Julia lived in Niagara Falls and she was a single mother with 3 children. Two of her daughters (ages 19 and 21) lived away from home. Her 15 year old son was living with her in a small townhouse in subsidized housing. In the past Julia juggled part-time, low-income jobs. In attempt to increase her income Julia made the decision to return to school to train as a paralegal. Julia’s Three Dimensional Narrative Structure appears in Table 2 at the end of this section. Julia experienced trauma-related issues as she described that her ex-husband was stalking her during her final placement in the paralegal program. As a result of the distraction created by the abuse her employer released Julia from her job. She was then looking for a new job as a paralegal. She applied to may different jobs but her search had not yet been successful (see Table 2, Past).
Julia then resorted to seeking any employment and was using a temporary employment agency to find a job. She described that she sometimes felt as if her diploma and training as a paralegal created a constraint for her, as people see her background and assume that she will not stay in another type of job. As a consequence, she was left feeling that she would like to delete some of the items on her resume (e.g., her education) so that potential employers would not raise questions (see Table 2, Social).

Julia believed that additional support was needed from community resources to help her find employment. While she had the education to pursue a career as a paralegal she felt that she lacked awareness and skills in searching out available jobs and that she lacked social networks to connect with potential employers.

Julia had received support through the local women’s shelter. Julia described that the support provided by the organization was essential to her and it helped her to make links with Ontario Works. Julia described financial constraints as one of the biggest challenges affecting her life. She lived in subsidized housing and owned a car but was unable to use it as she could not afford gasoline and insurance payments (see Table 2, Situation and Place). She originally applied for Employment Insurance but did not have enough employment hours to qualify. According to Julia, “I’ve been on it [OW] because of no other choice” due to her experience of spousal abuse and limited financial options (see Table 2, Present). Julia believed that the limited financial support ($695 from Ontario Works) was barely sufficient to cover the cost of her routine expenses (transportation, groceries, home telephone and other costs). Julia visited the local food bank each month to supplement her groceries. She found the use of these supports to be challenging and discouraging. She felt embarrassed about living on welfare (OW), but she said that she did not have a choice (See Table 2, Personal).
At the time of the study, Julia’s ex-husband owed her $27,000 from three years of back payments in child support. She had been in touch with the Family Responsibility Office but they had not yet been successful in gaining financial support for her and her son (see Table 2, Social). Julia was also owed $17,000 on a government student loan.

Julia described education as being a path to a better future. However, her future stability was made more precarious by OW requirements. She described that if she were to receive back payments from her ex-husband for child support she would then be required to pay back the money she has received from Ontario Works (see Table 2, Future).

Table 2

Julia’s Three Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Continuity</th>
<th>Ex-husbands and child support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>• I have an ex-husband who owes me $27,000 in back child support. He hasn’t paid me in over 3 years...</td>
</tr>
<tr>
<td></td>
<td><strong>Abuse and impact on employment</strong></td>
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<tr>
<td></td>
<td>• I cooped from March until June...with a lawyer then she hired me on a short-term contract for 3 months and in that time that I was employed with her I was having problems with an ex-fiancé, he was stalking me he ended up being charged with criminal harassment</td>
</tr>
<tr>
<td></td>
<td>• ...because I didn’t have enough working hours I had to go to welfare or OW...</td>
</tr>
<tr>
<td></td>
<td><strong>Balancing work, education and family</strong></td>
</tr>
<tr>
<td></td>
<td>• Before I went to school I was working 2 jobs, after I went to school I was working 2 jobs. I mean I cooped for 260 hours for free and I was cleaning hotel rooms, just to put food on our table...</td>
</tr>
<tr>
<td></td>
<td>• I worked at the casino. I mean...I was manager at the Delta bingo halls and I quit that to go back to school cause I was tired of working 3 shifts and I was tired of working weekends and coming home at 2am...so that I could be at home on weekends so that I could enjoy my kids social activities and things...</td>
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<thead>
<tr>
<th>Present</th>
<th>Financial Instability</th>
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<tbody>
<tr>
<td></td>
<td>• I owe the government lots of money in student loans...</td>
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<tr>
<td></td>
<td>• I don’t understand how they expect 2 people to live on $400 after you pay your rent, to pay your bills, to buy your groceries. We’re living in poverty in this country...</td>
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<td></td>
<td>• I’m being cut off [OW] because they don’t have the paperwork that I’ve already faxed not once but twice to them.</td>
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<td></td>
<td>• I have never been to a point in my life where I am right now... I can’t even buy my son a Christmas present; I can barely afford to buy my son a new winter coat.</td>
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<tr>
<td></td>
<td>• I don’t believe I should be making $3000 a month on OW but I think I should be able to live. I think I should be able to buy groceries and still have a phone and still have a TV...</td>
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<tr>
<td><strong>Limited employment opportunities</strong></td>
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<td>---</td>
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<tr>
<td>• I’ve applied to restaurants, I’ve applied online constantly to different jobs, I’ve gone to (employment) services...it’s a bad time. I mean it’s Niagara Falls off season.</td>
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<tr>
<th><strong>Future</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>An uncertain future</strong></td>
</tr>
<tr>
<td>• I don’t think that welfare’s the way to live...</td>
</tr>
<tr>
<td>• I’m looking for anything (job) at this time... I would like to get back into the field that I went to school for...</td>
</tr>
<tr>
<td>• Now OW also told me that if I receive anything from my husband, I have to pay them back. And I think excuse me, he owes me from 3 years back, so if I receive $2000 from my husband why should I not still qualify? Because that’s money that was owed to me 3 years ago.</td>
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</table>

<table>
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<tr>
<th><strong>Interaction</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Personal</strong></td>
</tr>
<tr>
<td>Experience of welfare assistance</td>
</tr>
<tr>
<td>• ...they [welfare assistance] make you feel like you’re nothing and I don’t think it’s fair... I’m educated and I’m having a hard time</td>
</tr>
<tr>
<td>• I don’t want to live on welfare for a long period of time. I mean, this is the first time I’ve been on it because of no other choice</td>
</tr>
<tr>
<td>• To me [living on welfare] is degrading, it really is...I don’t even tell I’m on welfare because I’m that ashamed.</td>
</tr>
</tbody>
</table>

**Importance of education** |
• I think education is a big thing, I truly believe it is. I mean this day and age without education you can’t go anywhere and even with education you’re still working as a waitress, some people, and it’s unfortunate. |

<table>
<thead>
<tr>
<th><strong>Physical Health</strong></th>
</tr>
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<tbody>
<tr>
<td>• I was stressed out. I was exhausted all the time. Not eating properly.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Social</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negotiating government bureaucracy</strong></td>
</tr>
<tr>
<td>• I’ve written to our MP, our MPP, I have not response from them, none whatsoever. I have written to the premier of Ontario. I got a response where he sent me somewhere else to the FRO (Family Responsibility Service) and the FRO sent me somewhere else.</td>
</tr>
<tr>
<td>• I have documentations and court orders that are meaningless. I have phoned the FRO regarding my ex-husband, I know he’s working, but I don’t know where and they tell me I should hire a private investigator, well how am I to afford that?</td>
</tr>
</tbody>
</table>

**Messages to government officials** |
• ...for the government to say this is all you need to live on ... it’s ridiculous what they ask you for...I’m very tired. I’ve been fighting this system for a long time, and nobody wants to talk to you...maybe they should walk in our shoes for a month and maybe they’d have a different outlook on what we need as people... |
| • I dare the MP or the MPP to go and live on $100 a week and support him and a child, or her and a child...I think our government needs to be woken up... |
| • Treat us like we’re people; treat us like we’re still human beings...there’s animal shelters that treat their animals better then what our government is treating people that are down and need to go on OW. |

**Unemployed and over qualified** |
• ...the first thing he [employer] asked me, you have a paralegal degree and you want to waitress? I know next time I’ll take it right off my resume... |

<table>
<thead>
<tr>
<th><strong>Situation/Place</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Julia lived in subsidized housing in Niagara Falls but she had to travel to St. Catharines to access the head office of the Niagara Regional Housing Authority. As she explained “why should we have to travel to St. Catharines? What about these people that don’t have a vehicle?” She had a vehicle but could not afford the cost of gas therefore, accessing the supports in St. Catharines was a challenge for her.</td>
</tr>
</tbody>
</table>

**Note:** All text in this table reflects verbatim quotes from the participant.
Mandy

Mandy lived by herself in a rented apartment in a detached home in St. Catharines, and had no support from family or friends. At the time of the study, her daughter was 23 years of age and lived away from home. Mandy and her husband separated 21 years ago. As described in Table 3, (Past), as a result of the abusive relationship with her husband (spousal abuse) Mandy was diagnosed with Post Traumatic Stress Disorder. She also struggled with depression, chronic fatigue and fibromyalgia.

Mandy believed that her disability was a large constraint in her decision making, and in her opportunity to return to paid work and to upgrade her education. Mandy's main goal in seeking paid work was to be able to connect with people. Despite her disabilities, Mandy believed that she would like to work 4-5 hours a day. She explained the experience of ‘good days’ (not struggling with pain) and ‘bad days’ (struggling with pain and fatigue) as part of her every day life.

Mandy received financial support from the Ontario Disability Support Program (ODSP) as her main source of income and she also received some funding from “Canada Disability” (see Table 3, Present). According to Mandy, due to some financial barriers, she could not afford to pay her rent and bills at the same time. She had applied for Niagara Regional Housing and she was still on their waiting list. Mandy described that there were limited opportunities to connect to people and support services in the local community. At the time of the study Mandy was fairly isolated. She was keen to have women’s supports services and believed that having a mentor would help her to connect to community resources and find a social support network. She described that she would like to do volunteer work with a public health program. She believed that there were a lot of women
her age who cope with family, life, and obligations alone and have a lot to contribute to community. As she stated, “there are so many single moms out there and women my age that have no where to go... and need that place to go, that voice to be heard”. Mandy suggested the importance of having a community place where younger women and their children can come together with older women like Mandy to engage in leisure, share resources and build stronger social networks with each other.

Table 3

Mandy’s Three Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Continuity</th>
<th>Employment history and education</th>
<th>Past</th>
<th>Disability</th>
<th>Lack of social support</th>
<th>Barriers in current housing</th>
<th>Future</th>
<th>Future hope and goals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Employment history and education</strong></td>
<td></td>
<td><strong>Disability</strong></td>
<td><strong>Lack of social support</strong></td>
<td><strong>Barriers in current housing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• I have worked a lot in my past... I worked for 35 years in a restaurant business I was a waitress and bartender... I was a licensed bartender back in the 70s...</td>
<td></td>
<td>• I’m on disability, I didn’t think I would ever be on disability, but I’m not able to work, which I miss it very, very much</td>
<td>• I am alone, I have no support system, I don’t have anyone to help me out, unless I pay for help, and my finances are very, very bad, doesn’t allow me to do very much for myself...</td>
<td>• I have been looking for housing and to get out of here for two years now, you know like I just can’t take care of it, because I can’t afford and because there is no money left over after pay the rent and the bills.</td>
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</tr>
<tr>
<td></td>
<td>• I did volunteering work with mentally challenged children...</td>
<td></td>
<td>• I am on Canada Disability which helps you out a lot more, like there’s counselling there, they pay for your medication, which is a great deal with me because I am on too much medication.</td>
<td>• I go to the women’s resource, just to be around people, because half the time I’m alone...</td>
<td>• I am alone, I have no support system, I don’t have anyone to help me out, unless I pay for help, and my finances are very, very bad, doesn’t allow me to do very much for myself...</td>
<td></td>
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<tr>
<td></td>
<td>• I was a single mom for a long time, and I volunteered at the hospital...</td>
<td></td>
<td>• ...on top of the two disabilities, physical disability I suffer from depression, and I have been diagnosed with post traumatic stress syndrome...</td>
<td>• I go to the women’s resource, just to be around people, because half the time I’m alone...</td>
<td>• I have been looking for housing and to get out of here for two years now, you know like I just can’t take care of it, because I can’t afford and because there is no money left over after pay the rent and the bills.</td>
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<tr>
<td></td>
<td>• I have a degree in child care... being a single mom I had to have two jobs so I worked driving a school bus for over ten years, and then a worked at a restaurant.</td>
<td></td>
<td>• I have a degree in child care... being a single mom I had to have two jobs so I worked driving a school bus for over ten years, and then a worked at a restaurant.</td>
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<td></td>
<td></td>
<td></td>
<td>• I’ve been really searching [for social support]. I’ve asked counsellors, I’ve asked, I go to [organizations] for abused women, I’ve asked them you know “is there anything available”, I’ve called What’s Up Niagara? I’ve asked around there, I’ve just, everywhere that I’ve been, I’ve just asked and asked and asked.</td>
<td>• I’ve been really searching [for social support]. I’ve asked counsellors, I’ve asked, I go to [organizations] for abused women, I’ve asked them you know “is there anything available”, I’ve called What’s Up Niagara? I’ve asked around there, I’ve just, everywhere that I’ve been, I’ve just asked and asked and asked.</td>
<td>• I have been looking for housing and to get out of here for two years now, you know like I just can’t take care of it, because I can’t afford and because there is no money left over after pay the rent and the bills.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- I've been thinking I want to go back to work, but then I'm only 53 years old, I want to be working when I'm 70. If I can.
- I would love a mentor or women's services, yeah, I really need it...I would love some kind of support system...
- I would volunteer down there...like to be around women my age too and develop relationships.

**Interaction**

**Personal**  
Grieving the loss of work and sense of self  
- I didn’t think I would ever be on disability, but I’m not able to work, which I miss it very, very much...  
- ...the area that I want to be in and making that money and that is something I grieve it is a big loss, it’s like losing, it is like burying a family member...  
- one of the reasons I have taken all of the little courses that I’ve taken...was if I can go back to work one day, (laugh) please God let me go to work back one day (laugher)...  
- ...it (employment) is connection to the world; it is great for your self esteem you think that you’ve accomplished something...

Health and disability  
- you have to learn to live with that chronic fatigue the entire, all of time sometimes you don’t have it, you know, but when it is really bad you can’t move, you can’t keep your eyes open, you can’t just focus  
- ...on top of the two disabilities, physical disability I suffer from depression, and I have been diagnosed with post traumatic stress syndrome...  

**Social**  
Challenges of being on welfare  
- I don’t get very much [financial support] because I am on Canada disability so it is really tough...  
- ...if you make a little bit money they will take that away from you...  

Limited choices and social opportunities  
- ...it is really difficult for a lot of women my age that are alone and don’t have any family if they do suffer from disability cause there is no where to go out there...  
- ...there should be a place for us to go we don’t have all the money.

Lack of understanding about disability  
- it is hard for [people] to understand cause they don’t understand the chronic fatigue and they don’t understand the fibromyalgia and then if, on top of that I got the discs too...they don’t understand the illness they don’t understand even when you are in disability Canada disability.  
- my doctor says “you have this you’re disabled you have to learn to live with this”, (laugh) but you know, I tell myself no, I am going to get better, you know because if I don’t tell myself that I would be negative and then I will get worse.

**Situation/Place**  
Mandy lived in a rented apartment and was on the waiting list for subsidized housing. To access some community supports she had to drive to Beamsville. As she explained “you know there is nothing in St. Catharines”. She owned a car, however with her disability it was hard for her to commute so frequently from St. Catharines to Beamsville.

Note: All text in this table reflects verbatim quotes from the participant.

**Linda**

Linda was a single mother with a 12 year old daughter living at home. In her previous relationship Linda experienced spousal abuse. She was with a new partner and was engaged the year before the interview was conducted. She and her fiancé were planning to get married as soon as they could afford it. She was living in a basement apartment, where the use of
stairs was challenging for her disability. Linda was looking forward to moving into a new house, where she did not have to use the stairs. Linda volunteered for a local organization and stated “I love every single minute of it…” (see Table 4, Present). Linda used to own a business (indoor playground for children) which she sold in the past. Linda depended on ODSP for her financial needs; she had “been off work for the past 10 years…” and was currently unemployed (see Table 3, Past). Linda wished to upgrade her skills and get back to work in an area such as customer services. As she explained, “…something where I can talk and meet people…” (see Table 4, Future). She wanted to be able to work 20 hours a week to pay her bills and afford her medications. She also wanted to be able to focus on creating stability at home for her daughter.

Even though she wanted to return to paid work and update her education, she feared not being able to stay in a job for a long period of time (See Table 4, Social). She described the experience of ‘good days’ and ‘bad days’ in her every day life. Linda preferred short term employment, but the fear of being (cut off) or being penalized by social assistance discouraged her from doing so. As she explained “my fear would be that since I’m working to make that extra money. I’m going to be told ‘you can work…get out there.’ So you don’t want to be able to make that extra money, because you’re scared you’re going to lose your base income” (see Table 4, Social). Linda travelled to St. Catharines to access support services and believed that there are limited choices and opportunities in terms of employment, housing, and transportation facilities in Beamsville.

She believed that having a mentor would be very helpful and stated the importance of having a mentor in both the pre-employment and post-employment stages. She noted that she would prefer a female mentor over a male in a work place (see Table 4, Future).
null
### Table 4

**Linda’s Three Dimensional Space Narrative Structure**

<table>
<thead>
<tr>
<th>Continuity</th>
<th><strong>Past</strong></th>
<th><strong>Present</strong></th>
<th><strong>Future</strong></th>
<th><strong>Interaction</strong></th>
<th><strong>Personal</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Different job experiences</strong></td>
<td>• I’ve been off work for about 10 years. ...at that point in time I had four jobs, I was shovelling snow from in front of the mailbox, I was working in a lingerie place, the computers, office cleaning...then I ended up working birthday parties...then I ended opening my own business of the children indoor playground...</td>
<td>• Enjoying volunteer work</td>
<td>• I volunteer at [an organization], often nights when it’s busiest...I love every single moment of it...</td>
<td>• Possible future employment</td>
<td>• Fear of employment</td>
</tr>
<tr>
<td></td>
<td>• I worked seven days a week doing on the weekends three parties a day up to 30 children...</td>
<td><strong>Economic barriers</strong></td>
<td>• I can’t afford to go off it [social assistance] because I need my medications, and my medications are just out of this world. They are very expensive</td>
<td>• It would have to be part time...</td>
<td>• I don’t think I could ever do full time work again. It would have to be part time...</td>
</tr>
<tr>
<td></td>
<td><strong>Fear of staying on a job</strong></td>
<td>• I am in a basement apartment...my rent is $700 a month and I get $1400...</td>
<td>• I don’t use the service [community support services] too much here...there are days like right now sitting this long with you my hips are bothering me...so I can’t sit for too long...I can’t stand for too long...so I need to be able to work this out...</td>
<td><strong>Limited choices and social opportunities</strong></td>
<td>• ...if I had someone [mentor, preferably a female mentor] that was going to be there and help me and teach me the ropes would be better and then I would want to be a mentor to someone else.</td>
</tr>
<tr>
<td></td>
<td>• I tried...I worked at [name of store] ...I lasted half a day....there was no way I could do it...</td>
<td><strong>Physical health and disability</strong></td>
<td>• ...with me it’s just the physical disabilities and challenges...</td>
<td><strong>Having a mentor</strong></td>
<td>• ...it is very, very hard to get a job right now and...it’s a difficult step, harder than anything</td>
</tr>
<tr>
<td></td>
<td><strong>Positive experiences of supports</strong></td>
<td>• I went to women resources center...It was just amazing the speakers we had in there and it helped me learn how to point my child in the right direction.</td>
<td>• I can’t afford to go off it [social assistance] because I need my medications, and my medications are just out of this world. They are very expensive</td>
<td>• I will probably never hit the level that I use to be at...</td>
<td>• I guess things are so different now, you know it is all computerized. You know even if you’re a cashier you need to know computers...</td>
</tr>
<tr>
<td>Situation/Place</td>
<td>Linda lived in Beamsville in a rented basement apartment in a house. She had to travel to St. Catharines to access support services. She had a car but transportation was a problem for her as she explained, “I don’t think there is a public transportation in Beamsville”. She was not happy with her current living situation, and described very limited opportunities in Beamsville. As she described, “it is very hard to get a job right now it is difficult specially in Beamsville there is hardly anything...I think there is just one place that has co-op housing here in Beamsville, that is it, so, if you are disabled you have to be in St. Catharines or Hamilton”.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: All text in this table reflects verbatim quotes from the participant.

**Christine**

Christine lived in a supportive housing facility in Niagara Falls. She was a single mother and sole caregiver to her two daughters (four and eight years old). She was married for ten years. She used to work with her husband and together they ran a business. Christine played a key role in running the business (Disc Jockey company) and managed the administration (bookings), human resources (hiring and firing), and finances (book keeping,
accounting) for the company. Christine experienced spousal abuse in the relationship with her husband. The relationship ended when he left and took the business with him. As she described, “he had left with the vehicles, the business, money and left me with the kids…” (see table 5, Social). Christine is currently receiving financial support from OW; however, she described that the financial support was limited and inadequate to meet her basic needs. She received $836 from OW ($820 of which goes towards rent) and each month she was left with $16 dollars after the deduction of rent. Christine struggled to live on a very tight budget; therefore she believed that limited financial support ($836 from OW) was barely sufficient to cover the cost of her routine expenses. Christine experienced some challenges using daycare supplements through OW due to the eligibility requirements that included a requirement of being on OW for 3 months to be eligible for daycare.

Christine was a high school graduate and she had skills in office work (administration, management and finances). Christine had been looking to find a job but her search had not been successful. She also had to fight her case with her husband in court.

NOVA house (a place for women who have experience abuse related trauma) helped her to connect with a lawyer, counselor, financial support, and support to get her driver’s license (see Table 5, Past). Christine had a positive experience of receiving services from community support organizations. She believed that community supports, “…will help you if you want to help yourself”. According to Christine the idea of having a mentor would be really helpful. Although Christine was wary of the stigma of welfare and being labeled an abused woman, she had a strong sense of self and direction in life—she believed she is a productive member of society and a good parent for her children.
### Table 5

**Christine’s Three Dimensional Space Narrative Structure**

<table>
<thead>
<tr>
<th>Continuity</th>
<th>Economic barriers after separation from husband</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>I haven’t paid (bills) in months so I had garage sales; I had 3 garage sales in a month I made like hundred dollars from each one just to pay my utilities. . .</td>
</tr>
<tr>
<td></td>
<td><strong>Limited choices and day care challenges</strong></td>
</tr>
<tr>
<td></td>
<td>...it was tough you know, I exercise on my options for three or four months, um, I was baby sitting just doing any thing I could do.</td>
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<td></td>
<td><strong>Positive experience with [women's shelter]</strong></td>
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<td></td>
<td>[the women’s shelter] was really helpful... they helped me find a lawyer ... I filled out a housing application through [the women’s shelter] and they pushed it and I got on housing within it took about nine months but that is quick compared to people on the waiting list for years .</td>
</tr>
<tr>
<td>Present</td>
<td><strong>Barriers in access to supports</strong></td>
</tr>
<tr>
<td></td>
<td>Right now I am working on getting my license um, and I have to go through graduate licensing all of that stuff...</td>
</tr>
<tr>
<td></td>
<td>I have two children it cost me almost $50 dollars for day care, I have got to make a lot of money for when I pay 50 dollars and bring money on top of that. So it was - it was tough...</td>
</tr>
<tr>
<td></td>
<td>...right now, because I don’t have a vehicle, and having to pay for, well now I qualify for house... umm for daycare, unfortunately there is no daycare in my area, that is available, which means I have to take the bus.</td>
</tr>
<tr>
<td></td>
<td>I think it is my biggest challenge right now is trying to balance what is going on here and keep one eye up- up ahead where I am going.</td>
</tr>
<tr>
<td>Future</td>
<td><strong>Employment</strong></td>
</tr>
<tr>
<td></td>
<td>I am always looking for an employment. . .</td>
</tr>
<tr>
<td></td>
<td>when I think for full time employment I think I am going to have to get a vehicle I am going have to drive and going, it doesn’t really matter what I am driving as long as it gives me from point A to point B.</td>
</tr>
<tr>
<td></td>
<td><strong>Education</strong></td>
</tr>
<tr>
<td></td>
<td>I am actually talking with my work right now about taking something back in school, refreshers of some sort but, I am scared.</td>
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<tr>
<td></td>
<td>I think I will take some night courses or something along the way, evenings are a lot better because students are off from school.</td>
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<td></td>
<td><strong>Mentor</strong></td>
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<tr>
<td></td>
<td>. . .having a mentor having somebody to kind of brainstorm with her or help you, not that I want somebody to answer everything for me sometimes I need somebody to just enable me to realize in my self and she was great at doing that, she[mentor] was great at that. . .</td>
</tr>
<tr>
<td>Interaction</td>
<td><strong>Personal</strong></td>
</tr>
<tr>
<td></td>
<td>The stress of being on welfare</td>
</tr>
<tr>
<td></td>
<td>I am middle age woman who doesn’t want to be on welfare because I am scared and I know better... my frame of mind is different than a young girl</td>
</tr>
<tr>
<td></td>
<td>I think that having, being treated (pause) like we’re still of value, and we’re still people, and we’re all not abusing the system, and we are trying to make things better, and we may make poor choices, because of where we’ve been doesn’t mean we’re a bad person, or we’re a bad parent...</td>
</tr>
<tr>
<td></td>
<td><strong>Social</strong></td>
</tr>
<tr>
<td></td>
<td>Transition to single parent</td>
</tr>
<tr>
<td></td>
<td>[after separating from her husband] the way that we eat, everything changed you have to have try to balance it up with keeping some sense of normalcy and then it is almost impossible.</td>
</tr>
<tr>
<td></td>
<td>[Children] they helped me as much as I help them. Because they are the reason I get off</td>
</tr>
</tbody>
</table>
**Experience with Ontario Works and welfare**
- "[Community Supports] they are going to help you as much as you help yourself and it must be frustrating to help people who don’t want to help themselves."
- "I was going to welfare and saying that I appreciate you know the $836 dollars you’re giving me but my rent is $820 and I have disconnects for hydro and gas."
- "Ontario Works has been great my worker has been great... I have nothing bad to say about Ontario Works they’ve been detrimental and getting me where I am right now, so my worker has been fantastic"

**Community supports**
- "I would feel more comfortable going with the agency that helped and focus more on women’s needs and absolutely because we are different..."

**Social connections**
- "I think that when you have support it’s amazing what you can do, every resource can be out there, but if you don’t have somebody to say it’s okay, or maybe somebody to give you that gentle nudge in the right direction, all those resources don’t mean anything."

| Situation/Place | Christine lived in a Niagara Regional Housing facility in Niagara Falls. One of the support services she used was a women’s shelter that connected her with Niagara Regional Housing and Ontario Works. She is currently working to get her driver’s license with the support from the women’s shelter. She used public transportation to access support services and [the women’s shelter] provided her with a bus pass. Christine had to take her children to a day care facility which was not near her house so she also needed a bus pass for her children. Christine noted that to get a job she needed a vehicle. |

Note: All text in this table reflects verbatim quotes from the participant.

**Connie**

Connie lived in a detached house in Fort Erie. She was the owner of the home and a single mother with two children. Connie had a long history of paid employment. In the past she experienced assault in her relationship with her ex-husband (see Table 6, Past) and also physical assault in the work place (by a customer). In addition to coping with abuse-related issues (Table 6, Past) Connie also talked about the experience of accidental trauma as she described, “I was in an automobile accident in Toronto on the QEW... my head was crashed open and I had a closed head injury. I had to learn how to speak and write and read and everything all over again. It was pretty tough...” More recently she had been seriously threatened by a stalker who then invaded her home.

She believed that her workplace was not a safe environment as she describes, “the racetrack is not a controlled environment. If it was a controlled environment then the man wouldn’t have been able to assault me”. Because of the traumatic memories from her
previous employment she did not want to go back to work (see Table 6, *Future*) as she stated, “I don’t ever want to go back to work at my job...I do not want to go back to the race track. I do not want to be in that gambling environment, I don’t want to be around those kinds of people”. Connie preferred working in a controlled environment where her safety was not threatened (See Table 6, *Present*). Connie also described experiences of powerlessness and a lack of control in her access to some community support services. She found the use of community supports to be challenging and discouraging as she further added, “I don’t want to be involved with them any longer...” (see Table 6, *Social*). She was not comfortable being around people and preferred having a second person with her when she went out into public places.

Connie believed that having a resource person (mentor) would be important and helpful in connection to community support services and finding employment. Connie was told by workers at Ontario Works to sell her house and to move into public housing. However, she described that she did not want to move to a housing facility because she had many memories attached to her current house and she wanted to stay there, “because I’ve worked so hard and bought a home”.

Connie was recently approved for the Canada Pension Plan (CPP) and Canadian Disability Program (CPPD). She was also on ODSP and received $1005.00 monthly. Connie believed that the limited monthly financial assistance was barely enough to cover her expenses.

Connie borrowed $5,000.00 from the bank to renovate her house, which she has to pay back in three years. She described having difficulty understanding why loans would count as income by social supports services. As she described, “the money didn’t come to
me, I got a loan from the bank, and then I had to pay the bank for 3 years...that’s considered income.”

Table 6

Connie’s Three Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Continuity</th>
<th>History of trauma and disability</th>
<th>Present Economic barriers</th>
<th>Future Staying at current place of residence</th>
<th>Future employment goals</th>
<th>Interaction Personal Economic barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>• I was assaulted at work, at my workplace that I worked for 27 years and I never had a problem before, a customer assaulted me...</td>
<td>• I’m trying to live off of $1005 and if I get this ODSP thing apparently they give you another $300 a month but then they take half of your baby bonus, and then they’ve got their nose in your business every month.</td>
<td>• I would like to keep this home for the children, perhaps rent it out and get myself something smaller but I don’t want something other than this area [her house in Fort Erie], just something with not all the floors. One floor with a finished basement. A little bathroom, a little rec room and maybe a laundry room, I’d be happy with that, no problem...</td>
<td>• I could maybe take a computer course or dental assistant where it would be Monday to Friday and it would be in a completely different environment.</td>
<td>• ...how’s someone supposed to live off of $670 a month, 3 children or 2 children and an adult?</td>
</tr>
<tr>
<td></td>
<td>• I was put in the hospital because I had a nervous breakdown because [ex-husband] assaulted me.</td>
<td>• I’m waiting to hear from the lady from victims witness services because she’s going on her computer to find all the dates of all the offences whatever she can find out so I can send it into the criminal injuries something board. I have all that over here...</td>
<td>• I have a head injury, you know and I think I do really well but this just, when all of this stuff comes it just gets, I’m overwhelmed and I just want to out it all in a pile and go to bed... I don’t go out.</td>
<td>• I just want something where I’m going to have benefits, a good benefit package and a salary that I can live off of it and pay my bills and not be worried this week how do I buy milk and bread and butter...</td>
<td>• I’m worried because I’m 45.</td>
</tr>
<tr>
<td></td>
<td>• the man assaulted me I have had a lot of pain in my neck and my shoulder, goes up my head, down my back, down my arm and I ended up having a nervous breakdown.</td>
<td>• I have been approved for CPP disability</td>
<td></td>
<td>• I don’t think I’d want to be stuck in an office; I need to be around people, but in a controlled environment.</td>
<td></td>
</tr>
</tbody>
</table>
• ...if I could financially afford it I’d never go back to work
I don’t ever want to go back to work at my job... I do not want to go back to the race track. I do not want to be in that gambling environment, I don’t want to be around those kinds of people.

Lack of supports and system bureaucracy
• ...you don’t know who to talk to and who can advise you on what to do and how to do things and what you’re, what is available to you... I’m really overwhelmed.

Social
Retraining
• I’m on CPP disability, why would they not want to retrain me so that I could do something that I wouldn’t feel unsafe and it would probably make my self esteem...

Negative experience from OW
• It just doesn’t make sense to me how the whole system works...
• Why would the government give me child tax credit every month if I didn’t need it? Why does OW take half of it? Well, because part of it’s a supplement they said. Well, yeah, it’s a supplement because I need it. It’s the same thing as when your child turns 7 they cut your baby bonus down.
• I have OW called last week and said I have good news for you, it’s no longer $12,000, it’s only $8,400, well it might as well be $8 million. How am I supposed to pay these people back?
• Now they want me to go to ODSP in St. Catharines and I don’t want to go because I don’t want to be involved with them any longer. I was told by a couple of people that they put a lien against your home.

Impacts of trauma and brain injury
• I hate going shopping, I have to, I like to have somebody with me. If I go by myself I’m in and out and half the time I forget things that I’m supposed to get even though I write them down on a list. I get like a panic thing happening. I don’t like going to the bank, I like going to a bank machine at night when nobody’s around.

| Situation/Place | Connie lived in Fort Erie in her own house. Connie owned a car and transportation was not an issue for her. |

Note: All text in this table reflects verbatim quotes from the participant.

Leeanne

Leeanne was in her early twenties and lived with her mother in a house in Thorold. As described in Table 7, (Personal), Leeanne had experienced child abuse. Leeanne had recently been approved for ODSP for income support. She was upgrading her skills and education, and taking two courses (English and Math) through the Independent Learning Center (see Table 7, Present). Leeanne used to provide supports to senior citizens in the community where she currently lives. She was not doing any volunteer work at the time of the study but indicated that she planned to do some in the future. Leeanne described that her long term goal was to return to volunteer work and eventually to full-time paid work. At the
time of the study she was focusing on her school and health (see Table 7, Present). She noted that she was not looking for employment in the near future (see Table 7, Future).

Leeanne travelled to St. Catharines to access some community support services for women who had experienced abuse, as well as services provided by local mental health agency. She experienced transportation barriers in accessing these services as she did not own a car and she was not comfortable using public transportation. She added, “I can’t even get on the bus because of the anxiety...” (see Table 7, Personal). Leeanne also preferred using services provided by females as she was not comfortable being around men. As she explained, “I think you know it would be everyone’s preference because a lot of victims, like of sexual abuse in particular, can’t stand to be around a male, like myself so I just prefer that [a women] versus a man”.

In her experience of using support services, Leeanne spoke about the experience of powerlessness and a lack of control in using these services. She believed that community support services were less welcoming and more challenging to access (see Table 7, Social). As she described, “when you are calling the agencies, you feel like you don’t get what you need”. However, she also described a positive experience when accessing ODSP and indicated that her counsellor treated her with respect. As she stated, “she has always treated me like a person, like in a lot of ways she is always accessible to me...”

Leeanne also noted that when talking to different workers in community support services, she often receives a different response. This, she described, made it difficult to know which answer was the correct one. Leeanne believed that additional supports were needed from community resources to help her achieve her goals (see Table 7, Social).
Table 7

Leeanne’s three Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Continuity</th>
<th>History of health barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>• I have had health issues since I was born, I have had surgeries and just a lot of medical problems.</td>
</tr>
<tr>
<td></td>
<td><strong>Lack of social supports</strong></td>
</tr>
<tr>
<td></td>
<td>• A lot of what’s already been there, just like you know falling through the cracks in the system. Not being able to get the support that I needed or I need, just being shifted around from one agency to another, saying oh this person should help you or this person isn’t doing their job and stuff like that. . .</td>
</tr>
<tr>
<td></td>
<td><strong>Previous life style</strong></td>
</tr>
<tr>
<td></td>
<td>• Before my weeks were just like, I just didn’t do anything; I would stay at home and take care of the house and all that stuff.</td>
</tr>
<tr>
<td>Present</td>
<td><strong>Education</strong></td>
</tr>
<tr>
<td></td>
<td>• Right now with the school, and just focusing on trying getting back on track, like health wise . . .</td>
</tr>
<tr>
<td></td>
<td>• ... there is a lot of stuff going on with school with exams and I may register for more, but just sort of trying to focus on school.</td>
</tr>
<tr>
<td></td>
<td><strong>Community supports</strong></td>
</tr>
<tr>
<td></td>
<td>• ... right now I am not really relying too much on agencies cause all the run around but I know I can’t do everything I need to do on my own but I have tried to...</td>
</tr>
<tr>
<td></td>
<td><strong>Managing change</strong></td>
</tr>
<tr>
<td></td>
<td>• I am not really comfortable living in an apartment in a way so I am just trying to see what I want to do and not want to do sort of thing.</td>
</tr>
<tr>
<td></td>
<td>• I am not used to the daily running around and stuff, and sometimes it gets to be more than others and sometimes it’s just very difficult.</td>
</tr>
<tr>
<td></td>
<td><strong>Disability</strong></td>
</tr>
<tr>
<td></td>
<td>• I just started on disability so I can’t even get on the bus right now because of the anxiety.</td>
</tr>
<tr>
<td>Future</td>
<td><strong>Uncertain future</strong></td>
</tr>
<tr>
<td></td>
<td>• I am not really looking for work at the very moment, for the near future, maybe like far down in the future sort of thing cause I have to take care of school and health.</td>
</tr>
<tr>
<td></td>
<td>• we will slowly get onto the volunteer stuff, that’s why I’ve got like [support worker] and eventually [I will] move onto the work, so that’s like way down the road.</td>
</tr>
</tbody>
</table>

| Interaction | **Personal** |
|            | **Coping with trauma** |
|            | • I am so used to being alone and doing things alone. |
|            | • I never really had that voice to say like this is my path and I am doing it. |
|            | • I just don’t want to get up and move I want to do things right this time. . . hoping in time it will all get resolved, it is slowly. . . |
|            | • . . . a lot of victims like of sexual abuse in particular can’t stand to be around a male, like myself. . . |
|            | **Hopes and goals** |
|            | • I think there are little small steps that I have to do first before I make a big change |
|            | **Transportation barriers** |
|            | I have transportation issues because of obesity and stuff. . . I can’t even get on the bus right now because of the anxiety. |

| Social     | **Difficulty trusting** |
|            | • I have a counselor now and I still have a really hard time trusting her because she is still a part of the “system”. |
|            | • I am still in that transition that like I can trust her (support worker) to do that with, because like trust is something that I can’t just do freely and it takes a lot for me to trust |
someone.

**Negative experience of accessing supports**
- when you are calling agencies, you feel like you don’t get what you need, you just shut down inside when you don’t say anything but your like how can I when they made me feel like this.
- … when you call an agency you get different people telling you different things… I don’t feel comfortable really calling anywhere…
- I am not really relying too much on agencies cause all the run around but I know I can’t do everything.
- I think [the agency providing support for women who have been abused], I sort of got involved with them but I am sort of on back burner but its just like for them cause I have transportation issues because of obesity and stuff and their like cause like Thorold is connected with St.Catharines so you have to come here.
- I think no just with [the agency providing support for women who have been abused] but for other agencies it would be helpful if they would have more [services].

| Situation/Place | Leanne lived in her mother’s house in Thorold and she had yet not decided whether to move to St. Catharines or another location in Niagara Region. She used community support services for example [mental health agency] in St. Catharines. She also used supports from Public Health services as well as Family and Children’s Services. She is currently on ODSP. |

*Note: All text in this table reflects verbatim quotes from the participant.*

**Wendy**

Wendy lived in a townhouse in Niagara Falls. She was single and had never been married (see table 8, Present). She did not have any family support in the area where she lived. She received monthly financial support from ODSP. Wendy described that she has a physical condition that makes her visually appear different and she had recently been diagnosed with hearing loss in both ears (see Table 8, Personal). She had experienced rejection from family because of her physical appearance. As she explained, this was “as a result of looking different in the family and coming from a European family. Everyone’s dark. I was rejected quite a bit, and then kids started teasing me in, you know junior high school and stuff. So I was left with much rejection”. Wendy also talked about experiencing mental health issues such as borderline personality disorder, which made it extra challenging for her to maintain employment. As she described, “being a borderline I don’t have very good relationship skills.” Wendy described experiencing different forms of abuse in the past.
Wendy had just completed a diploma in social work. She described a negative experience and some difficulties completing her field placement. As she noted, “I did [a] field placement and they tell me that I wasn’t professional enough to do the work…” (see Table 8, Social).

She described an interest in building connections with people and community support services (see Table 8, Present). She described the importance of building rapport with community support workers to be able to receive better support. She stated that community support service providers needed to focus on facilitating the process towards paid employment as opposed to just knowing the number of people staying on their current jobs. As she explained, “they want to know how many people got jobs this month? How many people kept the jobs this month? But nobody wants to ask the question. How did the poor person get through the process? All they want to know is how many people kept their jobs for more than six months?” She also believed that service providers needed to do more work to help people get comfortable and encourage them to use the support services, “I believe that the people working with these people whoever the service providers are not doing what they need to do. Because people get overwhelmed, frightened, discouraged and hopeless and they pack it in”

As described in Table 8 (Personal) Wendy found the experience of accessing community supports humiliating and discouraging, as she adds, “it feels like I’m being re-traumatized all over again, always over and over again”. In addition, she expressed having a poor sense of belonging to the community.
### Wendy’s Three Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Continuity</th>
<th>Abuse related trauma</th>
</tr>
</thead>
</table>
| Past       | I came from a background of abuse...lots of physical, verbal and emotional and a little bit of sexual.  
            | . . . as a result of looking different in the family... I was rejected quite a bit. |
|            | **Education and disability** |
|            | In the last couple of years. 4.5 years ago I started the process of going back to school, doing some upgrading.  
            | I wanted to do the work and when I took these steps 4 and a half years ago to do this course, I had to take the first step because emotionally I wasn’t capable. But I thought if I start the process and as I’m going through the journey my hope was that my emotions would start to settle down because I would see that I am keeping busy and that I’m accomplishing things, and that maybe, just maybe I’m ok and I could really do this work.  
            | I wasn’t able to see the material fast enough even thought the college is suppose to work out the disability problems with each person they can’t effectively work it all  
            | I’m an older person and because of that they didn’t really know how to personally help people with disabilities in the school system back then. |
|            | **Employment** |
|            | I did a lot of Joe jobs like cafeteria or mailroom work that kind of stuff.  
            | ... in the last 6 months periodically I have put out a resume somewhere, just so that against my better judgments I have still done it. I never received any phone calls though you know, for interviews or anything.  
            | I tried the volunteering thing this spring after I finished school.  
            | I tried to go to [a non-profit organization providing services for children] and you know just kinds help out there as a babysitter. I lasted from May till August then I quit. |
|            | **Social connections** |
|            | . . . in my experience of sessions [therapy sessions for borderline disorder] over the years what worked for me is taking the time to get connected. |

<table>
<thead>
<tr>
<th>Present</th>
<th>Challenges of finding employment due to disability and mental health issues</th>
</tr>
</thead>
</table>
|            | I’m being punished. I have mental health issues and I’m being punished because if I don’t meet up to that standard and stay up afloat, I’m not even going to get a chance to get the job.  
            | you don’t get rid of easily... some of the borderline issues would be what caused a lot of my work instability or my impulse controls thinking before I speak problems a lot of those kind of things or crying before I leave the room those kind of things are borderline related and are not something that you can actually solve in 6 weeks. |
|            | **Employment plan** |
|            | I’m working with employment supports through ODSP and they’re funding my supposed plan, work plan. And so now I’m working with the Niagara Employment Alliance (NEA) to try to make that plan happen. |

<table>
<thead>
<tr>
<th>Future</th>
<th>Hopes and goals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I believe I could be a really good help to people down the road because I know the ability is there. It’s just a matter of getting the right kind of help to make it happen.</td>
</tr>
<tr>
<td></td>
<td><strong>Expectation from a mentor</strong></td>
</tr>
<tr>
<td></td>
<td>Somebody that understands the diversity of illness like, I don’t know whether you are focusing on mental health issues or mostly other physical disabilities but I’m looking at the mental health component and I’m looking at the fact that for me, things would look big unless somebody helps me take the steps to bring down the bigness of it.</td>
</tr>
<tr>
<td></td>
<td><strong>Desire for relationship or intimate connection</strong></td>
</tr>
</tbody>
</table>
|            | I want [an intimate] connection. I want to be able to say you know what I would really
<table>
<thead>
<tr>
<th>Interaction</th>
<th><strong>Personal</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stress of pursuing employment</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Sense of self</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Having a lower self esteem</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Negative experience with school</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Experience of counselling and challenges of disability</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Fear of rejection</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Economic barriers</strong></td>
<td>![Insert table content here]</td>
</tr>
<tr>
<td><strong>Sense of self</strong></td>
<td>![Insert table content here]</td>
</tr>
</tbody>
</table>

**Situation/Place**

Wendy lived in Niagara Falls and had to commute to St. Catharines to access some community support services as she explained, “I have to take 3 buses. I have to go from here in Niagara Falls to get to St. Catharine’s to take the course, by bus and that’s not easy.”

Note: All text in this table reflects verbatim quotes from the participant.
Xantha

Xantha lived in a co-operative housing facility in St. Catharines (see Table 9, Social). Xantha was a single mother with two daughters (10 and 18 years of age). Her children were from two different fathers. At the time of the study, Xantha was receiving Canada Disability and financial support from ODSP. Xantha also experienced some health problems. She had experienced abuse-related trauma and had been diagnosed with chronic fatigue syndrome and fibromyalgia.

Xantha lived in a three bedroom apartment in Niagara Regional Housing. She described that when her 18 year old daughter moved out she became over-housed (house capacity exceeds family size) and the Housing Authority told her that she needed to move to a new location in St. Catharines. According to Xantha this was her number one challenge because of the financial cost associated with moving to a new location. As she described, “we became over-housed for 4.5 years, my other daughter and I have been over housed living in this situation and it has been a turmoil, because that meant then we were open to moving again and I having already moved twice in a very short space of time.” She explained the pressure from Niagara Regional Housing to accelerate the process of transferring to a new location.

Xantha described that due to transportation barriers she could not access the Women’s Resource Center in Beamsville, which she used in the past when she had a car.

Xantha wanted to go out and work in the community. She explained that staying at home was really stressful for her. For Xantha, the path of returning to work was slow as she was focusing on her housing and wanted to take one step at the time before returning to paid work.
Table 9

Xantha’s Three Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Continuity</th>
<th>Past</th>
<th>Present</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past</strong></td>
<td>House capacity exceed the family size</td>
<td>Disability</td>
<td>Moving and settling down</td>
</tr>
<tr>
<td></td>
<td>• We became over housed, so basically for 4.5 yrs my other daughter and I have been over housed living in this situation and it has been a turmoil, an absolute turmoil being in this position because that meant then we were open to moving again after her and I having already moved twice in a very short space of time.</td>
<td>• I'm currently on disability which is another big thing that I had to go through... • I'm in a position where now I've had to apply for community start-up... • Living on disability is an extremely limited income.</td>
<td>• I'm going to be moving into a space that's on the second floor there'll be...the option of the stairs or the elevator...I think life will become much more simplistic, • There again I am hopeful that just moving, and as you said, getting this limbo stage off my shoulders about our living arrangement which is you're basic survival, where you're going to live, getting that stress behind us, I think that's going to help me tremendously, because that's going to be a done deal, right. That's going to be finished, so then I can look forward.</td>
</tr>
<tr>
<td><strong>Present</strong></td>
<td>Economic barriers</td>
<td>• I need the money to keep surviving. And that's been my challenge; the big one is the financial challenge of my circumstances.</td>
<td>Employment supports and goals</td>
</tr>
<tr>
<td></td>
<td>• Housing is saying to me, you’re over-housed, you have to transfer. They don’t see it as a move by the way; they see it as a transfer from one of Niagara Region’s housing locations, transferring to another location. They don’t see it as an actual move, which is totally ridiculous • ...since I’ve gotten this call [from housing] and all this decision making, still the funding hasn’t been approved and the move is supposed to be now in less than a month now.</td>
<td>• Housing is saying to me, you’re over-housed, you have to transfer. They don’t see it as a move by the way; they see it as a transfer from one of Niagara Region’s housing locations, transferring to another location. They don’t see it as an actual move, which is totally ridiculous • ...since I’ve gotten this call [from housing] and all this decision making, still the funding hasn’t been approved and the move is supposed to be now in less than a month now.</td>
<td>• mentally still with all this going on that's still my goal to try to see if I can go through that program, get some vocational assessments, counselling whatever the program entails, • I’m hoping to utilize to do the step program. Um, I don’t know, I may be introduced to other things in the community through the [disability organization], so that’s, will be another avenue, probably, I would think, for me, things that I’m not even aware of.</td>
</tr>
<tr>
<td><strong>Future</strong></td>
<td>• I'm supposed to be moving now from here to west St. Catharines and with pain and fatigue. So that's been dead for a month. I'm pretty challenged by that alone. By having to get everything either by bus or foot.</td>
<td>• I'm supposed to be moving now from here to west St. Catharines and with pain and fatigue. So that's been dead for a month. I'm pretty challenged by that alone. By having to get everything either by bus or foot.</td>
<td>• I have a lot to look forward to and I'm excited, I mean I'm going to be very excited if I can actually go out to work</td>
</tr>
<tr>
<td><strong>Interaction</strong></td>
<td>Personal</td>
<td>Interaction</td>
<td>Interaction</td>
</tr>
<tr>
<td><strong>Personal</strong></td>
<td>An increased sense of self</td>
<td>• I'm in survival mode and it really changes your attitude and your perspective on how</td>
<td>• I think that's the route that I should take now. Just to do things as simple as possible, because that's the way I keep managing, is to keep life simple</td>
</tr>
</tbody>
</table>
you’re living, and affects you know, all your relationships in your life.
- I have finally made the decision I’m quite fine being on my own.
- I think you’ve got to be pretty self reliant if you’re on your own.
- You have to have a lot of I guess mental capability to keep meeting all these challenges whatever they may be. But you’ve got to count on yourself...

Ready to change
- ...much of my life here has been in limbo again; I don’t want to keep waiting for life to start.

Managing chronic disability
- ...two weeks before I moved out here, I was diagnosed with Fibromyalgia and chronic fatigue syndrome in the city in Toronto.
- ...for these 3 yrs, my health has just gone ...and I’m progressively getting worse because I’m aging.
- I didn’t think that this was an illness when I was diagnosed that was progressive but I can see it’s quite progressive, so the aging thing. I’m peri-menopausal.

Adjustment with transition
- I have been for a long number of years, having a lot of trouble with this transition in life. ...

Social

Stress of moving to a new housing facility
- I’m getting all over the place [juggling from one place to other]. cause there’s so much going on here, I’m in a position where now I’ve had to apply for community start-up ...
- It doesn’t look like I’m maintaining, because you know, um, I’m challenged enough by that and I honestly don’t feel the need for another relationship right now...

Community involvement and leisure
- I have had zero money to go out there and find a life, and I don’t care what anybody says, you need a certain amount of money to entertain and have leisure activities.

Parenting under stress
- trying to keep managing a chronic illness and you know, being a long distance parent at the end of a telephone with my 18 yr old, being a full-time parent 24/7 to a very, very active girl who just turned 10, running and maintaining a household.
- I’ve never been under so much adversity in my life but still you know, my daughters look up to me.

Meeting the requirements of system
- ...you are legally in a system and you know, you have to be part of this because if you are unwilling to do what they need or want you to do then you are out of it.
- So you don’t get the advantage of the financial rewards from it...it[ housing] hasn’t been a very good experience for me quite honestly...

Lack of accommodation of difference
- Over the past 5 years I never quite got to the point where I went in and I said to them [physical disability organization], have you ever had anyone with Fibromyalgia and chronic fatigue want to enter your program?

Situation/Place

Xantha lived in a town house in St Catharines (public housing). Xantha’s had a car but it had broken down and she could not afford to fix it. Therefore she found it extra challenging to move to new location and access community support services.

Note: All text in this table reflects verbatim quotes from the participant.

Chapter Summary

In the following table (Table 10), a summary of the Three Dimensional Space Narrative Structures created for the eight women in this study is provided.
Table 10

*Summary of the Three Dimensional Space Narrative Structure for the women in the study.*

<p>|                | Julia                                | Mandy                           | Linda                                      | Christine                                      | Connie                                      | Leeanne                                   | Wendy                                      | Xanther                                      |
|----------------|--------------------------------------|---------------------------------|--------------------------------------------|------------------------------------------------|--------------------------------------------|-------------------------------------------|--------------------------------------------|
| <strong>Continuity</strong> | <strong>Past</strong>                             | <strong>Present</strong>                     | <strong>Future</strong>                                 | <strong>Past</strong>                                      | <strong>Present</strong>                                | <strong>Future</strong>                                 | <strong>Past</strong>                                   | <strong>Present</strong>                                 |
|                | Ex-husband and child support         | Employment history and education| Different job experiences                  | Economic barriers after separation from husband| History of trauma and disability            | History of health barriers and disability | Abuse related trauma and disability         | House capacity exceeds the family size     |
|                | Abuse and impact on employment      |                                 | Fear of staying on a job                   | Limited choices and day care challenges       | Lack of social supports                     |                                          |                                             |                                             |
|                |                                      |                                 |                                             | Positive experience with NOVA house           |                                            |                                          |                                             |                                             |
|                | Financial Instability                | Disability                      | Enjoying volunteer work                     | Barriers in access to supports                | Education                                  | Challenges of finding employment due to disability and mental health issues | Disability                                  | Economic barriers                           |
|                |                                      |                                 | Economic barriers                           | Economic barriers                             | Community supports                         |                                          |                                             |                                             |
|                |                                      |                                 | Physical health and disability             | Compensation                                  |                                            |                                          |                                             |                                             |
|                | An uncertain future                  | Future hope and goals           | Possible future employment                  | Employment                                    | Staying at current place of residence      | Uncertain future                          | Hopes and goals                            | Moving and settling down                    |
|                |                                      |                                 | Having a mentor                             | Education                                     | Education                                  |                                          | Expectation from a mentor                  | Employment supports and goals               |
|                |                                      |                                 |                                             | Mentor                                        | Future employment goals                     |                                          | Relationship or intimate connection        |                                             |
|                |                                      |                                 |                                             |                                              |                                            |                                          |                                             |                                             |</p>
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<tr>
<th>Interaction</th>
<th>Personal</th>
<th>Social</th>
<th>Situation/Place</th>
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<tr>
<td>Experience of welfare assistance</td>
<td>Grieving the loss of work and sense of self</td>
<td>Fear of employment</td>
<td>The stress of being on welfare</td>
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<tr>
<td>Negotiating government bureaucracy</td>
<td>Challenges of being on welfare</td>
<td>Lack of accommodation of difference (e.g., disability)</td>
<td>Experience with Ontario Works and welfare</td>
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<td>Negotiating government bureaucracy</td>
<td>Limited choices and social opportunities</td>
<td>Fear of the welfare system</td>
<td>Social connections</td>
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<tr>
<td>Negotiating government bureaucracy</td>
<td>Lack of understanding about disability</td>
<td>Experience with Ontario Works and welfare</td>
<td>Social connections</td>
</tr>
<tr>
<td>Subsidized housing in Niagara Falls.</td>
<td>Rented apartment in St Catharines</td>
<td>Lives in Beamsville in a rented basement apartment in a house.</td>
<td>Lives in a Niagara Regional Housing facility in Niagara Falls</td>
</tr>
<tr>
<td>Travelled to St Catharines to access the head office of the Niagara Regional Housing Authority.</td>
<td>On the waiting list for subsidized housing.</td>
<td>Had to travel to St. Catharines to access community support services.</td>
<td>Working to get her driver's license</td>
</tr>
<tr>
<td>Had a vehicle but could not afford the cost of gas.</td>
<td>Drove to Beamsville to access some community supports.</td>
<td>Had a car, there is no public transportation in Beamsville</td>
<td>Women's shelter gave her a bus pass.</td>
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CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

The purpose of this qualitative narrative inquiry was to explore the experience of accessing community supports among eight women who had experienced abuse-related trauma. In Chapter Four, a Three Dimensional Narrative Structure was used to examine the women’s past and present experiences as well as their future hopes. The use of narrative inquiry to illustrate various aspects of the participants’ perceptions, experiences and stories of accessing supports in a rich thick descriptive way helped to convey a sense of realness and immediacy of each woman’s experience.

In this Chapter, five themes emerging from the narrative structures are explored in further detail and examined within the context of the literature. These themes emerged from the narratives of the participants in Three Dimensional Narrative Space Structure.

Following this a new conceptual framework is presented as the themes and narratives are brought together with the literature to create a detailed picture of social inclusion and social exclusion experiences. As reported in the literature, there is need for social inclusion research that incorporates the voices of people belonging to marginalized groups (Stanley & Wise, 1997). From the narratives, five main themes arose which provide insight into the experience of social inclusion among women who have experienced trauma and are receiving community supports. These themes are shown in table 11, including five sub-themes under the determinants of health.
null
Table 11

List of the themes and sub-themes

<table>
<thead>
<tr>
<th>Main Themes</th>
<th>Sub-themes</th>
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<tr>
<td>Impact of the Past on Present Circumstances</td>
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<td>Lack of Accommodation of Difference</td>
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<td>Experience of the Determinants of Health</td>
<td>• Access to Income and the Stress of Negotiating the Welfare System.</td>
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<td></td>
<td>• To Work or not to Work...Is That Really the Question?</td>
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<td></td>
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<td>• The Need for Broad Educational Supports.</td>
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<td></td>
<td>• Social Isolation and the Impact on Other Determinants of Health.</td>
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<tr>
<td>What Will the Future Bring?</td>
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These themes speak to the participants’ past and present experiences of social inclusion and exclusion. The research questions that guided the study were as follows:

1. How are the personal and social experiences of social inclusion different or similar among women who have experienced trauma?
2. What experiences of social exclusion have been encountered in the past, and, what type of struggles are presently encountered by women who have experienced trauma?
3. What are the women’s perceptions of changes needed to community support services to increase their social inclusion?

The first two research questions are addressed in the narrative structure (Chapter Four) and in the themes described in the section that follows. Research question three is addressed in the conclusions to this chapter. Following this, at the completion of Chapter Five, the implications, strengths, and limitations of the study and suggestions for future research are discussed.
**Impact of the Past on Present Circumstances**

As reported in the literature, trauma can impact individuals’ psychological conditions and result in psychiatric disorders, depression and post-traumatic stress disorder (PTSD) (Center for Disease Control and Prevention (CDC), 2004; Freeman et al., 2002; Hartman, 2003; Sanchez-Huellas & Gamble, 2006; van der Kolk, 1996). Trauma can also impact social conditions such as a lack of social support, poor coping skills, and lack of access to resources (Bremmer, 2002; CAMH, 2004; CDC, 2003; Royal College of Psychiatry, 2004). Individuals may also experience economic conditions such as difficulties pursuing employment and career (Alisen, 2003; Brown, 2001; CAMH, 2006; Russell, 1999).

The first research question focused on similarities and differences among the women in terms of their personal and social experiences of social inclusion. From the findings it is apparent that almost all the participants had similar experiences of a struggle for social inclusion in their past, and almost all of them have experienced further isolation in their present life conditions. As the participants experienced social exclusion of the magnitude reflected in the definition provided by Galabuzi (2004) who stated that social exclusion is the:

...inability of certain subgroups to participate fully in Canadian life due to structural inequalities in access to social, economic, political, and cultural resources arising out of the often interesting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, immigrant status, and the like. Along with the socio-economic and political inequalities, social exclusion is also characterized by processes of group or individual isolation within and from such key Canadian societal institutions as the school system, the criminal justice system and the health care system, as well as spatial isolation or neighborhood segregation. (p. 238)

As appeared in the Three Dimensional Space Narrative Structure, almost all of the participants described experiencing barriers and challenges in accessing community support services. These barriers were reflected in the participants’ personal and social interactions.
The participants also described challenges in accessing community support services in their past and present life as shown in the Three Dimensional Space Narrative Structure.

The findings indicated that while all of the women had previous experiences of trauma and abuse which continued to effect their lives, some of the women’s challenges were also increased by the concurrent experience of a disability or mental health issue. Six of the eight women described a continued struggle with a disability or mental health issue in addition to the experience of trauma.

As reported in the literature, individuals who have experienced trauma are at a higher risk of developing mental health problems (Canadian Health Network, 2003; Canadian Mental Health Association, 2003). It was also reported that individuals with a disability are more vulnerable to experiences of social exclusion and are at greater risk of experiencing poor health status (Shookner, 2002; Wilkinson & Marmot, 2003). The women differed in their experiences as they attempted to overcome the barriers associated with trauma, disability and mental health and other issues identified in their past (e.g., family breakdown, job instability, loss of social supports). One group of participants (Julia, Christine) had secured stable housing and were enthusiastic about returning to employment. These participants were in the process of upgrading their skills and capacity, finding employment through employment help services, and connecting to social supports. Julia was enthusiastically looking for an employment opportunity and was ready to take any position offered to her. For Christine, support received from a women’s shelter facilitated the process of change in her life. As she described, “[the women’s shelter] was really helpful . . . they helped me find a lawyer . . . I filled out a housing application through [the women’s shelter] . . . I got on housing. . . I am working on getting my license”. Christine hoped to return to work
with the support from a possible mentor. However, she believed that having transportation was important to be able to get to work. As she described, “when I think for full time employment, I think I am going to have to get a vehicle”.

As reported in the literature, social support networks including support provided by family members, friends and community resources play an important role in an individuals’ health and coping with traumatic events (WHO, 2005). Individuals who have experienced trauma are at higher risk of social isolation due to fear of rejection, difficulty trusting and socializing with people (CAMH, 2004; CDC, 2003; Royal College of Psychiatry, 2004). As reported in the literature, structural and social factors in society are linked to health, as people’s health may be affected by illness, poverty or social exclusion (Eriksson, 2000). Abuse related trauma can have serious consequences on women's health and their state of well-being (Status of Women Canada, 2004). It was also reported that women who have experienced social exclusion due to their disability and race are at greater risk of mental health concerns and being on social assistance (Canadian Women’s Foundation, 2000).

The second group of women in the study continued to struggle with their current life challenges (Leeanne, Linda, Connie, Xantha, Mandy, Wendy) and struggled with stability in terms of their health and mental health, as well as one or more of the determinants of health. This group identified their process of change as being slower and taking more time; they described themselves as taking it one step at a time. The women noted that they needed to stay on social assistance so that they could focus on their health, upgrade their education and address some immediate challenges such as housing and mental health issues before returning to paid work. However among the second group, three participants (Mandy,
Connie, Linda and Leanne) also spoke about their interest in doing volunteer work before returning to paid employment.

Connie described that she was still in the process of coping with the trauma (assault) that she had experienced in the work place. She also talked about focusing more on the current challenge of fighting with ODSP about her housing. Connie also indicated that she was willing to return to work (see the impact of trauma on employment in Table 6) and at the same time engage in skill development courses to prepare her for work in a different occupation. Connie indicated that after overcoming these challenges she will be able to focus on her long term goal which is returning to work. Similarly, Leeanne indicated that her first focus was to take care of her health, and then return to school and upgrade her education.

Leeanne adds “right now with the school, and just focusing on trying getting back on track, like health wise...I think there are little small steps that I have to do first before I make a big change”. She was recently approved for disability supports and will not immediately return to paid work. For Xantha the steps before employment included moving into a new housing facility, and coping with fibromyalgia and chronic fatigue. However, she described that after overcoming her biggest challenge, which is moving into a new house, she will be able to focus on her goal of returning to work.

For Mandy, Wendy and Linda the process of change first involved managing mental health (e.g., anxiety, depression) or disability (e.g., fatigue, chronic pain) issues and about establishing social connections. Mandy described that the first priority for her was to find a social support group. Finding social support may be through employment or help from community support services. Mandy also described that her physical health challenges and age created a barrier in her future goal of returning to work. Mandy described, “I want to
fight this illness. . . I want to go back to become social worker”. Wendy also indicated that she was currently focusing on her mental health issues and was also willing to take some training courses before returning to work. Wendy also described that through the supports from ODSP she was hoping to find employment. Similar to Mandy, Linda also described physical health barriers as constraints in her path towards paid employment as she explained, “I can’t sit for too long. . . I can’t stand for too long...so I need to be able to work this out.” However, she also described a lack of employment opportunities in her local community as another challenge. Linda is not optimistic about finding employment but indicated that she is interested in returning to work with support from a mentor.

The women had different resources, challenges and were at different places in finding stability in their present lives. Past struggles continue to impact on the women’s access to the determinants of health including: balancing family responsibilities, upgrading education, difficulties finding employment, health barriers (physical, mental), lack of social support network, lack of support from community organizations, lack of housing, limited choices and social support opportunities, stress of economic hardship, discouragement in accessing supports due to negative experience, and having a poor sense of self and self esteem. These determinants of health are discussed further in the sub-section titled, Experience of the Determinants of Health.

**Lack of Accommodation of Difference**

As reported in the literature, the corner stone of social inclusion includes valued recognition, whereby an individual or group identity is deemed to be valid (Freiler, 2002). In an inclusive society the diversity of people’s different backgrounds and circumstances are appreciated and positively valued (Mitchell & Shillington, 2002; Wylie, 2004). However, a
lack of recognition of difference was a central theme that most of the participants’ reflected upon in their description of their experience with community support services. This included a lack of recognition of their experiences of: abuse related trauma, physical disabilities, being a single parent, having a learning disability, and mental illness.

It was also reported in the literature that employment can decrease risks of social exclusion and mental health problems, while unemployment increases risks of mental health problems and social exclusion (Evans & Repper, 2000). The literature indicates that individuals who have experienced trauma have difficulties in establishing work, a career and personal and social relationships (CAMH, 2006; Russell, 1999). Individuals may encounter problems at work such as a lack of ability to fully function (Alisen, 2003). In this study it was found that the women struggled with the consistent energy required for full-time work as they experience ‘good days’ and ‘bad days’ as a result of their mental health issues or disabilities. In addition, some of the women who have experienced trauma described difficulties managing interpersonal communications and the stress associated with the workplace. These differences were not able to be supported or accommodated in the workplace, leading to job loss.

Similarly, some participants believed that workers in community support services were less aware of issues such as physical and mental health challenges (fibromyalgia, chronic fatigue, and learning disabilities). Due to the lack of recognition to the participants’ mental health challenges, they were discouraged from further accessing community support services. In addition, the participants experienced feelings of being devalued. Mandy explained that workers at ODSP gave little or no recognition to her physical health barriers as she added, “I talked to my coordinator before, but it is hard for them to understand because
they don’t understand the chronic fatigue and they don’t understand the fibromyalgia and then, on top of that I got the discs too.” She further talked about having difficulty coping with fibromyalgia and chronic fatigue and the community supports being less sympathetic towards her disability issues. Mandy further described that people are also less sympathetic to her mental health challenges:

I have been depressed before I’ve done all of it, and then they alienate you or they push you around because they think like now you depressed you have to be stupid and it is really horrible. . . I am depressed I am suffer from depression but I work at that too and it is a disease but people don’t understand.

Mandy further described a lack of recognition of the needs of people with disabilities in terms of the leisure activities available in the community. As she stated:

. . . if you are disabled lets say, you can’t belong to bowling or anything. . . it is really difficult for a lot of women my age that are alone and don’t have any family if they do suffer from disability cause there is no where to go out there. . .

She further explained that mental health barriers such as depression are hard to manage. Mandy described that for individuals who have not experienced similar health issues, it is hard for them to understand what it is like to experience depression. As she added, “sometimes I wonder if people haven’t experienced depression they don’t realize how much intelligence and how much strength it really takes to manage depression in everyday [life].”

Xantha had found that some community support services (e.g., a non-profit serving people with physical disabilities) had given little or no recognition to her health barriers. Xantha described that the organization may not have dealt with, or known how to deal with, individuals with fibromyalgia. As she stated:

I went to the [non-profit serving people with physical disabilities] and I approached them, um, didn’t get into this huge conversation, I tried a couple of times to do this but for one thing or another over the past 5 years I never quite got to the point where I
went in and I said to them, you know, have you ever had anyone with Fibromyalgia and chronic fatigue want to enter your program?

Connie also described experiencing a lack of recognition of her health barriers. She explained that her employer did not acknowledge her health problems and even her family physician was not supportive enough in terms of providing referrals. As she describes:

I’d already been going through a really bad time because my employer didn’t believe what I was; they forced me to go back to work. My doctor said I wasn’t ready. They sent me letters threatening that they were going to terminate my employment. And so I went back and I wasn’t ready, fell down the stairs sustained another injury to my ankle.

Wendy had difficulties with people understanding how to accommodate her blindness and the supports she used to read printed text. Wendy described:

if it’s somebody with my limited vision I have to address the needs that I need Zoomtacks or large print monitor, like a 21” monitor or something to make accommodations. . .well obviously they’ll probably e-mail nowadays as opposed to writing a memo in pencil or pen and then I’ll be able to read it with the large print.

She then described the differences in accommodation of her lack of vision compared to her mental health issues:

But if it’s mental health issue, or even people from [the women’s shelter] who are having shelter or abuse issues you have to address the mental health need. So in the work place, and the thing is a lot of people who don’t have mental health issues, don’t understand mental health issues.

Wendy talked about the lack of recognition given to her mental health issues. She described having a hard time completing her diploma. She described, having Borderline Personality Disorder and associated symptoms such as instability at work, difficulty controlling impulses, and crying during a work placement. As she stated, “[these] are not something that you can actually solve in 6 weeks” and therefore she believes there is a lack of support and less recognition of the needs of people with borderline personality disorder.
Other participants such as Julia reflected on the lack of recognition given to the
different needs of single parents. As reported in the literature on single parents, women in
disadvantaged situations and people with a disability may experience isolation from society
and are at greater risk of poor health challenges (Galabuzi, 2002). The women in this study
talked about struggling to combine their roles as a parent and sole bread winner in the
family. Some of the participants talked about experiencing financial barriers and
experiencing challenges in providing a better support for their families. However, some
participants (single mothers with children) emphasized their desires to provide a better
future for their children. For example, Julia described her struggles of being a single parent
and the challenges of balancing family with the development of her own skills and
education in order to secure more stable income. As she described:

My daughter was in hockey, which again I solely supported her with. She was in travel
hockey, she's been in travel hockey since she was 5 years old up until this year, so I
was trying to attend what hockey games I could, I did do tournaments. I had a 14 year
old son at the time... I would come home and cook meals and then I would be up
until 1:00, 2:00 in the am studying myself... 

Julia explained that she felt that her experience of trauma and being a single parent
were not being recognized. When owed a significant amount of child support from her ex-
husband, she approached the Family Responsibility Office. But she was shuffled between
different levels of decision makers:

I've written to our MP, our MPP, I have no response from them, none whatsoever. I
have written to the premier of Ontario. I got a response where he sent me somewhere
else to the FRO [Family Responsibility Office] and the FRO sent me somewhere else.
And I just think that the government has to stop pretending that we don’t matter...

The findings confirm that there is a lack of recognition of participants unique
differences that played a major role in their experience of social exclusion and
discouragement from accessing community support services.
Maintaining a Sense of Self in a World of Assumption and Labels

As indicated in the literature, a language of labelling creates an image of certain people being inferior, judging them as different from others. This may result in individuals’ exclusion and a decrease in feelings of belonging to society (Pickering, 2001). Language can bring positive and negative changes in life. Example of negative change includes the experience of racism among individuals in everyday life (stereotypical views of a group of people held by professionals and a lack of cultural sensitivity which leads to decreased access to a program or service) (Corker, 2000; Galabuzi, 2002). It was also reported in the literature that discrimination against marginalized and disadvantaged groups may result from a power imbalance and domination of the superordinate group which then leads to the creation of structural constraints and inequality (Saloojee, 2003). However, increasing the flow of resources to individuals, and building their capacity to become more powerful, organized and self confident will help them fight against barriers to social inclusion (Galabuzi, 2002).

Most of the participants described their concerns about being labelled or judged instead of being seen as whole people. Some of the women indicated they did not want to be labelled as an ‘abused woman’ often associating this with a connotation of powerlessness (Wendy, Christine). In describing her fear of being labelled as an abused woman, Wendy commented, “it’s mostly my inability to accept criticism because you see I came from a background of abuse.”

Christine described feeling embarrassed about receiving support from the local organization for women who have experienced abuse. As she stated, in the past she had made charitable donations to this organization, and now she finds herself needing their services. Christine describes this experience:
I am helping out somebody else and then you know, I feel, like I said, a few days later when I am on their door steps because I am beaten. I got two kids and I got no work. I am again at the back door because I am ashamed to go to the front door and I am embarrassed being there and I am angry because I am there and because I am in that situation.

Christine felt embarrassed at being identified as a woman who had experienced abuse, “I didn’t want to leave the house, I didn’t want to talk to people, I was embarrassed, and I mean I was embarrassed to go to school. I didn’t want to tell people what had happened.” As she explains, “it made me feel stupid for being in that situation so I didn’t want to end up, you know, the sad part was when I went there I looked at the other women, I thought shame on these women for putting themselves in this situation’ because I thought I was different.”

Linda resisted the association that she felt was made between being an ‘abused woman’ and anger toward all men. She expressed that support services who take this approach are creating further barriers in coping with hard conditions. For example she was referred to a community support organization that provided services for women who have experienced abuse related trauma and she found the support less effective and further damaging. She described, “...to me it was nothing but to put men down...and now not all men are like that so it was just that...and mentally its damaging because it puts you further and further down...instead of helping you through it”.

Other women were sensitive to the labels associated with being on social assistance, and felt at times they were treated like criminals and being labelled a welfare fraud. Julia talked about the challenges of having lower self esteem as a result of living on social assistance. As she explained, “I have never been to a point in my life where I am so low. I mean I know some people have lived on welfare all their life. To me, it’s degrading, it really
is... why we have to go degrade ourselves to go wait in a line-up to apply for a food basket”. Julia believes that there are people who abuse the system but that does not mean everyone is abusing it. She described that people who are utterly dependant on community supports are not treated well, as she adds, “the people that really need it in a time of need are treated like garbage.”

Some of the women described having a poor sense of self due to the embarrassment of receiving welfare services. Julia explained her frustration as follows, “(t)hey (community supports) make you feel like you’re nothing and I don’t think it’s fair.” Similarly, Connie states, “(t)reat us like we’re people; treat us like we’re still human beings... there’s animal shelters that treat their animals better then what our government is treating people that are down and need to go on OW.”

Julia also spoke about the impact of stigmatization on her son. She spoke about sending her son to a Catholic school so that she did not have to worry about him being excluded and “centered out” by other students. She further explains:

_I sent him to a Catholic school mainly so he wouldn’t be recognized as maybe one of the less fortunate children because he doesn’t have all of the name brand clothes because even when I was working I couldn’t really afford to do that._

Related to the labels of “abused woman” and “welfare fraud” some of the women, like Christine, also described a fear of being labelled as a ‘unfit mother’, “I didn’t want to be labelled as an abused woman I didn’t want to go to welfare and be labelled a single unfit mom, I didn’t want to be, unfortunately this is the way society is...”

**Experience of the Determinants of Health**

The active and democratic participation of individuals in public life and the efforts of institutions and society will help to achieve collective goals (Putnam, 2000) to address the
challenges of exclusion, discrimination and inequality (Saloojee, 2005). From the findings, it appeared that all participants were hopeful for future social inclusion in society through employment, access to skills and capacity development programs, access to community resources, and increased social support network. This hope existed in spite of their past and present experiences of social exclusion due to the instability caused by trauma, disability, mental illness and being on social assistance. However, as reported in the literature, barriers created by community support service providers and organizations contribute to experiences of social exclusion and decreased access to community support services among women who have experienced trauma (Hilbert & Krishnan, 2000). Barriers to participation which create social exclusion include: institutional dependency; limited choices; lack of access to community resources; and having no role in decision making on social, political, economical, and cultural issues (Raphael, 2004; Shookner, 2002; Warburton et al., 2001). These barriers may impact an individual’s health and quality of life and access to the social determinants of health, and contribute to premature morbidity and mortality from chronic illnesses, such as heart disease, stroke and diabetes (Wilkinson & Marmot, 1998). In contrast, individuals with access to the determinants of health and social inclusion generally have improved coping skills and resiliency to trauma (Galabuzi, 2002; Raphael, 2005). It is apparent from the findings that trauma, disability and mental health were related to participants’ access to the determinants of health such as income, employment, housing, education and social supports.

As reported in the literature, a lack of emphasis on social inclusion by mental health services and barriers to engaging in community such as a lack of adequate transportation and housing forces individuals to become excluded from a "normal" functioning society (Abrams et al., 2005). This makes it very difficult for people to be fully included in a society and to
access supports. The specific community organizations the participants spoke about included housing, transportation, legal services, family and children services, mental health services, shelter, legal advocates, and financial aid or welfare services. The following is a discussion of the impact of trauma on specific determinants of health as described by the participants.

**Access to Income and the Stress of Negotiating the Welfare System**

Most of the participants anticipated staying on social assistance for a short period of time and being able to find employment, but due to negative experiences in their access to social supports, staying on social assistance had been prolonged. Some of the participants explained the experience of further stigmatization in seeking supports.

The findings support common experiences among participants of stress in negotiating the welfare system. This played a major role in their experiences of social exclusion and isolation from the society. According to some of the participants, the social assistance organizations they have accessed (OW, ODSP, etc), were of very little assistance and rarely supportive. However, some participants (Christine, Mandy and Linda) also described how these supports helped to create some stability in their lives. Furthermore it appears from the findings that connections with specific community support workers (counsellors) played a key role in making their experiences positive.

Seven of the eight participants (Julia, Connie, Mandy, Linda, Wendy, Christine and Leanne) shared a common negative experience of accessing welfare supports. The negative experiences of the women included: a loss of trust in welfare support due to communication difficulties and challenges accessing accurate and timely information, the experience of powerlessness and lack of control over their lives, being unfairly treated by social assistance workers (OW, ODSP, etcetera), fear of violating the rules and regulations of OW and ODSP,
a prolonged stay on welfare, being shuffled between different community support services, and challenges in accessing day care supports.

Six participants experienced communication difficulties in accessing OW and ODSP; these participants included Connie, Linda, Mandy, Wendy, Julia and Leeanne. The participants indicated that workers were less welcoming and at times discouraging. As a result of these experiences most of the participants lost trust in community support services and were discouraged from receiving supports. One participant (Connie) for example, explained her frustration as follows, "...you don't know who to talk to and who can advise you on what to do and how to do things and what you're, what is available to you... I'm really overwhelmed." To Wendy the fear of connecting to welfare organizations was associated with the difficulty of getting directed to the right person, "when you call an agency you get different people telling you different things." Similarly, Julia experienced difficulties communicating with staff in the Regional OW office. Julia further reflected on not getting the right response from the supports:

... it's like a telemarketing thing. That it's a bunch of people hired to answer phone calls and have a computer in front of them. The government implemented this system, they need to fix it. There's something definitely wrong with it. It's the same thing as our court system. I mean, you can have as many court orders as you want out there but once you have it, that's it, nobody backs you...

In accessing some financial support services (OW, ODSP) most of the participants indicated a constant fear of violating the rules (for example, receiving loans, child support from ex-husband etceteras) and fear of losing their financial aid (for example being cut off and or being penalized for having additional income). Some of the women (e.g., Mandy, Linda) described their challenges in understanding the rules and requirements of OW and ODSP. Mandy describes "[i]t has a lot to do with how much (income you have), if you make
a little bit money you know, they will take that away from you...” Similarly, Linda fears being charged for violating the rules of ODSP and being denied by ODSP as she added, “my fear would be that since I’m working to make that extra money. I’m going to be told ‘you can work, get out there’ so you don’t want to be able to make that extra money because you’re scared you’re going to lose your base income”. Mandy also talked about having limited opportunity and choices around employment with the current financial support, as she explains, “... in Canada Disability you’re only allowed to work so many hours”.

This fear left the participants with the idea that staying on welfare is better than finding employment. One woman (Linda) with a disability is interested in part time work, however due to the fear of losing her base income she does not want to attempt to find employment. She describes her fear as follow:

I don’t even want to attempt to [work]...I’m scared they are going to say ‘listen you’re out there working. You can go out there can get a job’... but I know that I can’t...so you don’t want to be able to make that extra money... because you’re scared you’re going to lose your base income.

Julia raises her concerns and difficulties understanding the requirements of support services. According to Julia to be able to meet the requirements of OW for example, one has to be without any kind of assets. She added:

OW doesn’t want you to have anything. They don’t...you can’t have RRSP’s, a vehicle; they’d tell you, ‘well sell it.’ That to me is a problem. If you owned a home, ok I could understand if you owned a home you should be able to go on it and then once you get back on your feet then you pay it back, but the whole problem with our government is in order to qualify for welfare you have to be a nothing. You can’t own a home, you can’t own a vehicle, and you can’t have RRSP’s...

Julia and Connie described similar difficulties understanding rules and regulations of OW. Julia described her experience of having a hard time providing documents to Ontario Works:
...they wanted to see 4 months back of all my bank statements. What does it matter, what my bank statements look like 4 months ago compared to what they look like today? They wanted my income tax from last year, what does that have to do with anything when I lost my job. Had I been fired I would not have qualified.

I had to go apply for social services because my ex-husband was ordered to pay support; they needed to see my court order, like they want everything from you. You’re child’s bank account; it’s ridiculous what they ask you for. I mean they make you feel like you’re a nothing and I don’t think it’s fair.

Accessing OW was also difficult and exhausting for Julia. Her frustration with the bureaucracy is illustrated in the following quotation:

I’ve been devasted at times where I’ve gotten a notice from OW stating that I wasn’t going to get November’s cheque because I didn’t have proper documentation to them. When I phoned and finally got through to my worker which it takes her 48 hours to return her calls because of her workload, the info she was looking for had been faxed to her office by [a worker from women’s shelter] not once but twice. So, it, but that’s an emotional, stressful issue for a person who is looking for that money to pay their rent, to put food on their table for their children or even for themselves.

Similarly, Connie expressed her feelings of being overwhelmed when OW demanded repayment after she had received $12000 from Canada Pension:

I got something in the mail today from them (OW) telling me that...the income that you reported this month was more than you basic financial assistance. I didn’t report any income in November. I mean they’re talking about the $13,000 that I got and then I had to show them where all the money went and then they send me a bill for $12,000. I freaked...I mean all these things, you don’t know who to talk to and who can advise you on what to do and how to do things and what your, what is available to you and right. I’m really overwhelmed...and I don’t know who to go to.

Connie indicated that she had difficulties understanding the complex rules of deduction from monthly financial aid and sometimes being cut off from receiving further financial support. Connie talked about the complexity understanding the rules as follows:

...when you get your baby bonus which is $200 I get $230 something or $240, they take half of it off, which doesn’t make sense to me. Why would the government give me child tax credit every month if I didn’t need it? Why does OW take half of it?
Connie took out a loan from the bank to renovate her house; however, she explained having a difficult time understanding why this loan would count as income that she has to pay back to the bank. As she described: "I borrowed $5,000 from the bank, I have to pay that back over the next 3 years." Connie further explained:

...the money didn't come to me, I got a loan from the bank, I paid the contractor and then I had to pay the bank for three years...that's considered income. Now how's it income? I had the contracts, the contractor's statement of how much it cost and everything. I had the letter from the bank, why they were approving this loan, that it was for home improvements and I mean a statement from the contractor showed everything that they did.

Connie also talked about not knowing where to go for advice, and who to approach for support. Connie also talked about having difficulty understanding why OW staff asked her to sell her house. She stated that she had to work hard to buy the house and she has a lot of memories attached to her home:

I've had the OW worker... told me that I should sell my house and get something smaller or apply for Niagara housing and move into one of those places. Well, you know what, I worked my whole life for this house and my children, my daughter was raised here since birth and my son was raised here since he was 20 months old, this is their home. I'm going to go live with all the grubbies and druggies, no thank you, I can't do it.

Wendy describes her experience of accessing ODSP negative and humiliating as she commented, "...it feels like I'm being re-traumatized all over again, always over and over again. In a lot of things confronting me, which I have had a lot of those, and helping me to learn what I'm not doing right in relationships that suck or work situations. I just cry."

Leeanne explained her struggles with not being able to get the support she needed. Part of her negative experience in accessing ODSP included: being shuffled between different community organizations: "...not being able to get the support that I needed or I need, just being shifted around from one agency to another, saying oh this person should
help you or this person isn't doing their job and stuff like that.” She further talked about getting different responses from different community support workers which made it challenging for her. She further added, “. . . from talking with other people they are just like, they won’t take responsibility, it’s like you are the one that gets blamed. . .”

One of the reasons Connie feared the system and dealing with financial aid organization that she received support from (ODSP) is that the government may put a lien on her house and if she decided to sell her house the government would demand repayment.

Connie further illustrated:

I’m worried about with this ODSP thing, if they put a lien against your home when you go to sell it; they are going to take some (money) too. So whatever they give you they’ll end up, taking it back and I don’t think that that’s right. I really don’t think that that’s right.

Christine raised a different type of concern, which is meeting the requirement for a daycare program. She had troubles balancing family with low budget and needed daycare for her children. However to meet the requirements for a subsidized daycare program she had to be on welfare. As a result of having inadequate daycare she had to quit her job:

I’ve got a job for $10.75, I don’t need to be on welfare if you are not going to help me with day care, but there is a three month probation period that you have to be on welfare before you can qualify. So I lost that job I tried to shuffle as best I could but I couldn’t. And by this time now it was the end of June and kids of out of school now I have them all day.

To Work or not to Work...Is That Really the Question?

As reported in the literature, individuals who have experienced trauma are at a higher risk of social exclusion due to difficulties seeking and maintaining employment, stigma and discrimination (Abrams et al., 2005). It was also reported that unemployment, inadequate income, poor access to resources, lack of education and lack of a supportive environment are
considered as economic barriers that lead to social exclusion (National Strategy for Neighbourhood Renewal, 2000; Shookner, 2002; WHO, 2005). The key focus of community support services is often on supporting individuals to find employment; however, as reported in the literature, different approaches to social inclusion such as supporting individuals to become volunteers, parents, family members, and community members are often ignored (Chenoweth & Stehlik, 2004).

Among the women in the study, their absence from the paid work force varied from one year to ten years. While, almost all of the participants spoke about their intentions of returning to paid work, the path of returning to work varied based on: the immediate challenges in some of the participants’ lives (economic, disability, mental health); the type of work they wanted to do; and whether they were seeking part time or full time positions (see Impact of the past on present circumstances). Focusing on these variations, the women may be divided into two groups. The first group of participants had secured stable housing (Julia and Christine) and were more enthusiastic about returning to paid employment. The second group (Leeanne, Linda, Connie, Xantha, Mandy and Wendy) were still focusing on their immediate challenges such as housing and health related issues (coping with trauma, disability and mental health problems). Some talked about the need to upgrade their education before returning to work. However among the second group, three participants (Mandy, Linda and Leanne) spoke about the importance of volunteering and their contribution through volunteer work in the community.

It appears in the findings that most of the participants experienced barriers in finding employment. The experiences of finding employment for almost all the participants included the challenges and difficulties connecting with employment supports. Participants described
experiencing difficulties accessing the right employment support program. The lack of employment opportunities were related to not only a lack of accommodation of disability and mental illness, but also a lack of full-time work opportunities that offer adequate income, and in some communities of the region the emphasis on seasonal employment opportunities. For example, Niagara Falls is a tourist area and consequently many of the jobs are offered during the summer months. Some of the women feared attempting to find employment due to previous experiences of trauma. As discussed previously, a fear of finding employment was also related to the fear of reduction in monthly payments from financial supports (OW, ODSP).

Julia, Linda and Wendy described difficulties finding employment due to lack of employment supports and lack of employment opportunities. Julia felt she needed more support with job searches. According to her it is hard to do a job search on a website available at the Employment Insurance (EI) office, "...if you go online and do a job search which is what you’re going to do at EI... and you type in legal or law assistant, no jobs available..." and there are fewer opportunities in finding employment and a lack of social connections to help her find a job. According to Julia most of the jobs are being offered for younger people. She further talked about a lack of employment support in the area where she lived, “... all of the employment supports are in St. Catharines.”

Similarly, Linda lived in Beamsville and described the lack of employment supports in her community. According to Linda most of supports were located in St. Catharines or Hamilton and there was less available in Beamsville, particularly for a person with a disability. Linda also had a fear of returning to paid work because of her age, and the challenge of not being able to meet the requirements of employment, “... it is very, very
hard to get a job right now and it’s a difficult step, harder than anything... I guess things are so different now, you know it is all computerized... even if you’re a cashier you need to know computers...”. Linda also talked about the limited employment opportunities as well as a lack of skill development opportunities particularly for women in Beamsville. However, due to a fear of losing her base income she did not attempt to find short term employment.

Linda also described a lack of choices in life as she shed light on her struggle to balance work and family with low or minimum income, “I don’t have a choice I have to live like this in order to give [daughter] a stable life and to me, kids are future.” Linda also spoke about the lack of employment help for people with disabilities.

Wendy also described limitations and challenges in finding employment, however she also pointed to her mental health challenges, “I’m being punished. I have mental health issues and I’m being punished because if I don’t meet up to that standard and stay up afloat, I’m not even going to get a chance to get the job.” Wendy emphasized on the need for additional support in the workplace and community supports for people with mental health issues. Wendy also spoke about the need for additional support in terms of having more counsellors available within community support services to provide employment assistance:

If you only have one counsellor who’s working in that position... you have this wait list that’s happening so instead of talking to people every two weeks now you got to make it every three weeks so you can still see more people in the system and that’s not really beneficial and I don’t really think that that’s fair. If it takes longer to help that person to get to that end goal and you’re only helping 60 people this year instead of 200 people, well tough luck.

For Wendy the idea of returning to paid work was about mental stability and being able to handle the job, “I know for myself if I’m going to take that step to want to get a paid employment, I better darn well know that I can handle it and how am I going to know that unless I do that volunteer work.”
Some of the participants described that they are not willing to return to paid work in the near future. Connie, for example, explained that after the experience of assault in the work place she does not want to return to work and described that she was not mentally ready to do so, "... I don't ever want to go back to work at my job... I do not want to go back to the race track. I do not want to be in that gambling environment, I don't want to be around those kinds of people". She also described that she is willing to work only in a controlled environment, "I want to go back to work and live the way that I was living and be normal... honestly, if I could financially afford it I'd never go back to work."

Despite experiencing barriers to employment, three participants (Julia, Linda and Christine) are looking forward to returning to work. Julia’s main goal is to get into a job related to her educational background, or a job that involves extra money in the forms of receiving tips. Even though she knows that working will affect her financial support from OW, she believes she will be able to make good money with tips from customers. As she added:

*I'm looking for anything (job) at this time. I mean yesterday I had an interview with [name of restaurant] for a waitress position... I'm looking at serving because of tips. I mean, even though I go out and work and make whatever servers make, $6.25 an hour, that's going to come off my OW.*

Linda wants to work in a small store. Her main employment goal is to connect with people, "I wouldn't mind working, like in a small store something, where I can talk and meet people and talk with people and things like that..." She further described that she would like to do customer service jobs or any type of job that involves interaction with people, "I'd love to work at the cash where I can spend time with people or even customer service at Zellers."

Linda indicated that her goal behind taking some training courses is to be able return to work, "one of the reasons I have taken all of the little courses that if I can go back to work one
Christine is also enthusiastic about returning to paid work. She described that she is interested in upgrading her education (in a law school), getting her drivers’ license, and eventually looking for full time employment. Christine also described that she is willing to take any kind of job (particularly office jobs) as she adds “I am always looking for an employment... I don’t really have a preference, what’s feasible is probably working at some form of an office...” Christine described that it is hard to find employment locally (Niagara Falls), because most of the jobs are seasonal, “...it is tough, being in Niagara Falls, it is off season right now, so any hotel work which is probably where I will end up doing...”

Two participants (Xantha and Leeanne) despite focusing on their immediate challenges, talked about the possibilities of returning to paid employment. Xantha for example described that she was looking forward to returning to paid work and hopes to work in an office. However, she also spoke about the importance of having a vehicle to access employment supports. Leeanne talked about her goals for returning to work in the future, however in the mean time she wants to focus on her daughter’s school and health, “I have to take care of like, Lisa’s [her daughter] school and health right now, and we will slowly get onto the volunteer stuff... and eventually move onto the work, so that’s like way down the road though”.

For some of the women returning to paid employment was neither the short or long term goal. Three participants (Mandy, Linda, Wendy) talked about their goals for retuning to volunteering. Mandy and Linda described an interest in volunteering to provide support to other women in the community. Mandy wanted to volunteer with single mothers in the community and identified a lack of spaces where single mothers can come together. Mandy added, “there are so many single moms out there and women my age that have no where to
Mandy believes that there are women her age who have a lot to contribute to community, "I would volunteer down there...like to be around women my age too and develop relationships." Mandy also spoke about an interest in volunteering with a public health program.

Linda is currently volunteering for a non-profit organization. Linda expressed her satisfaction of volunteering as follows: "I volunteer for [name of organization] often nights when it's busiest...I love every single moment of it." Even though Linda talked about returning to paid employment she was more enthusiastic and passionate about volunteering for a community center for women. Similar to Mandy, Linda talked about the need for a place where women (particularly single mothers) could come together and share their experiences, "I would volunteer down there (possibly a community center for women).

Wendy believes that there should be more flexibility in terms of an individual's contribution to community. According to Wendy one can contribute to the community by engaging in the labour market or volunteering, however, she also emphasized the need for volunteering before returning to paid employment:

... it's going to take time [returning to paid employment]. You can't put time on mental health issues, not if you really want the person to succeed in that job...the volunteering piece is about getting experience and building up confidence so that when you decide to take the step to go and get the paid employment...you can feel secure and comfortable with that decision to take that next step.

Stability and Instability in Housing

The findings indicate that participants with unstable housing were more vulnerable to experiencing social exclusion. As reported in the literature, access to housing is an essential condition for social inclusion (Abrams et al., 2005; Dominelli, 2005; Friedkin, 2004; Jenson, 1998) and people who are homeless experience isolation from cohesive community and thus
have a poor sense of belonging to the community (Jenson, 1998; Williams, 2004). In this study it was found that the participants with a lack of access to affordable and stable housing as well as transportation experienced difficulties returning to employment and upgrading their education. Therefore, they were more vulnerable to experiences of social exclusion.

The participants lived in different locations of Niagara Region. Three of the eight participants (Mandy, Linda and Wendy) lived in rented houses or apartments, three participants (Julia, Xanthia and Christine) lived in government subsidized housing; one participant lived with her mother (Leeannne); and one participant lived in her own house (Connie). In terms of housing, there was a significant difference among the women who had secure housing (Julia, Christine, Wendy, Leeannne), and the women who did not (Mandy, Linda, Connie, Xanthia). Among the women who did not have secure housing, Mandy and Linda lived in rental housing, Xanthia lived in government subsidized housing (was deemed to be “over housed”). Although Connie lived in her own house she believed she was being told to sell it by OW. Mandy, Linda, Connie, and Xanthia all described that stability in their housing would increase their access to other community support services such as employment assistance, education and skills development.

Some of the participants described a lack of access to available and affordable housing in their local communities. The participants talked about a lack of housing facilities for people with disabilities, difficulties moving to new co-operative housing facility, and a fear of moving to housing environments that could potentially have a negative effect on their children. Some of the women also described current struggles with the cost of their housing. One of the participants (Mandy) was on the waiting list for Niagara Regional Housing.
Almost all participants experienced some challenges with the stability and security of their current housing. However, the participants’ challenges were different from each other. For some of the women, the challenge was in covering the costs of housing and being charged for extra maintenance by the landlord. The participants who did not have secure housing explained a lack of access to available and affordable housing in their communities, which in turn created one or multiple barriers to accessing community support services. Linda explained that there was a lack of supportive housing in Beamsville, in addition to a lack of transportation and employment supports. Linda also spoke about difficulties in covering the cost of housing and the negative impact of this on her children’s future, “income wise on disability we are just barely scraping by and you can’t get all the extras...it is very stressful to try and make opportunities for your children.”

Mandy described that she is struggling to cover her rent. She applied to Niagara Regional Housing and is looking forward to moving to a place she can afford:

I have been looking for housing and to get out of here for two years now...I just can’t take care of it because I can’t afford and cause there is no money left over after pay the rent and the bills here...I want to get into seniors but I am not old enough and it is just a real hassle and the housing is terrible...I have been on the list (NRH) for quite a few years.

Unlike the group of participants who did not live in secure housing, Julia (despite living in government subsidized housing) talked about experiencing difficulties covering the cost of housing, groceries and transportation costs for accessing supports. She states, “I mean $65 of that is a bus pass for me. I mean I do have a vehicle but I can’t really afford to put gas in my vehicle.”

Xantha expressed her concerns about the current barriers with subsidized housing. Unlike Mandy, Xantha already lived in subsidized housing; however, she had been struggling
with moving from her current location to a new location as mandated by the Housing Authority. Xantha adds, "my main challenge has been this housing thing...one of the highest things on that stress category." Xantha also described having limited choices in terms of moving to a new housing facility within the same area. Xantha described not being financially and mentally ready to make the move but she does not have a choice as she adds:

They don't see it as an actual move, which is totally ridiculous...It's been a real lot of hard work personally for me, but I have no other option. I have to accept, you know, what life has given to me because what else can I do, curl up on the couch and cry and feel sorry for myself...

Xantha found it tough to be part of the Niagara Regional Housing (NRH) system.

She expressed her frustration and irritation:

Why put me under more stress? Then they said don't have the movers [fax us], I don't want six pieces of paper coming in at once, you have to produce a package for me. Then when I told them, the movers aren't cooperating, they're not faxing blah, blah, she says ok, then they can fax in. It's a total contradiction from beginning to end.

I am in NRH, NR housing, as you can tell I'm just totally thrilled to be part of that process because honestly it's been more of a hassle than anything, for me it's been not a good thing to be in this system.

**The Need for Broad Educational Supports**

As reported in the literature, improving individuals' skills and capacity facilitates their access to employment and maximizes economic productivity (Bates & Davis, 2004). The development of life skills through education and training increases opportunities for income and job security, and enhances life management potential, the ability to cope with change and a sense of control over life circumstances (Canadian Public Health Association, 1997). It was also reported that unemployment rates are higher among individuals with low literacy skills and these individuals also have poor health conditions and a lower life
expectancy rate compared to individuals with high levels of education (Galabuzi, 2004; Health Canada, 2002; Shookner, 2002; WHO, 2005).

Almost all of the participants indicated an interest in upgrading and updating their education and skills. Julia and Leanne wanted to upgrade their education and skills to find meaningful employment. Linda, Xantha, Wendy, Mandy and Connie wanted to upgrade their skills and take short term courses. The skills training workshops and courses focused on developing personal and social skills, such as parenting, self esteem, and decision making.

The women in the first group (Julia, Leanne) experienced barriers to upgrading and updating their education and skills that contributed to their experiences of social exclusion. The specific education barriers included: not being able to find employment with current education and work experiences, limited learning opportunities for skill development, unavailability of specific skill development programs and a lack of flexibility in the variety of skills development programs offered in the community. In addition, some participants indicated that the services available for developing skills and capacity are often repetitive, time consuming, less helpful and less flexible in the variety of services offered.

Julia had gone to college to upgrade her education and encountered some challenges finding employment in a field related to her education and skills. She has considered going back to school to train in a different area:

...my problem is because I've graduated with a paralegal degree, they don't think or OW doesn't think that I should go and get a different degree as a PSW or something else. I mean I'm sure I could go to a college and apply for a student loan again but then I'm constantly owing the government money.

Leeanne is currently upgrading her education and taking two courses (English and Math) through an Independent Learning Center. Even though she has experienced some challenges in continuing her education, she was enthusiastic and focused on finishing her
courses, "there is a lot of stuff going on with school with exams and I may register for more, but just sort of trying to focus on school." Leanne described that her goals were to focus on her education, take more training courses, do some volunteering and eventually return to the labour market. As she explains, "I always liked, for a long time sort of wanted to get into the psychology area but I am not really too sure yet, so possibly working with children that's another thing, I was sort of thinking about it but I can't really see myself at that yet."

Some of the participants spoke about upgrading their skills and education as part of their future goals. Among this group there were Mandy and Linda who talked about taking care of their health and family prior to upgrading their education. Mandy talked about upgrading her education, however she added that she had to focus on her health and then go back to school, "I want to fight this illness that I have . . . I'd like to go back to school and I would like to become a social worker". Linda described that to return to a management positions she would need to take some courses to feel more confident. For Linda developing skills and capacity was a challenge due to limited learning opportunities, "I would have upgraded a lot, like I know enough for myself to learn if someone taught me."

For Connie, the challenges to developing skills and capacity were created by financial barriers, "if you're on EI or OW or ODSP they will pay for you to take some training to learn another field but if you're not, they won't." In comparison, Julia expressed her experience of difficulties upgrading her skills due to lack of support from OW, "I've gone to OW to see if there are any college courses I could take and the only thing they offered me was to go and upgrade my computer skills at an adult learning centre." Julia emphasized that there is a lack of awareness about support programs that provide resume writing skills and job development skills. For example, she talked about a course in computer skills through OW, "... there are
apparently computers at OW in the basement, and I never even knew that until my worker told me. There's not to my knowledge anywhere that tells you.” Julia also talked about upgrading her computer skills at a community support center in St. Catharines; however, she indicated that transportation barriers were a major constraint for her, “I've been hired by them and upgrade my computer skills there, but then I'm traveling from Niagara Falls to St. Catharines, paying for parking downtown St. Catharines and I would need to be there a couple of hours.” Wendy is taking a customer service course funded through HRDC (Built Network). She described that the course duration is eight weeks and there are ten people in the same class:

... the first two weeks or three weeks is spent on personal self assessment and all that kind of stuff, self esteem, self image, and conflict resolution and communication skills all that lovely stuff. Then they do the computer training part where you do Microsoft and Excel and Word and all that stuff and then they do resume writing and interview, mock interviews.

For Wendy there was another course that she was interested in taking but due to the cost of public transportation she was not able to access the course. As she explains, “I tried to explain to them that, that was the reason that I was taking the course can you please fund transportation so I can take the course.” Wendy further adds that she has to use three different buses to be able to attend the course:

I have to take three buses. I have to go from here in NF to get to St. Catharine’s to take the course, by bus and that’s not easy. So anyway they didn’t buy it. They figure that the college is supposed to set up a way to over-cross all the barriers so therefore I don’t have a claim to needing to take the course.

Despite experiencing barriers in accessing skill and capacity development programs, the participants of the study described the importance of improving skills and capacity in order to access employment. Skills and capacity development were different from taking short term courses or going back to school and upgrading education. For Linda, taking some
training courses through the Women’s Resource Center were helpful as she learned more about the law and how to better take care of her child:

from the courses we did and things like that, the women resource center can be very-very helpful in that aspect, like the time I came from a lawyer that I could ask the questions as to what I need to do in case something happen what I need to do for my child. These are things that don’t just go to a lawyer you can’t just go up and ask.

Linda believes that joining self esteem classes for women will help her to develop her skills, increase her self esteem and sense of belonging to the community. Similarly, Xantha took some skill development courses through Niagara Regional Housing. She found the courses really helpful:

I’ve actually done a very smart thing. They have offered skills for success program. It’s being offered through NR housing, started last week here in a unit... it’s a ten week program, I will get a certificate at the end, and this gearing towards jobs and employment... it’s about budgeting, legal matters, self care, self-esteem, healthy relationships and communications, all the things that I think just putting focus on self.

Xantha considers the skill development course as an important opportunity for her to learn more about developing her skills and found the course exciting. Xantha looked forward to taking more skill development courses. She states, “this is an opportunity, so I’m doing it and it’s exciting”.

Social Isolation and the Impact on Other Determinants of Health

As reported in the literature, individuals often experience social exclusion when they are not part of mainstream society and lack social support networks (family, friends, community, and employment) (Shookner, 2002). Social inclusion challenges community support programs to focus on how an individual’s own network of people and interests can help them heal by removing barriers and factors which lead to exclusion (Butterworth & Berry, 2004). The experience of social isolation was a challenge that most participants experienced in their access to community support services. A well built social support
network contributes to women’s personal and social empowerment (Worell, 2006) and increases their chances of social inclusion (Freiler, 2002; Galabuzi, 2004; Richmond & Saloojee, 2005). A lack of social support and unemployment contribute to an inability to participate in society and the conditions that increase risks of social exclusion and poor health (Raphael, 2004; Wilkinson & Marmot, 2003).

Findings from this study indicate that participants with a better social support network (such as family, community and friends) had higher participation in the community and a more positive perception of self, compared to participants without or with limited social supports. The participants with a lack of social support reported experiencing social isolation.

Almost all the participants have gone through experiences of social isolation; however, four participants (Christine, Mandy, Linda and Leeanne) also described some positive experiences of accessing community supports that resulted in social connections. For these participants the availability of certain community support services had a positive impact on their access to other social determinants of health. Linda’s experience of accessing supports was positive as she adds:

*I do have to go to Community Care to help us with food. I went to Women Resources Center. It was just amazing the speakers we had in there and it helped me learn how to point my child in the right direction...the women resource center can be very-very helpful in that aspect, like the time I came from a lawyer that I could ask the questions as to what I need to do in case something happen what I need to do for my child. These are things that don’t just go to a lawyer you can’t just go up and ask*

Similarly, through ODSP Mandy was able to access counselling services and assistance with paying for her medication:

*I do get a little bit of Ontario Disability...they help you out a lot more, like there’s counselling there, they pay for your medication, which is a great deal with me because I am on too much medication...and they will help with other things too, which makes a big difference.*
Mandy further explained that the counsellor she had was really helpful and Mandy felt comfortable talking about her problems. Similarly, Leeanne valued the social support received through her counsellor. She described that her counsellor was very sympathetic and supportive as she adds, "she has always treated me like a person, like in a lot of ways she is always accessible to me, either through email or the phone and she is not afraid to say anything personal about herself."

Christine’s positive experience included connecting to different community resources through a women’s shelter. In addition to providing support for Christine to find a lawyer and housing, she described:

[the women’s shelter] was helpful and kinda make sure that everything happen...they just issued me a cheque for 125 dollars to go get my beginners (driver’s permit)...[the women’s shelter] has been very-very helpful one hundred percent. I couldn't have done all without their help. There is no doubt.

Christine described how satisfied she was with the level of help she received from the women’s shelter as she stated, “(l)ots of single moms who have been married are a lot younger than I am, they curse the system and the system has been great with me...they are going to help you as much as you help yourself.” Christine also described that she was supported by OW to pay her bills in some situations:

My cheque was $839 a month my rent was $800 dollars. I paid five or six hundred dollars a month because I had to feed my kids so I figured that something is better than nothing and then after three of fours months they’d tell me they were going to take me to court. I’d called my welfare worker and I’d say “can you pay this” I can’t pay it and they paid it for me. Nobody else would do that.

Despite having some positive experiences of accessing social support, Linda, Mandy, Christine and Leeanne also shared experiences of social isolation. The experience of social isolation included: difficulties finding social connections, lack of social support networks such as family and friends, and a lack of support from community support services. Almost
all of the participants reported experiencing social isolation and/or lack of social support network; however, it was more common among some participants including Xantha, Wendy and Connie.

Almost all the participants (Christine, Connie, Xantha, Wendy, Mandy and Linda) experienced isolation due to a lack of family supports. In addition, Wendy, Mandy and Connie also described a lack of community support as well.

Christine felt that she had no where to turn due to a lack of family support and economic barriers after separation from her husband. She added, “I’ve no family here I am by myself I had no where to turn...it’d been disruptive enough with the changes of him leaving and the money and the vehicle...everything changes.”

Similarly, Linda spoke about experiencing challenges of isolation as she did not have family in the geographic area in which she lived. However, she believed that having family support is crucial because she had been struggling with being lonely, “I am alone, I have no support system, I don’t have anyone to help me out, unless I pay for help and my finances are—are very—very bad.” Mandy and Connie also talked about the challenges of living in isolation due to a lack of support from family and friends, Mandy states:

I have laid here for more than two years by myself. But I wanted to get out but no where to go other than like I will go walking, but when you don’t have any friends or you don’t have any family what you do...sometimes they need a shoulder to cry on, and sometimes, they just, they need to hear, you’re doing okay.

Connie states:

My children grew up without me because I had to work weekends and now that I’m not my son’s gone, my daughter hardly associates with me at all unless I’m taking her shopping...You know, I’m dealing with empty nest syndrome.

Similarly, Xantha experienced the challenges of isolation; she spoke about a lack of family support. Her closest family member was her sister who lives 3000 miles away.
Wendy also reflected on having a lack of family as well as friends support. She added that her family members are not supportive and they live in Toronto. Wendy also talked about the experience of rejection from her family. She added that she does not feel special to anyone. Wendy spoke about experiencing isolation as she had limited choices and opportunities to return to work. Similarly, Mandy explained that a lack of social support can hinder the search for housing:

...trying to get out my self and look at housing and I want to get into seniors but I am not old enough and it is just a real hassel and I want, it is just terrible the housing is terrible...I would love some kind of support system, I really would love a support system.

Connie described the experience of isolation and indicated having a poor sense of belonging to the community. She feared being around people after the experience of assault in the work place. Connie did not feel comfortable going out alone:

I don’t go out. I hate going shopping. I have to, to have somebody with me...I like going to a bank machine at night when nobody’s around. I don’t as much as I’d like to go out for a walk, ride my bike, take the dog for a walk, I feel intimidated...

A common theme that emerged from the participants’ narratives was their hope for social connections. Despite experiencing the above mentioned challenges in accessing social supports, the participants indicated their future hopes for social connection through employment, volunteering, upgrading education and access to support services.

The goal of returning to work for Mandy was about having a better social support network. She described the need for progressive supports, "I would love some kind of support system...some people have family. I don’t." Mandy explained that she is hoping to be able to work for a department in the public health system. Mandy also described a need for a place in the community where women her age can come together and share their stories and learn
from each other's experiences. Mandy explained that she is passionate about working in such a place and sharing her experiences with other women.

Xanther explained that staying at home is really stressful for her as she hoped to connect with people and access some support services as soon as she overcomes her housing challenges (moving to a new house). She further explained:

_I have a lot to look forward to and I'm excited, I mean I'm going to be very excited if I can actually go out to work. . .I'm hoping to utilize to do the step program. . .I don't know, I may be introduced to other things in the community through the March of Dimes, so that's, will be another avenue._

Similarly, Julia hoped to connect with people through employment. Even though she is trained as a paralegal, she felt that she lacked awareness and skills in searching out available jobs and the social networks to connect with potential employers.

**What Will the Future Bring?**

The findings from the study revealed the women's common experiences of uncertainty about the future. However, despite the barriers in the participants' past and present lives, most of the participants expressed their hopes for overcoming these barriers in the future and gaining access to the broader social determinants of health. The focus here is on the stability that is created by the presence of the determinants of health in their lives. The women's main focus in their future hopes was on expanding their social connections, finding employment and no longer being a recipient of social assistance. However, some of the participants expressed their concerns about an inability to return to work due to a lack of employment opportunities in their local communities, fear related to trauma, and chronic pain and fatigue related to disability. Most of the participants indicated hopes for getting into an affordable housing facility, and hopes for upgrading their skills and education as part of their future plans. The participants, who were interested in returning to employment, indicated the
importance of having a mentor in facilitating the process of employment for them. The idea of having a mentor for most of the participants was about broader community connectedness, access to community supports and social support networks. Most of the participants emphasized the importance of having a female mentor. The participants believed that female mentors may have a better understanding of the challenges involved in women’s lives.

The women indicated their desire to minimize the challenges of social exclusion in their lives and to increase their social connections. A general reflection of their hopes is illustrated in Julia’s words:

...women that are alone in their life whether they are bringing up children or whether it is in the situation I am in [not bringing up children], to could get involved together, be able to feel needed, wanted, get help, be able to get away from our situation. Whether it is playing cards, playing games, exercising together, doing a club together [and] crying together.

A Model of Social Inclusion and Social Exclusion for Women Who have Experienced Trauma

The results of this study clearly articulate the experiences of social exclusion and inclusion among women who have experienced trauma. The findings indicate a close relationship between the women’s personal lives and their social connections and interactions. In most of the participants’ cases, ignoring their personal life issues contributed to their experience of social exclusion and isolation from their communities. A lack of balance between the women’s personal and social life also resulted into experiencing more mental health issues and difficulties finding social connections. These findings clearly demonstrate the experiences of social exclusion among the participants in the past, the possibility of further isolation in the present, and feelings of uncertainty about what future will bring.
A conceptual diagram of social inclusion and social exclusion for women who have experienced trauma is presented in Figure 2. The purpose of this diagram is to give an overall picture of the impacts of trauma on the participants’ health and their experiences of social inclusion and exclusion in accessing supports. The diagram brings together the existing literature and the findings from this study. This model can be used by community support services in designing initiatives focused on social inclusion for women who have experienced trauma. The conceptual diagrams in Figure 2 and 3 were developed based on discussion of the conceptual framework in the review of literature in Chapter Two. Previous experiences of trauma, disability and mental health issues are linked to the impact of the past on present circumstances, lack of recognition to diversity is linked to a lack of accommodation of difference, barriers to social cohesion are linked to maintaining a sense of self in world of assumptions and labels. Access to the social determinants of health differs among the participants and is linked to social inclusion. The lack of access to the social determinants of health is linked to social exclusion.

The conceptual diagram helps us to understand the experiences and processes the individual goes through in the movement toward social inclusion and away from social exclusion. We can place different participants in the circles in Figure 3. The circle in the center of the diagram reflects the participants’ previous experience of trauma. Most of the participants in this study in addition to the experiences of trauma in their past also experienced disability, and mental health challenges which might have also played a role in increasing their risks of social exclusion. Individuals closer to the center of the diagram are more vulnerable to the experiences of social exclusion (e.g., the different components of
social exclusion shown in table 1). Based on the participants’ experiences, it is evident that social inclusion and social exclusion are not binary opposites.

As reported in the literature, individuals’ exposure to trauma can lead to troubling memories, intense fear, panic, or a sense of helplessness, social isolation, and a long-term trauma can lead to the development of Post Traumatic Stress Disorder (PTSD) (Alisen, 2003; Allen, 1995; CDC, 2003; Sanchez-Hucles & Gamble, 2006; van der Kolk et al., 1996; Yule, 2001). In Figure 2, the circle in the center of the diagram articulates the participants’ previous experience of trauma and its impacts on their health. This includes psychological, physical and social health as experienced by some of the participants when they described their experience of PTSD, depression, fibromyalgia and social isolation. Trauma also has an impact on economic health as reported in the literature and described in the findings.

Community support services may be designed for women who are in search for relationships or groups within which they can seek inclusion and belongingness. This sense of belongingness will allow them to restore their self-esteem and self confidence so that they can continue a normal life by being in control and creating a positive social identity (Abrams et al., 2005). The second circle shows the participants’ personal conditions, which reflects their internal conditions, feelings, hopes, aesthetic reactions, and moral dispositions. The participants in the study described barriers to social inclusion as part of their personal conditions in the past and present. These barriers included: barriers to social cohesion such as poor sense of belonging, fear of being labelled, and lack of accommodation of difference and barriers to diversity (see Figure 2).
Figure 2. A revised conceptual diagram of social inclusion and social exclusion for women who have experienced trauma.
Wilkinson and Marmot (2003) identify barriers to participation and conditions that contribute to and increase risks of social exclusion and poor health. These barriers include experiences of racism, discrimination, stigmatization, and unemployment, which prevent people from full participation in the society (e.g., education, training, access to community support services) and are significantly harmful to individuals overall health and well-being. Removing barriers for participations means all individuals (people with disabilities and people without disabilities) have the right to a normal life and chance of equal living, as well as the right to have access to social determinants of health and the choice to participate in different cultural or leisure activities (Raphael, 2004). As reported in the findings the participants’ experienced barriers to participation and they hoped for broader social connections and increased access to support services as part of their future hopes.

The third circle in Figure 2 includes different themes described by the participants’ after their experience of trauma as part their experiences of social exclusion (present). The third circle also depicts the participants’ social interaction with their environment and with other people (social workers, family and friends). Under the theme related to the determinants of health, five sub-themes are explored: access to income and the stress of negotiating the welfare system, to work or not to work, stability and instability in housing, the need for broad educational supports, and social isolation and the impact on other determinants of health.

According to Frazee (2003) social inclusion reproduces a practical approach of human development which not only removes barriers and maintains social well-being for individuals, but also promotes action and facilitates ways for creating an inclusive environment. As reported in the literature, barriers to participation include: experiencing
marginalization from society, institutional dependency, limited choice, lack of access to community resources, having no role in decision making on issues (social, political, economic, and cultural) that affect their lives (Shookner, 2002; Warburton et al., 2001).

The barriers to social inclusion described by the participants in the third circle of Figure 2 included barriers to services and support, barriers to skills and capacity (economic barriers), and barriers to citizenship and participatory democracy. The fourth circle of conceptual diagram reflects the system that includes different community support services the participants accessed (See Figure 2). Social inclusion challenges community support programs to focus on how an individual’s own network of people and interests can help them heal by removing barriers and factors which lead to exclusion (Butterworth & Berry, 2004). Similarly, as reported in the findings of this study, the participants hoped for increased access to community support services and different determinants of health through increased social connections.

Despite some similarities in accessing support services each participant’s experiences of social inclusion and social exclusion are different. Even though the experience of social exclusion is significant (Connie, Linda, Xantha, Mandy and Wendy) comparing to the experience of social inclusion (Christine, Julia and Leeanne) among most of the participants, there are a lot of differences and uniqueness in each participant’s experience in accessing supports as shown in Figure 3.

Based on the participants’ narratives and experiences of the five themes, two participants’ (Connie and Christine) experiences of social inclusion and exclusion in accessing support services are described in Figure 3. Connie and Christine’s experiences are different. Most of the barriers to social inclusion identified in this study were described by
Connie. In comparison, in Christine’s experience fewer barriers to social inclusion were described and she had a comparatively positive experience in accessing community support services.

Figure 3. Two participants experiences of social inclusion and social exclusion in their access to support services.
As shown in Figure 3, participants closer to the center are more vulnerable to experiencing social exclusion. Connie had gone through multiple challenges to social inclusion such as: a loss of trust in welfare support (social assistance) due to communication difficulties, the experience of powerlessness and lack of control over her life, fear of violating the rules and regulations of support services (OW, ODSP). Therefore, she is located in the center of the diagram as she is more vulnerable to experiencing social exclusion. Christine, however, is located closer to the edge of the diagram indicating the more positive nature of her experiences with community supports (including the women’s shelter and OW). Christine indicated better access to support services comparing to Connie. Connie is not sure about what will future bring for her and she is not looking forward to returning to employment. Christine is enthusiastic about her future and she is looking forward to have connections and access to different determinants of health with support from her social worker (mentor).

**Conclusions**

Research question one was responded to in the themes: impact of participants’ past on present circumstances, lack of accommodation of difference, maintaining sense of self in a world of assumption and labels and impact of trauma on the determinants of health. Research question two was responded to in the discussion of the following themes: access to income and the stress of negotiating the welfare system, to work or not to work, stability and instability in housing, the need for broad educational supports, social isolation, and the impact on other determinants of health.
The third research question that this study explored was: What is the women’s perception of changes needed for community support services to increase their social inclusion? As reported in the literature, social inclusion includes dynamic participation by people, equality of opportunities, and basic levels of well-being (Frazee, 2003; Guildford, 2000; Sen, 2000), so that people despite their race, colour, employment, educational or health status can develop programs based on their needs, collective power and resources (Askonas & Stewart, 2000; Canadian Mental Health Association, 2006; Minkler, 1997). The findings of this research support that there is little or no participation from the women in developing the programs that affect their lives (welfare, employment help, skill development, housing etceteras). In addition, participants further described a lack of control over their lives in accessing community support services. Almost all participants indicated a need for increased levels of aid and support. This included access to different determinants of health such as employment support services, social support, increased educational opportunities, and access to affordable housing. In addition, some of the women wanted to find different ways (beyond participation in the labour market) to participate in community and to make a contribution. Although some women were not able to return to paid work they were keen to volunteer as part of their contribution to their communities. Some participants were also keen to provide mentorship for women who have gone through similar experiences of trauma. Some participants also would like to see system changes with regard to the rules and regulations of the welfare system. (See Figure 3, the differences between Connie’s and Christine’s experiences of social inclusion and social exclusion in accessing support services.)

As reported in the literature, social cohesion is about creating progressive opportunities for shared values, shared challenges and equal opportunities. It is also about
social belonging, participation in local community, and recognition of individuals’ diversity and legitimacy (Social Cohesion Network, Policy Research Initiative, 2003).

As reported in the literature, all citizens are entitled to equality rights (lawful treatment, equal protection and benefit), democratic rights (participation in political activities, and decision making), legal rights (access to lawyer, interpreter in court, reputed innocent unless proven guilty by law), mobility rights (choice of living and moving within the country or living outside the country), language rights (access to the official languages, French or English in dealing with Canada’s federal and provincial governments), minority language education rights (to receive education in one’s own language) (Citizenship and Immigration Canada, 2005). However, the participants in the study described the need for community support services to give valued recognition to their differences, for example giving recognition to the participants’ issues of trauma, abuse, disability and mental health issues. The participants suggested that decision makers create supportive systems, programs, and resource allocations that consider differential treatment. Further the participants expressed the desire to have the freedom to make choices, to achieve their existential hopes, and to have their opinions and expressions of their needs to be heard.

Social inclusion in these women’s experiences is not merely about returning to paid employment, upgrading and updating their education and leaving welfare supports. It is about valued recognition, it is about social connections, it is about increased access to community resources, it is about the freedom of making choices, it is about the removal of barriers (economic barriers, physical barriers, functional barriers and political barriers). As reflected in words of one woman:
being treated like we’re still of value, and we’re still people, and we’re all not abusing the system, and we are trying to make things better, and we may make poor choices, because of where we’ve been doesn’t mean we’re a bad person, or we’re a bad parent.

Implications of the Study

Research into the quality of services provided by social assistance programs such as OW and ODSP for women who have experienced trauma has been relatively neglected until recently (Mosher et al., 2004). Most research tended to focus on the development of more specific programs and services such as general health care (cf. Commonwealth Fund’s Surveys of Women’s Health, 1998; Family Violence in Canada, 2005; Public Health Agency Canada, 2005; Statistics Canada, 2005). However, as reported in the literature, a body of evidence suggests that the health status and quality of life among women may be improved through better quality of community support services, integration of services and more encouragement of women who have experienced trauma (WHO, 2006). There is also a fundamental need for the development of more specific interventions and community support services for women who have experienced trauma (Mullender & Hague, 2001).

Drawing on the findings and discussion of this study, implications arise in three main categories. First, there is a fundamental need for more specific interventions and community support services for women who have experienced trauma (Mullender & Hague, 2001). Based on participants’ experiences of social exclusion in their access to community supports, it would be important for community organizations to address the barriers and challenges that are often encountered. To recognize individual difference, there is a need for training programs for people providing community supports (social assistance, counsellors and other staff members) about trauma, abuse, disability and mental health issues. In addition, there is a need for more sensitivity towards women’s differences and the provision of safe and
confidential opportunities for communication which will help them achieve their future goals. There is also a need promote alternative conflict resolution strategies, specialized services with knowledge about domestic violence and coordination of court and community services.

Second, social policy would be strengthened by adopting a social inclusion approach for individuals who are at higher risks of social exclusion by providing economic opportunities for this group and improving their access to community services. As illustrated in the definition of social inclusion by Saloojje (2005), all the different dimensions of social inclusion need to be considered in developing social policy. Policy makers need to think about ways to remove or minimize the barriers to social inclusion for those who are excluded from mainstream society and are disadvantaged (e.g., individuals with experience of trauma, disability and mental health problems). Social policy makers (specifically for OW and ODSP) might consider increased attention to the needs of women with multiple traumas (abuse, mental health problems and disability) in the development of policy. As reported in the findings of this study, employment goals were different for each participant. However, almost all participants were interested in returning to paid or volunteer employment. Therefore, it is crucial that flexible policies with maximum options for individuals should be in place that can respond to their individual interests (volunteer or paid). More volunteer opportunities might be provided for individuals based on the identified barriers in their paths toward employment. However, more community support services and social support groups should be available in the community to provide awareness and support. These supports may then also create informal connections that enable the women’s access to support services and community resources. A specific community support that most of the participants reflected
upon was having a mentor. Most of the participants reflected on having female mentor who will provide them with moral support and connections to community resources (employment, housing) and social supports. Therefore, social policy makers might also consider the importance of having a supportive mentor in increasing individuals access to social inclusion and reducing their risks of social isolation. A practical example of the impact of mentor in increasing access to social inclusion can be seen in Christine’s experience with the women’s shelter. In addition, as described by the participants with transportation barriers, removing transportation barriers can increase their access to support services and contribute to their experience of social inclusion.

Third, as reported in the literature, participation in the process of decision making around the issues that affect their lives (employment, education, health and other determinants of health) may result into positive changes in individuals’ lives and increase their representation and voice. The findings from this study clearly demonstrate the experiences of participants who were on OW and/or ODSP and were not provided with adequate information about the services and options available for them in the community. Further these women only knew about the penalties from social assistance programs. To address the stress of negotiating the welfare system, some awareness programs need to be initiated for women who are recipients of OW and ODSP so that the rules are clear and comprehensible. In addition, the women’s knowledge should not be limited to knowing the penalties for reduction in monthly payments, but also the underlying benefits.

**Strengths and Limitations of the study**

The use of narrative inquiry to illustrate various aspects of participants’ perceptions, experiences and stories of accessing supports in a rich thick descriptive way helped to convey
a sense of realness and immediacy to the nature of each individual’s experience. As reported in the literature, there is an emphasis on the need for social inclusion research that incorporates the voices of people belonging to marginalized groups (Stanley & Wise, 1997). The insight from this study into the participants’ experience of social inclusion will contribute to the literature on social inclusion for women who have experienced trauma and are on social assistance. Examining the intersections between the women’s experiences of trauma, social inclusion and social exclusion adds to the literature on trauma.

Additionally, the previous experiences of the researcher about abuse related trauma and qualitative research made this narrative inquiry a more engaging, meaningful, and provocative study. Here, the participants’ experiences of social inclusion and exclusion were studied from broader issues affecting different dimension of social inclusion for example, social cohesion, citizenship, barriers to social inclusion, rights and responsibilities, differences, democracy, injustice and inequalities.

Another strength of the study was the attention paid to techniques for establishing trustworthiness in qualitative research as suggested by Lincoln and Guba (1985). Patton (1997) defined credibility as, “a complex notion that includes the perceived accuracy, fairness, and believability of the evaluation” (p. 250). In addition, credibility can be established, in part, by stating clearly the procedures by which the study was conducted, the data was analyzed, and the conclusions were drawn (Patton, 1990). To ensure credibility, this study was based on multiple comparisons between the participants’ (similarities and differences in their experiences of social inclusion and social exclusion). Reflections of the experiences of social inclusion and social exclusion among the participants in their own words (verbatim quotes) added to the credibility and validity of this study. Using multiple
sources such as eight participants' interview transcripts that were selected through purposeful sampling, including a wide range of participants of different ages, with different experiences provided rich description of their experiences of social supports. The use of multiple methods (Three Dimensional Space Narrative Approach and thematic analysis) added to the credibility of the study. In addition the bi-weekly meetings with my thesis supervisor added to the credibility of the study. In doing so, I became more aware of alternative interpretations of the data.

The findings were reported in a thick and descriptive way that can add to transferability of the results to similar situations as described by Patton (2002). Lincoln and Guba (1985) defined transferability, as whether or not the research is useful in another situation, and it is demonstrated by the use of thick, rich description. In this study, the context of the study and the characteristics of the participants have been described. However the degree of transferability will depend on identified similarities between the two contexts.

Other strengths of the study included dependability. According to Guba and Lincoln (1985) dependability can be established through the development of an audit trail. Dependability was addressed through systematic process of data analysis using the QSR NVivo software for all the participants. Creating the audit trail using NVivo enabled the researcher to verify different steps in the process of data analysis/interpretation as well as the logic and chronology of the research process.

Despite the strengths of the research (as mentioned above), a technique known as 'persistent observation' suggested by Lincoln & Guba (1985) was not incorporated in this study due to the fact that the study was based on a secondary data analysis. Although the
member check was incorporated by the Principal Investigator, a member check of the themes that emerged in this thesis (secondary data analysis) was not carried out.

**Future Research**

Despite the limitations noted above, the findings presented in this study represent a first glimpse at the experience of social inclusion and social exclusion among women who have experienced trauma in accessing community support services. To that extent, they can be used to develop hypothesis research questions that can be explored in future research. A direction for future research would be a study of the perceptions of workers and counsellors in the community and social assistance support organizations (e.g., OW, ODSP) with respect to women who have experienced trauma. This will help provide more in-depth insight into women’s experiences of social inclusion and exclusion as well as the efforts of community support workers.

There is also a need for more specific research on the impacts of multiple traumas (disability, abuse, mental health issues) among women in their access to the social determinants of health. The findings from the study were explored to identify the core issues influencing women’s overall social inclusion and/or social exclusion in accessing social and community support services.

While this research has added to our knowledge of experience of social inclusion and social exclusion among the participants, there is further need to identify policies that will help support women in similar situations to increase their social inclusion.

In addition, more research is needed to broaden and deepen the attention given to the issues of experiences of social exclusion among women who have experienced trauma. It also important to explore the root causes of social exclusion (e.g., exclusion by institutions,
social policy, social attitudes and values, power differences among groups) for women who have experienced trauma.

Although this study contributes to the literature on social inclusion and social exclusion among women who have experienced trauma, additional research conducted with a broader populations of women who have experienced trauma will help to document further the impact of trauma on the broader determinants of health.

The conclusions of this study also bring forth some fruitful and interesting possible avenues for future research that might be explored in relation to the themes of the study. The most important avenue for future research lies in the longitudinal examination of social inclusion and/or social exclusion among these participants in the future.
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APPENDIX 1: UNSTRUCTURED INTERVIEW GUIDE

Section 1: The complexity of women's lives

1. Can you tell me a bit about yourself?
   What do you enjoy doing?
   Do you have children?
   Can you tell me about the part you play in your family? What sort of obligations do you have at home?
   Do you provide care or support for someone else in your community?
   Who do you go to for help?

2. What is a typical week like for you?
   Time spent volunteering or doing community participation through Ontario Works?
   Time spent doing things for other members of your family (e.g., children, caring for an older family member)?
   How much time do you spend doing work that you are paid for?
   Who looks after your children while you work?

Section 2: Women's goals and hopes for paid employment

3. In terms of paid work or employment, where are you at right now? What types of paid jobs have you had?
   Are you currently doing work for which you are getting paid?
   Can you tell me about your current job/your previous job?
   How long have you been looking?
   How long have you been unemployed?

4. What are your hopes and goals around employment, or a job? What kind of work are you hoping to find?

5. If you achieve your hope/goal, what will that bring to your life?

Section 3: Need for employment supports.

6. We talked about where you are right now, and where you would like to be in terms of paid work, what do you need to help you get there?
   What would you need to do that job?

7. What limits your choices in the type of paid work or employment you can pursue? What life issues keep you from keeping paid work?

8. When you think about paid work, what factors will make it difficult for you to achieve your goal?


...
Some of the factors that women spoke about (external) include... do any of these apply for you?

- lack of available service
- transportation
- childcare
- lack of support from family
- lack of connection
- differences in communication styles between men and women etc.
- not be valued based on race, sexual orientation

Some of the factors that women spoke about (internal) include... do any of these apply for you?

- illness or disability
- abuse-related trauma
- feel like I have no skills to contribute
- unsure where to look for paid work
- negative self-talk

9. Do you feel like you have choice and control over your paid work? What would help you increase your choice and control over your paid work?

Section 4: Preferences around supports for paid work

10. When you were looking for a job did you have help? Who helped you? In what way?
    Did you go somewhere official, to an agency, for help?
    What other employment services have you accessed? What have you found useful in terms of job skill training?
    Did it help you to move along? Did it help you connect to paid work? Gain a new skill or knowledge?

11. Have you used a mixed service for both men and women?
    Were you able to speak about the issues that affect you? What was your experience like?

12. If you had a choice would you use a women's only service? How would this type of service be helpful to you?

13. Have you used a women's only service?
    If yes, was it useful or helpful? How so? Did you feel like you were moving along?
    How important would a women's only service be to you moving forward?

14. Do you prefer services that are done as a group, or individually (1:1)?

15. As you are trying to move from where you are now, to where you would like to be, would you find having a mentor useful?
    What would this mentor provide you with?
What would you want this person to be like? Would you prefer that this person, this mentor, were a man or a woman? Why?

16. Is there someone that you go to for support and advice? Can you tell me a bit about this person?
   - If yes,
     Has this person, or someone else, helped you to find paid work? How did they help you? (e.g., help you connect with a job, help with a resume, help you by looking after your kids)
   - If no,
     Do you know someone who can provide you with employment support or access to a network?

Section 5: Impact of social assistance and supports on paid work.

17. Are you currently receiving government income support (e.g., Ontario Works, ODSP, EI) or support payments from an ex-spouse/partner?
   How has it helped you in your daily life?
   How has it affected your ability to engage in paid work?
   How has it not been helpful?
   What are the barriers you experience as a result of being on OW/ODSP? (e.g., rules or restrictions, stigma) Are levels of support adequate?

18. Do you require other supports or accommodations due to a disability or illness? How do they affect your ability to engage in paid work?

19. How has your experiences with Family and Children’s Services (FACS) affected your ability to engage in paid work?

20. Are you happy with your current housing? How does it impact your ability to engage in paid work?

21. As an individual, if you could send a message to decision-makers about the supports that are available to you, what would that message be?

22. Do you have any other thoughts or ideas that you would like to share?