EXPLORING THE LIVED EXPERIENCES OF SEXUAL MINORITY WOMEN IN EMERGING ADULTHOOD WHO USE SUBSTANCES

by

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ABSTRACT

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Under the Supervision of Dr. Virginia Stoffel

Substance use disorders are growing in prevalence globally, including in the United States. Sexual minority women (SMW) (women who are lesbian, bisexual, asexual, pansexual, queer, questioning, etc.) have increased rates of harmful substance use and disparities differing from heterosexual females. Additionally, substance use in emerging adulthood (between ages 18-29), is often high, with SMs having an increased risk for harmful substance use. This is a critical period in which to evaluate substance use for SMW. While occupational science and therapy have important roles in addressing substance misuse, practitioners report challenges with working with persons with harmful substance use and varying sexual identities related to a lack of education, comfort, and competency. This results in the need for research informing practitioners of populations' substance use-related needs (including SMW) and expanding our professional conceptualizations of substance use.

This study explored the lived experiences of student SMW in emerging adulthood who are using substances and explored women's recommendations regarding their preferred approaches to healthcare interactions. This was accomplished through the implementation of Photovoice methodologies and phenomenological interview methods. Twelve women explored their substance use experiences and service needs, with reflexive thematic analysis used to generate resulting themes. Women who participated served as co-researchers across the study. Member checking was

conducted to assess the acceptability and trustworthiness of the study themes and recommendations. Co-researchers who engaged in the study explored their personal substance use patterns, defined misuse, and detailed personal coping strategies for addressing misuse. Women also discussed the impact of familial, religious, and discriminatory factors on their substance use, including the role of substance use in the queer community, their experiences with healthcare providers, and the mutable relationship of substance use as a stand-alone occupation and influencer of others.

Co-researcher recommendations for healthcare providers included creating safe, intentional spaces to discuss substance use/sexual identity, practicing with love, and providing women with beneficial resources. These findings must be directly applied within our occupational science and therapy practices in improving the lives of SMW, with initial steps for this implementation outlined in this work.

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I dedicate this work to:

The women who selflessly guided this study in sharing their experiences and expertise.

To my husband Nick, the great love of my life, and my unconditional supporter.

To my steadfast parents Kathy and Bob, and brother, Hayden.

To every friend and colleague who walked with me on this journey.

To every queer woman looking for her voice to be heard, and to those who continue to experience challenges in being seen, accepted, and cared for.

This is for you.

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LIST OF ABBREVIATIONS

OS	Occupational Science
OT	Occupational Therapy
OTP	Occupational Therapy Practitioner
PAR	Participatory Action Research
PEO	Person, Environment, Occupation
SM	Sexual Minority/Minorities
SMW	Sexual Minority Woman/Women
SUD	Substance Use Disorder

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“Because love is an act of courage, not of fear, love is a commitment to others. No matter where the oppressed are found, the act of love is commitment to their cause--the cause of liberation”

(Paulo Freire, 2018, p. 89, as cited in Freire et al., 2018).

Chapter 1: Introduction

Statement of Problem

Substance use disorders (SUD) are growing in prevalence across the world (United Nations Office on Drugs and Crime, 2023), including the United States (U.S.) (Substance Abuse and Mental Health Services Administration (SAMHSA), 2022, 2023). In looking at individual U.S. populations experiencing harmful use, women's behaviors differ from men's, requiring unique approaches to assessment, care, and provider interactions (e.g., Blume, 1991; Campbell et al., 2007; Cottler et al., 2001; Elms et al., 2018; Gartner et al., 2018; Green, 2006; SAMHSA, 2020; Wechsberg et al., 1998). With the addition of varying identities, specifically sexuality, sexual minority women (SMW) (women who are lesbian, bisexual, asexual, pansexual, queer, questioning, etc.), demonstrate an even greater risk of harmful substance use and disparities in behaviors and care when compared to heterosexual females (McCabe et al., 2009), with factors such as discrimination playing a significant role in SMW's levels of use compared to heterosexual women's (Krueger et al., 2020).

In looking at substance use patterns within the period of life commonly referred to as emerging adulthood (the period between age 18-29 (most commonly 18-25) (Arnett, 2014; Arnett et al., 2014)), use is often at its highest (Kessler & Wang, 2008). The substance use behaviors within this age group have been tied to increased independence (Goodman, 2014; Stone et al., 2012) potential new responsibilities in caring for others (Goodman, 2014), peer pressure, and stress (Andrews & Westling, 2016). Within the sexual minority (SM) population, individuals in emerging adulthood, particularly those who identify as a minority at the start of this period, and who lack familial support surrounding sexual identity (Rosario et al., 2014), may be at increased risk for harmful substance use behaviors compared to their heterosexual peers

(Talley et al., 2010). One hypothesis related to these differences in use behaviors and increased risk of harmful substance use for sexual minority women includes minority stress theory (Brooks, 1981; Meyer, 2003). This theory posits that stress from negative internalized views of the self (Amadio, 2006; Lewis et al., 2012), strain on one's mental health, (Irwin, 2009; Lehavot & Simoni, 2011), and negative societal behaviors surrounding gender expression (Herek, 1995) can result in potential increased levels of harmful substance use (e.g., Dyar et al., 2022; Lehavot & Simoni, 2011). In focusing specifically on those in emerging adulthood who are students in higher education, substance misuse occurs at higher rates than non-collegiate individuals (Skidmore et al., 2016), with sexual minority students demonstrating heavy use (Conner et al., 2022). Emerging adulthood and a focus on students, therefore, serves as a critical period and role in which to address substance use, including within the sexual minority community (Andrews & Westling, 2016; Conner et al., 2022; Rosario et al., 2014; Skidmore et al., 2016; Talley et al., 2010).

The profession of occupational therapy (OT) emphasizes services to "improve well-being, health and social participation through occupations" and examine and address the effect that substance use has on one's occupational engagement (Doğu & Özkan, 2023); it is a profession that is well situated in collaborating with individuals and communities to examine their substance use given the "complex" factors surrounding substance use and our varied practice skillsets (Davies, 2006). Despite the profession's positioning in addressing substance use (Amorelli, 2016; Davies, 2006; Doğu & Özkan, 2023; Kiepek, 2016; Stoffel & Moyers, 2004), occupational therapy practitioners face challenges in meeting the needs of persons with SUDs or harmful substance use (Amorelli, 2016; Stoffel & Moyers, 2004). This issue centers on our profession's education on, competency, and comfort in addressing substance use (Amorelli,

2016; Blanco et al., 2015; Mattila & Provident, 2017). The OT profession (and our societal lenses), tend to view substance use disorders as specific to the person (a disease) rather than a large scale, systemic health issue (Godoy-Vieira et al., 2018; Hyman, 2014; Spiegel et al., 2015). In shifting from this person-centric view (Godoy-Vieira et al., 2018; Hyman, 2014; Spiegel et al., 2015), some have noted that the profession might consider viewing substance use broadly, as an occupation in which individuals participate (Helbig & McKay, 2003; Hocking, 2020; Kiepek 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014), akin to other occupations, such as dressing, sleeping, and engaging in social interaction, which will be explored in this dissertation work. Historical OT practice emphasis on occupations that are considered “positive,” (Hart, 2020; Hocking, 2020; Kiepek et al., 2014; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2013, 2020a,b, p. 1), can lead to an avoidance of addressing occupations assessed as “negative” by the profession (Hart, 2020; Hocking, 2020; Twinley, 2013, 2020b, p. 1) including substance use (Hart, 2020; Hocking, 2020), despite such occupations carrying positive attributes and serving as identities for individuals (Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2020b, p. 7; Wasmuth et al., 2014).

In addition to the challenges present in addressing SUDs (Amorelli, 2016; Blanco et al., 2015; Hyman, 2014; Mattila & Provident, 2017), provider comfort and competency surrounding serving SM individuals is similarly lacking, (Bolding et al., 2022). Current challenges in this arena include inadequate access to quality educational resources (Hansen & Himley, 2020), and a shortage of information on what continue education learning providers are interacting with how often they are doing so (Bolding et al., 2022). Occupational therapy practitioners can also hold

personal biases and stigma that make the incorporation of sexuality and gender into care a difficulty (McGrath & Sakellariou, 2016). These shortcomings within our profession have consequences for SM individuals, with disparities in care resulting in increased risk for negative health outcomes including mental health diagnoses, harmful substance use, homelessness, and more (Tschurtz & Burke, 2011).

In strengthening our profession's (and the healthcare community's) approach to and understanding of SMW in emerging adulthood's experiences with substance use through qualitative, person-driven means, a participatory action research (PAR) emphasis (McIntyre, 2008) was upheld across this study. Through a PAR lens, demonstrating respect and co-defining roles across the study members is an important aspect of enacting community-member driven research (McIntyre, 2008, pp. xii-xiii, 15-32). While an explicit discussion with each woman who participated in the study regarding what their desired role identity did not take place given the individual nature of how the women engaged in the study (McIntyre, 2008, pp. xii-xiii, 15-32), I provided each woman with verbal emphasis on their ability to enact autonomous decision-making across the study, shape the study findings, and create recommendations for occupational therapy practitioners that would be denoted in the dissertation to create an environment of empowerment and women-led knowledge-building (Hitchen & Williamson, 2015). In addition to this practice, I chose to refer to the women as co-researchers across the study process to demonstrate respect and emphasize the active leadership role the women had through sharing their lived experiences and generating the study findings and recommendations (Hitchen & Williamson, 2015; McIntyre, 2008, pp. xii-xiii, 15-32). Given this, the women who engaged in the study will be referred to as co-researchers across this dissertation work. In addition, emphasis across the dissertation has also been placed on using person-first language (e.g., "person with a

substance use disorder" vs. "addict") in recognizing that "Language has the power to shape perceptions, influence biases and attitudes, and create levels of privilege and oppression for various stigmatized groups" and looking to demonstrate respect towards all those we serve (Baker et al., 2022, p. 39).

Photovoice (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014) and qualitative interview methods (Gallagher, 2012; Giorgi, 1997; VanManen, 1990) were the primary methods of data collection used within this research, and have successfully been used across a number of different studies to explore specific aspects of the women's lived experience (e.g., Bukowski & Buetow, 2011; Drabble et al., 2015; Fitton, 2019; Miller et al., 2021; Redmond et al., 2020; Sallmann, 2010; Wright, 2003). However, these study methods have not solely focused on SMW or been within the context of OT in exploring this populations' substance use, demonstrating a need for further research. This study was implemented to address the current gap in our profession's occupational science and therapy literature and inform our profession's policies, education on, and practice regarding SMW in emerging adulthood's substance use and service access.

Purpose of Study and Research Aims

The purpose of this study was to explore the lived experiences of student sexual minority women in emerging adulthood who are at risk for, have been harmed by, or are evaluating their substance use. The specific aim of the proposed study included:

1. To examine the lived experiences of student sexual minority women in emerging adulthood who use substances.
    a. To explore co-researcher recommendations regarding sexual minority women who use substance's preferred healthcare approaches and interactions.

Lived experiences, can be understood within the context of this dissertation as building from one's "immediate" lived reality and "emerging" from "explicit retrospection where meaning is recovered and reenacted, for example, in remembrance, narration, meditation, or more systematically, through phenomenological interpretation and "inscription"" (Burch, 1990, p. 134). This co-researcher "retrospection" (Burch, 1990, p. 134) within the study was facilitated with a focus on aspects of one's lived experience that included intersecting identities, experiences, and perspectives related to substance use, sexual identity, and healthcare access. Exploration into co-researchers' lived experiences was implemented through Photovoice (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014) and phenomenological interviewing methods (Gallagher, 2012; Giorgi, 1997; VanManen, 1990).

Given this study's transformative underlying philosophical paradigm (Mertens, 2009; Mills, 1959) and application of Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) and phenomenological approaches (Gallagher, 2012; Giorgi, 1997; VanManen, 1990) across the study including emphasis on co-researchers constructing their realities (Harding, 2004a, p. 7-8; Harding, 2004b; Harding, 2004b, p. 128-130; Jaggar, 2004; Sandoval, 2004), the lived experiences focused on within the study are co-researcher identified.

Significance

This qualitative study applied a unique transformative (Mertens, 2009; Mills, 1959), occupational science lens (Farias & Laliberte Rudman, 2014; Lalibertie-Rudman, 2014, 2019;

Yerxa et al., 1990) in that such research has not yet been implemented with a combined application of the Person-Environment-Occupation model (Law et al., 1996, Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) and "Queer'ed" (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) to this populations' experiences. A transformative (Mertens, 2009; Mills, 1959) occupational science (OS) lens (Farias & Laliberte Rudman, 2014; Lalibertie-Rudman, 2014, 2019; Yerxa et al., 1990) lens was used to ground the study and tie the findings back to occupational science and therapy practice. This lens (Farias & Laliberte Rudman, 2014; Lalibertie-Rudman, 2014, 2019; Mertens, 2009; Mills, 1959; Yerxa, 1990) was used in conjunction with non-OS and OT-based approaches (Queer Theory (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) and Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sholock, 2012)) to explore the various intersecting standpoints of SMW and their co-constructed knowledge surrounding substance use, sexual and gender identity, race, familial relationships, healthcare experiences, and more in challenging the way we as a profession conceptualize substance use and all that it can be to a person and community (Lalibertie-Rudman, 2014, 2019).

The findings from the study are uniquely situated in expanding our occupational imagination (or our understanding, knowledge, and vision) surrounding substance use and all that use can be for SMW (Laliberte-Rudman, 2014, 2019). While the PEO model (Law et al.,

1996, Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) was used in conceptualizing the approach to the study activities, particularly the phenomenological interviews, across the analysis process, it became clear from women's experiences that this model was too constrictive in attempting to organize the nuanced factors influencing shared experiences, standpoints, and roles into themes, leading to important discussions about the potential shortcomings of applying this model singularly with the people we serve. This is explored in detail in Chapter 7.

The study data (Photovoice pieces, co-researcher interviews and recommendations, field notes, and workshop transcripts), have culminated in seven primary themes and co-researcher-driven recommendations for OT and other healthcare providers to better address SMW's needs surrounding sexual identity and substance use. Findings include differences and similarities across the women regarding personal patterns of substance use and definitions of misuse, as well as coping strategy use for substance use that has become harmful. Stigma and discrimination across religious, social, and healthcare spaces impacts SMW's substance use, with healthcare interactions determining future healthcare access. Substance use was highlighted as both an individual occupation and an activity that affected other occupations, and co-researchers emphasized the importance of creating respectful, safe, non-discriminatory healthcare environments for SMW to discuss their sexual identity and substance use.

It is my hope that these conclusions will be used to grow our profession's body of knowledge, education, policies on, and understanding of harmful and non-harmful substance use, particularly as substance use intersects with sexual identity. This study and its findings stand apart from previous research on SMW's substance use, given that work of this nature has not been conducted within our profession, and there is a current lack of available research and evidence-based practice surrounding SMW, their emerging adulthood substance use practices,

and their healthcare decision-making and experiences. The findings are significant in that they offer insight into the lived realities of SMW in emerging adulthood and generate actionable recommendations for OT and other healthcare providers in improving the care we provide.

Discussion

This study explored student SMW in emerging adulthood's lived experiences and perceptions surrounding substance use, the decision-making process behind choosing to seek or not seek care services for SUDs or assistance for managing a SUD, and the effects of substance use on daily functioning and social relationships. Photovoice methods (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) and individual phenomenological interviews (Gallagher, 2012; Giorgi, 1997; VanManen, 1990) were used to carry out the study. The choice in using qualitative Photovoice methods was made as such methods have been shown through historical (Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) and current work (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014) to be impactful in examining the needs of various populations and engaging individuals within communities to enact community-change using a unique, participant-driven visual medium that engages other interested parties.

In implementing individual phenomenological interviews with the co-researchers, I was able to explore the wider network of factors that influence SMW's substance use (e.g., familial substance use, community perceptions of substance use, strengths pertaining to personal use of substances, etc.). Phenomenological interviews were chosen as a method to illicit personal reflection (Gallagher, 2012; Giorgi, 1997; VanManen, 1990) and to address my personal experiences and biases that could impact the study (Crew, 2021; Finlay & Gough, 2003). The

appendices included at the end of the dissertation can be used in reviewing the study materials for future research and are organized by order of implementation within the study. This study can expand our profession's and the healthcare community's knowledge of SMW's lived experiences surrounding substance use and healthcare during emerging adulthood, while empowering women to share their stories and engage in action-based research.

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Chapter 2: Personal Positionality and Reflexivity Approach

Abstract

Self-reflection regarding one's positionality and its impact on the research process is an imperative aspect of transformative occupational science (OS) based research and Queer'ed Women's Standpoint Research on women's lived experiences (and all research). In this chapter I acknowledge and explore the impact of my personal positionalities, including those of being a bisexual, white, middle-class, cisgender female with multiple higher education degrees, personal experience with loved ones' harmful use and clinical experiences on this dissertation work. I also detail a reflexive framework that invokes critical evaluative questioning that I used across the study methods and dissemination processes. This framework may be applicable to our practice, research, advocacy work, and teaching.

Personal Positionality and Reflexivity

Self-reflection on and acknowledgement of one's personal and professional morals, standpoints, beliefs, and influences on knowledge production have been highlighted as bedrocks of transformative, emancipatory work within occupational science and feminist literature (e.g., England, 1994; Farias & Laliberte Rudman, 2016; Haraway, 2004; Harding, 1991; Harding, 2004c; hooks, 1989; Jaggar, 2004; Laliberte Rudman, 2014, 2019; Rose, 1997). In bringing these lenses to my work, I acknowledge that I cannot separate who I am from my work. I came to understand this even more so through the research process. Despite this, it is my hope in being open with who I am and my experiences across this dissertation that I am not eclipsing the voices of the women who I engaged with; my aim is instead to show that it is through our relationships and critical internal reflection that we can build a better

collective understanding of sexual minority women's (SMW) lived experiences with substance use (England, 1994; Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Haraway, 2004; Harding, 1991; hooks, 1989; Jaggar, 2004; Laliberte Rudman, 2014, 2019; Rose, 1997).

I wanted first to highlight the ethics and morals I brought with me to this work; exploring these can contribute to the reader's understanding of my sexuality and pre-conceived perceptions surrounding substance use (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019). I was raised in a religious household (though am no longer religious) by parents who often reinforced morals through demonstration and tied the importance of moral behaviors, empathy, and compassion to positively impacting others' experiences. I recognize the impact this upbringing and my other lived experiences and roles have had in shaping the beliefs and values I came to this work with, to my roles within academia, and to my practice as an occupational therapist (OT). I strongly value kindness, compassion, justice, equity, commitment, respect, and introspection. I believe in the need to let go of one's non-immediate personal needs and ambitions when they do not serve the greater good. I have strong sentiments regarding individual and community autonomy surrounding substance use, bodily autonomy, and equitable healthcare access and engagement for the purposes of preventing systems of oppression.

My views on substance use are influenced by both personal experiences and systemic and community structures and phenomenon. I am strongly aligned with the LGBTQIA+ community and believe in the ability for individuals and communities to be able to safely thrive no matter their personal racial, educational, socioeconomic, religious, cultural, sexual, and gender identities. My personal experiences have led me not just to my dissertation topic and processes, but to my profession, choice in specializing in mental and behavioral health, obtaining my PhD, and becoming the person I am today (England, 1994; hooks, 1989; Jaggar, 2004; Rose, 1997). I grew up in a white, middle-class, Catholic, nuclear family in a small, affluent city twenty minutes north of Milwaukee. I do not identify as having a disability, though I have generalized anxiety and depression. Across my life, I have experienced individuals I care deeply for struggle with substance use disorders and harmful substance use, though I did not always recognize this until after receiving a formal health-based education. At times prior to this education, I was only aware that I felt scared, concerned, and powerless to help the people I loved given my age and inexperience.

Like so many who have substance use disorders, maintaining sobriety has not always been easy or possible for those I care about. Sobriety is not a straight path with clearly defined steps; it ebbs and flows, which can serve as a source of frustration and anxiety for those impacted by substance misuse. I am so incredibly proud of the people in my life who are working

towards and maintaining their sobriety as a personal choice in their lives. In reflecting on my life, while I have not always been able help the people who I care about in all the ways I wish I could, I have had the opportunity to channel that desire into my practice and dissertation research with the recognition that my energy and experiences can be used in serving others. My experiences with loved ones and their substance use have impacted my personal use of substances. I am not afraid of substances but am careful with my use. While I have never felt a dependency on alcohol, I do not drink frequently, and do not use other substances. My friend groups are of varying ages, professions, and backgrounds, with each differing in their substance use behaviors; I have never felt pressure from my relationships in terms of substance use, nor the need to police the use of others.

As my education and clinical experiences have deepened with age, I have looked back on my younger years and the feelings with which I grappled with kinder eyes; my experiences have given me a better understanding of the nuanced, complex personal factors and decision-making that influences the choices surrounding substance use. I have also learned to make peace with the knowledge that you cannot push someone to seek care services or make services meaningful for an individual until, if ever, they are ready. In my practice as an occupational therapist, I experienced the removal of specified substance use services in a behavioral health setting and have felt frustrated with the prevalence of provider

stigma, lack of access to substance-use-specific care services, and dearth of community supports that are available for supporting mindful, safe substance use or sobriety. The challenges to addressing substance use in treatment have further strengthened my desire to conduct this dissertation work.

Initially, I had a large population of women in mind for this study, in a hope to reach across the span of women's lived experiences surrounding substance use. Through the guidance of my dissertation committee members and deeper personal reflection on my personal identities, I was challenged to further hone my study lens from both a practicality standpoint and service perspective to focus on sexual minority women in emerging adulthood. This change in direction regarding the study population has served as a true gift; it's made me interrogate my own substance use, sexuality, positioning within the queer community, and biases or "subjectivities" (Gorman-Murray et al., 2010) stemming from personal privilege.

While I have been open with my friends (and at times when appropriate and beneficial, the individuals I serve) about identifying as bisexual, I have not openly come out to most of my extended family and have actively avoided discussing my sexuality throughout most of my time in higher education. This has been for a multitude of reasons, but first and foremost, my intent has been to avoid potential judgement, doubt, and, what I fear most: rejection from both within and outside my communities.

This sentiment of hesitancy was often echoed by the co-researchers in this dissertation work, which was both affirming and saddening. In the academic setting, I have struggled to define where my sexuality fits into the systems that I am a part of as a student, researcher, and educator. I continue to wrestle with these questions as a woman operating across multiple roles and systems, though my experience with this dissertation helped to more firmly appreciate that I can and must create safe spaces for women in the queer community to discuss on sexual identity through my teaching, mentorship, and research.

Ultimately, much of my silence related to my bisexuality has also been attributed to the recognition that I carry protective factors that shield me from many of struggles and stigma that individuals within the LGBTQIA+ community face regularly. I am cisgender. I tend to dress in feminine and gender-neutral clothes. I am white. I am married to a white, heterosexual, cisgender male. I reside in a middle to high socioeconomic community who, for the most part, is friendly towards LGBTQIA+ individuals. I attend a university that supports queer students, though from the initiation of this dissertation journey to now, we have seen this support challenged across national and state-based legislature in removing financial and social support for queer and other minority academic spaces. My sexuality is a part of who I am, as it is for those who bravely stepped forward to engage in this research and queer individuals living in our communities; our intimate

relationships and experiences have shaped the way we look at sexuality, aromantic/asexual and romantic/sexual relationships, substance use, occupational therapy practice, and academia.

In focusing my research on women in the queer community and emphasizing the importance of reflexive practices across the study, I grappled with the understanding that I would need to come out to my immediate family regarding my sexuality, as they were likely to engage with this dissertation work in their unwavering support of my PhD process. In listening to the stories of the co-researchers and recognizing the additional challenges bisexual women take in having their identity recognized and affirmed within and outside the queer community (e.g., Shaw, 2023), I was anxious regarding this coming out process, and I briefly explore my experiences with coming out in Chapter 7.

This dissertation has made me recognize how important it is to celebrate supportive environments (and people) who affirm our sexual identity and create a safe space for us to be ourselves. In that spirit, I want to include my own Photovoice piece in further contextualizing my desire to conduct this study, and my positioning within the queer community (shown in Figure 2.1):

Figure 2.1

New Orleans Adventures in Identity

I had dreamed of visiting New Orleans for a very long time. During our first visit, Nick (my now husband) and I spent the day ambling about the Vieux Carré, marveling at the colorful homes, discussing the history of this gorgeous place, and communing with tourists and locals. We stopped to rest in front of a brightly painted home on Royal Street, with another couple asking if we would like a picture. From there, we continued to slowly make our way down the street as the sun set, deciding to stop for a drink at the first neighborhood bar we came upon, the Golden Lantern.

Almost every seat was taken, with everyone engrossed in conversation; the bar tenders were friendly, and someone thoughtfully offered their seat to Nick. We sipped our drinks and chatted in the warmly lit, convivial space. It was only after getting settled and taking in the rest of the bar, looking at the flags and interspersed rainbow décor, that we realized this was specifically a gay bar. To my delight, shortly after realizing this, the weekly drag show began, and soon we found ourselves sipping, swaying, and talking with another couple at the bar as a disco-esque version of Gordon Lightfoot's "If You Could Read My Mind" played and a Queen danced about the bar.

The couple we talked with lived in New Orleans, with one partner having returned from residing elsewhere. We discussed the love we each had for the city, particularly as a haven for members of the LGBTQIA+ community in the state of Louisiana. I felt my sexual identity supported and affirmed as we chatted; not once did I feel out of place as a bisexual woman with her cisgender, straight partner in an unfamiliar queer space. As someone who has not always experienced this in various social purlieus, in the moment, I reflected on how wonderful it felt to feel safe, and out with my identity.

Had we not chosen to stop for a drink, alcoholic, or otherwise, or felt welcome from the moment we entered the bar, we would have missed engaging with local queer New Orleans community members, hearing their stories, being supported in our own, and learning more about spaces like the Golden Lantern, which we learned serves as a historic gay bar to the

community. We continue to return to the Golden Lantern (cash only) each time we come back to New Orleans. We need to foster safe, accepting, communal spaces like this amazing bar in celebrating each other, our stories, and our futures as members of the queer community, no matter one's identity or whether one chooses to use or not.

In including commentary on my sexuality, I do so with the intent to show that I carry experiences and perspectives that may be similar (or different) to some of the women who participated in the study, and that the struggles of the LGBTQIA+ community and my sexual identity motivated me to engage in this work. In learning from SMW regarding their perspectives regarding substance use, I felt I was able to use my experiences with my sexual identity to build rapport and establish trusting relationships that enabled us to get at the heart of women's experiences (England, 1994; hooks, 1989; Rose, 1997).

Reflexivity Practice Application Within this Work

While illustrated in detail in Chapter 4, it is critical to understand as the reader that I came to this dissertation work with the desire to generate actionable change within our profession related to serving SMW who use substances. In recognizing this desire, my commitment to applying a transformative research paradigm (later detailed in Chapter 4) (Mertens, 2009; Mills, 1959) and the influence of Queer'ed Women's Standpoint Theory tenets (Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b;

Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) emphasized that the first step in creating a study promoting professional change was to first account for my influence on the study process.

Through my initial detailing of my perspectives and experiences surrounding substance use and misuse in this chapter (and within my dissertation proposal), I began the critical journey of reflexivity. Entering into this work, I anticipated that my perceptions of substance use and misuse, specifically SMW's use, would be challenged by the co-researchers, including the applicability of my chosen guiding theories and models and their appropriateness in conceptualizing co-researchers' lived experiences. This challenge did indeed occur during the study process and demonstrates the importance of incorporating reflexivity into our work, particularly in addressing our pre-conceptualizations of occupations (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019), including my own. Reflexivity is an important aspect of building new knowledge from these challenges and enhancing our occupational imagination (Laliberte Rudman, 2014, 2019). Going forward in this chapter, I will detail my reflexive approach to this work.

Application of Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Finlay & Gough, 2003; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) in the study is detailed later in Chapter 4, and is enmeshed with my positionality practices within the study, including my

reflections just noted. Standpoint theorists emphasize that our unique positions in society (our race, gender, sexuality, class, etc.) make up our experiences and understanding of reality, with some positions (standpoints) prominently standing out, and others being more concealed (Jaggar, 2004). For Feminist researchers who ascribe to this approach, Jaggar (2004) describes that we must maintain awareness that we come to each decision and judgement with personal standpoints and subsequent perspectives, which is imperative in conducting research. Standpoint theorists Harding (1983) and Jaggar (2004) note that if we do not acknowledge, account for, respect, and explore the ways in which our standpoints differ, we risk missing the opportunity to interrogate the impact of oppression on women with differing and overlapping standpoints, and biasing our work towards populations who have traditionally dominated research.

Standpoint theorists Maria Lugones and Elizabeth Spelman (1983) suggest that to be able to build theory and an understanding of the lived experiences of women who have traditionally been kept out of research and academia (e.g., women of color, queer women, working-class women, and more), we must come to "know the text," (p. 580) through learning about alternative ways of viewing and experiencing life (p. 579):

> "You need to learn to become unintrusive, unimportant, patient to the point of tears, while at the same time open to learning any possible lessons. You also have to come to terms with the sense of alienation, of not belonging, of having your world thoroughly disrupted, having it criticized and scrutinized from the point of view of those who have been harmed by it, having important concepts central to it dismissed, being viewed with mistrust, being seen as of no consequence except as an object of mistrust."

This is a learning process that takes time; I would argue similarly to other feminist scholars Heldke (1998) and Sholock (2012) that coming to "know the text" (Lugones &

Spelman, 1983, p. 580) of women who have been oppressed will never be complete. Nevertheless, in crafting my study guiding theories, methods, data analysis, positionality practices, and approaching my engagement with the co-researchers, I sought to uphold an exploration into women's lived experiences that are derived from women who share standpoints that have been oppressed, including women of color, queer women, working-class women, etc. (Collins, 1986; Lugones & Spelman, 1983). The purpose of this research was to create a platform for SMW to "critique," and "scrutinize" the societal and healthcare systems in which they operate and use substances; I, as a white, cisgender, middle-class healthcare provider and academic, am a part of these systems of oppression (Lugones & Spelman, 1983; Schenwar & Law, 2020), and was often reminded of this during the research process.

Within my dissertation proposal, I identified that an important first step in the process of challenging my worldviews and better understanding the lived experiences of the study co-researchers was in taking accountability for my role in oppressive societal systems that provide education and services surrounding substance use (Lugones & Spelman, 1983; Schenwar & Law, 2020). To do this, I proposed a framework of accountability which I applied across the dissertation work. In building on this framework, I have included the use of a similar reflexive "vocal" approach to that of my colleague, Dr. Michelle Perryman-Fox (2020) and her mentor (Morris, 2012). Within each chapter, I have included my personal "voice" in addressing my identities and decision-making across the research methods and in critically analyzing the impact of these factors on aspects of the study (Veranda Pro font), as well as my academic voice (Times New Roman font), and the voices of the co-researchers (Sitka font) (Morris, 2012; Perryman-

Fox, 2020). A final voice, the "collective" voice (Calibri font) serves as a conglomeration of my personal and academic voices with the experiences and voices of the co-researchers, which is used to denote the synthesis of the shared lived experiences, previous research, and my personal identities within the study findings (Morris, 2012; Perryman-Fox, 2020).

The use of these differentiated voices (Morris, 2012; Perryman-Fox, 2020) within the dissertation includes my recognition that my personal identities, study reflections, and personal perspectives and experiences across the study and analysis process, and my understandings of the findings impact who I am and my occupational therapy practice (England, 1994; Farias & Laliberte Rudman, 2016; Haraway, 2004; Harding, 1991; Harding, 2004c; hooks, 1989; Jaggar, 2004; Laliberte Rudman, 2014, 2019; Rose, 1997). My academic voice includes the voices of other scholars and my synthesis and application of their work as it applies across the study process (Morris, 2012; Perryman-Fox, 2020). The voices of the co-researchers include direct quotes from the women who engaged in the study in sharing about their lived experiences and their recommendations for health care providers (Morris, 2012; Perryman-Fox, 2020). The collective voice comes from the recognition that we cannot separate who we are from our research (England, 1994; Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Haraway, 2004; Harding, 1991; Harding, 2004b; Harding, 2004c; hooks, 1989; Jaggar, 2004; Laliberte Rudman, 2014, 2019; Morris, 2012; Perryman-Fox, 2020; Rose, 1997) and that we are influenced by the sources of "knowledge" we choose to engage with, including academic texts, and the experiences and stories of others (England, 1994; Harding, 1991; hooks, 1989; Rose, 1997). Each of the voices represented within the dissertation are influenced in part by one another, meaning that in reality, each "voice" present in the study is not

truly the voice of one, but many, including my own (Collins, 1986; England, 1994; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Rose, 1997).

It is also worth noting that in addition to the standpoints of mine, co-researchers', and other academic scholar's resources who are cited here, there are voices that are not represented in this work, leaving room for continued exploration into where the study findings may be lacking. The iterative reflections across these voices (Morris, 2012; Perryman-Fox, 2020) culminate in a proposed reflexive framework for all who engage with the work (including myself) to analyze the personal experiences, positionalities, biases and personal, occupational, and environment contexts we bring to this research (Heldke, 1998; Sandoval, 2004; Sholock, 2012). There is also the opportunity to seek out additional voices and sources of knowledge regarding sexual minority women's lived experiences with substance use (Heldke, 1998; Sandoval, 2004; Sholock, 2012).

Study Reflexive Framework

While this proposed framework's underpinnings (explored next) have not changed since the dissertation proposal, my understanding of the interaction of my personal identities, sources of knowledge, and privileges within the study process has deepened; I delve into this development process in my reflections on the study in Chapter 7.

Feminist scholars have aptly described our need to assess our areas of ignorance as a continuous process to which we must commit to, knowing that it is never fully complete (e.g., Heldke, 1998; Sholock, 2012). I looked to follow in my feminist forebearer's footsteps through actively engaging in racial (and other positional) "disaffiliation" (Harding, 1991) across my dissertation work; this "disaffiliation" was practiced through the active positioning of

marginalized individuals as the primary voices in telling the stories of SMW's experiences with substance use (Harding, 1991; Harding, 2004a; Harding, 2004b; Harding, 2004b, p. 128-130; Harding, 2004c; Sandoval, 2004). This process (Harding, 1991) is also addressed through highlighting my personal and academic voices across the dissertation (Morris, 2012; Perryman-Fox, 2020) and actively discussing my differing identities, privilege, and moralistic leanings.

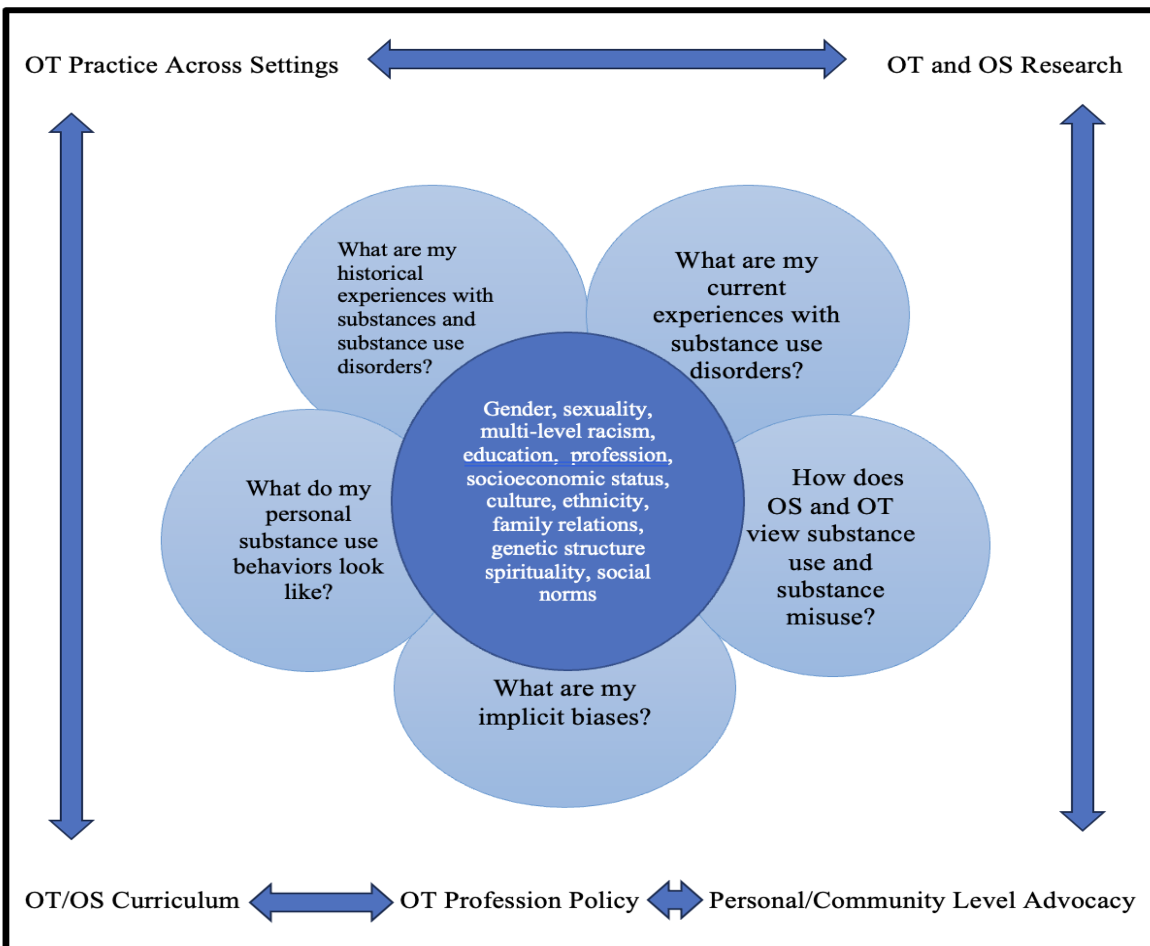
Within the study, the co-researchers guided and informed the data analysis and dissemination of the study materials, and explored the stigma, biases, racism, sexism, and classism that surround the personal and societal views of personal substance use practices (Harding, 1991; Sholock, 2012). As the facilitator of the research and for readers of this work, I wanted to ensure that there was and continues to be a critical reflection on our positionality and how it effects the way we interact with and understand the study findings and their implications for practice (Harding, 1991; Heldke, 1998; Morris, 2012; Perryman-Fox, 2020; Sholock, 2012). In engaging in positional disaffiliation (Harding, 19991), I worked to infuse the study with co-researcher-driven processes, and practiced personal reflective journaling that was guided by two of my underpinning sets of theories (Queer Theory (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) and Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012)) in critically addressing the impacts of who I am on my dissertation research and practice. I strongly encourage those who interact with this research to do the same (Harding, 1991; Heldke, 1998; Morris, 2012; Perryman-Fox, 2020; Sholock, 2012).

Guiding Positionality Approach. Figure 2.2 explores my study's applied conceptualization of positionality assessment that emphasizes personal reflexivity.

Figure 2.2

Substance Use Disorder Occupational Therapist Positionality Approach

Transformative Implications for Occupational Science and Therapy



Note. Transformative Implications for Occupational Science and Therapy are influenced by the detailed intersecting factors at the personal and broader systemic levels.

At the heart of reflexivity practices and influences on oneself are one's experiences with gender, sexuality, race, and one's education experiences, familial functioning and genetics, profession, and cultural, ethnic, cultural norms, and spiritual background (Andersen, 1983;

Carastathis, 2014; Reid & Frisby, 2008). These intersecting experiences and internal characteristics drive the decisions we make and influence how we perceive substance use (Andersen, 1983; Carastathis, 2014; Reid & Frisby, 2008). In asking ourselves pertinent questions surrounding our views and approach to substance use, we must be aware that our internal beliefs and experiences not only impact our views on personal and non-personal substance use and sexuality, but health care professions' (and through this, occupational therapy and science's (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) practice, research, advocacy, and policy (Harding, 1983; Harding, 2004c; Jaggar, 2004). In examining our beliefs, practices, and cognitions regarding substance use, we must actively recognize the influencing external and internal factors, and critically assess how they may be biasing our practice, policy, research, and other professional aspects surrounding substance use and substance use disorders (England, 1994; Finlay & Gough, 2003; Harding, 1983; Harding, 1991; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Rose, 1997; Sholock, 2012).

This framework (Andersen, 1983; Carastathis, 2014; England, 1994; Finlay & Gough, 2003; (Farias & Laliberte Rudman, 2016; Harding, 1983; Harding, 1991; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Laliberte Rudman, 2014, 2019; Lugones & Spelman, 1983; Reid & Frisby, 2008; Rose, 1997; Sholock, 2012) was used across the study to reflect on my positionality using the framework questions and their intersection with various aspects of my identity (e.g., race, education, socioeconomic status, etc.) in assessing how I responded to the co-researchers and their data when creating and analyzing my fieldnotes, conducting and analyzing workshops, carrying out and analyzing the phenomenological interviews, journaling across the study, and in engaging in the overall data analysis process. In reflecting on these

questions through my fieldnotes and personal journaling, my desire was to assess my engagement in the study in "live" time and address areas of continued learning and bias to improve the study co-researchers' experiences and my own practice. Reflection on this process is included within Chapter 7.

Discussion

In applying a reflexive approach within the dissertation study, I looked to uphold a transformative (Mertens, 1999; Mills, 1995) and occupational-science-based spirit of imagination (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) through my application of Queer'ed Women's Standpoint Theory (Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) and positional disaffiliation tenants (Harding, 1991) in this work. To uphold this approach, I sought out substance use resources that are written from the perspectives of women who have been oppressed, placed focus on methods that encourage co-researchers-led measures, and consistently assessed and addressed the impact of my positionality across the study process through framework-guided journaling (Andersen, 1983; Carastathis, 2014; England, 1994; Finlay & Gough, 2003; (Farias & Laliberte Rudman, 2016; Harding, 1983; Harding, 1991; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Laliberte Rudman, 2014, 2019; Lugones & Spelman, 1983; Reid & Frisby, 2008; Rose, 1997; Sholock, 2012) and identifying the various "voices" present in the study (Morris, 2012; Perryman-Fox, 2020). The framework of personal reflective questions can serve as guidance for those who interact with the dissertation materials, and in recommending practitioner positionality

practices within care, research, advocacy, curriculum. This application will be explored in the results and discussion in Chapters 6 and 7.

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Chapter 3: Review of the Literature

Abstract

Substance use disorders are rising throughout world, including the United States (U.S.). This rise is notable particularly within student sexual minority women (SMW) in emerging adulthood, who have unique care and support needs. Populations across racial, socioeconomic, gender, and sexual orientation backgrounds experience distinctive factors that influence the development of substance use disorders (SUDs) and access to support services. In focusing on SMW, SMW's possess a unique relationship with substance use that warrants further assessment, including into minority stress experiences and the influence of community events centering on substance use. The student role and associated factors also play specific roles in SMW's substance use that are unique. Society and occupational science (OS) and therapy (OT) professionals tend to view substance misuse from a negative lens, which has implications for practice and social policies, and promotes stigma related to substance use and SUDs. Occupational therapy, while qualified to assess and treat substance use disorders, faces unique challenges across education and practice in meeting the needs of sexual minority (SM) individuals (including SMW) with harmful substance use or SUDs. To better examine student SMW's experience with substance use, qualitative Photovoice methodology and individual phenomenological interviews were used, which, while heavily implemented in exploring substance use and mental health challenges, have yet to be applied to this population through an OT lens.

Literature Review Query Methods

Google Scholar, PubMed, CINAHL, EBSCO Consumer Health Complete, Academic Search Complete, Medline, and Taylor & Francis online were used as primary search sources to build a comprehensive literature review surrounding the following:

- Substance use prevalence
- Sexual minority women's experiences and factors surrounding substance use
- Substance use factors in emerging adulthood
- Impact of the student role on substance use
- Current societal and health care approaches to substance use
- Current occupational science and therapy approaches to addressing sexual identity and substance use
- Available body of Photovoice and phenomenological interview-based research involving SMW students and substance use

In applying the chosen practice of using person-first language within the study (Baker et al., 2022) the following common phrases were used in conducting this review (shown in Table 3.1):

Table 3.1

Dissertation Study Search Phrases

Topic	Literature Review Search Phrases
Substance Use	'sexual minority women's substance use' 'student sexual minority women's substance use' sexual minority women's substance use disorder prevalence,' 'sexual minority women's barriers to substance use disorder treatment,' 'sexual minority women, substance use,' 'perceptions of substance use,' 'psychosocial factors in substance use

	disorders,' 'stages of change and substance use disorders,'
Emerging Adulthood	'emerging adulthood,' 'substance use in emerging adulthood,' 'sexual minority substance use in emerging adulthood,' 'sexual minority women's substance use in emerging adulthood'
Occupational Therapy	'sexual minority substance, occupational therapy,' 'occupational therapy treatment for substance use disorders,' 'occupational therapist's comfort with treating substance use disorders,' 'occupational therapist's comfort with addressing sexual identity,' 'occupational therapist's comfort with treating sexual minorities,' 'role of occupational therapy in substance use treatment'
Photovoice Methods	'Photovoice and occupational therapy,' 'Photovoice and substance use disorders,' 'Photovoice and sexual minority substance use,' 'Photovoice, sexual minority substance, occupational therapy,' 'Occupational Therapy, Photovoice, and Substance Use Disorders,'

Phenomenological Methods	Phenomenological interviews, sexual minority women, and substance use,' 'Phenomenological interviews, substance use, sexual minority women,'
Guiding Frameworks	'Transformative Research Philosophy,' "Occupational Science and Substance Use,' 'Transformative Occupational Imagination,' 'Occupational Imagination,' 'Person, Environment, Occupation Model,' 'PEO Model,' 'Person, Environment, Occupation Model and substance use,' 'PEO Model and substance use,' 'Women's Standpoint Theory,' 'Women's Standpoint Theory and substance use,' and 'queer women's standpoint theory and substance use,' and 'Queer Theory and Substance Use'

The literature review is organized by first examining SUDs as a general diagnosis in the United States (U.S.). From there, exploration into SMW's use in emerging adulthood and the impacts of the student role are described. The chapter then goes on to examine the implications of and attainment of SUD services for SMW. From there, societal and occupational science/therapy perspectives on sexual identity and substance use are detailed. Next, current research using this dissertation study's data collection tools are examined, with an overview of current available Photovoice and qualitative-interview-based research both in the field of OT and

on SMW's experiences presented. The review will conclude with a statement regarding the significance of the study.

Definition of Terms

Prior to defining the terms used throughout this review and dissertation work, it is important to note that a conscious choice was made in addressing the targeted study population as SMW with 'substance use,' 'harmful substance use,' substance misuse,' 'risky substance use,' or a "substance use disorder" experiences as opposed to other terminology ('substance abuse' 'user', 'addict', etc.). As our understanding of addiction being tied to a foundational neurochemical relationship grows (Ashford et al., 2018; Blum et al., 2012), some have argued that using terminology that separates the various types of addiction from one another can lead to a disjointed, non-comprehensive approach to care (Blum et al., 2012). Terms such as 'substance abuse' or 'substance abuser' can also cast a negative light on those experiencing addiction by not recognizing the role the brain (Blum et al., 2012) and larger social systems of inequity (e.g., Jegede et al., 2024; Sprague Martinez et al., 2018) play in the development of SUDs. These terms can lead to negative biases from the "general public, service team members, and healthcare professionals" related to individuals who use substances (Ashford et al., 2018, p. 131).

Terms Used

Some of the terms defined here and used throughout the proposal are operationalized using personal definitions to assist readers in the conceptualization of the dissertation work and substance use. This conceptualization influences the definitions used to define substance use, harmful substance use, and other terms. They are also indicative of "person-first" language for the purposes of respecting individuals with lived experiences related to substance use and

recognizing the power and impact that language can have on our conceptualizations of substance use (Ashford et al., 2018; Baker et al., 2022).

Co-researchers - the term used to describe the women who engaged in the study who served as experts in sharing their lived experiences in being student SMW in emerging adulthood who use substances (Hitchen & Williamson, 2015; McIntyre, 2008, pp. xii-xiii, 15-32).

Lived experience(s) - "explicit retrospection where meaning is recovered and reenacted, for example, in remembrance, narration, meditation, or more systematically, through phenomenological interpretation and "inscription"" (Burch, 1990, p. 134).

Substance use – will be viewed as any use of the following substances that can be either harmful or non-harmful and risky, or non-risky use: alcohol, tobacco, legal/illegal drugs, medications, stimulants, etc.

Substance Use Disorders (SUDs) - the definition that will be used throughout this dissertation is guided by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2020b): "Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."

Harmful Use/Misuse – the definition of harmful use that will be used throughout this dissertation is guided by the World Health Organization, 1994 (as cited by S. Smith et al., 2013): "A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (eg, hepatitis following injection of drugs) or mental (eg, depressive episodes secondary to heavy alcohol intake)."

Occupational Therapy Practitioners (OTPs) – Occupational Therapists, Occupational Therapy Assistants

Substance use disorder services/care services – the array of potential preventative, social, treatment, and community services and interventions that one can receive pertaining to substance uses, with a focus on occupational therapy services occurring across healthcare and community settings.

Sexual Minority Woman(en) (SMW) – "women defining themselves by sexual identity (lesbians, bisexual women), behaviour (women who have sex with women, women who have sex with men and women) or relationship status (women who are married to or cohabit with other women)" (Meads et al., 2019, p. 1).

Student Sexual Minority Women – Sexual minority women who are in higher education, including university, college, technical college, etc.

Findings

Substance Use Disorders in the United States

As recently as 2021, 39.5 million people were estimated to have a drug use disorder, a 45% increase from the previous 10 years (United Nations Office on Drugs and Crime, 2023). Globally, harmful substance use and negative health and morbidity outcomes related to substance use continue to persist (Connery et al., 2020). Here in the United States, 48.7 million American adults, 12 years of age or older dealt with a substance use disorder per the 2022 Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health, an increase from 2021's 46.3 million adults (Substance Abuse and Mental

Health Services Administration [SAMHSA], 2022)) (SAMHSA, 2023). This SAMHSA survey 2022 survey (SAMHSA, 2023, p. 2) also noted that:

> "Among the 39.7 million adults aged 18 or older in 2022 who had an SUD in the past year and did not receive substance use treatment in the past year, 94.7 percent (or 36.8 million people) did not seek treatment or think that they should get it."

Substance use has also been on the rise in students in higher education across substance type (Welsh et al., 2019). These findings illustrate that substance use and SUDs play a significant role in the lives of individuals (SAMHSA, 2023; United Nations Office on Drugs and Crime, 2023), including Americans who are young and middle-aged adults (SAMHSA, 2023), and students (Welsh et al., 2019). This demands the attention of healthcare providers across professions.

In understanding the relationship that the U.S. has with substance use, the personal and large-scale costs of harmful use warrant consideration. Overdoses can have expensive implications: a 2018 study by Schuring et al. found that within one "mid-sized" midwestern city, the average medical costs for intensive care services for an overdose could total over five thousand dollars, in addition to over twenty thousand dollars in overall hospital fees. In 2017, a study examining over 120 million emergency departments and 33 million inpatient encounters found that SUD services cost more than $13 billion dollars in the U.S. (Peterson et al., 2021). These fees can lead to long-term challenges for the individuals and communities affected (Peterson et al., 2021; Schuring et al., 2018). After gaining an understanding of the current prevalence of SUDs in the U.S. and the costs accrued from substance misuse medical care, we can explore specific populations' relationships with substance use.

U.S. Sexual Minority Women's Substance Use

While women have traditionally not been at the center of most SUD-based research (Greenfield et al., 2010a; McHugh et al., 2018), trends point towards women gradually "catching up" with men's levels of SUDs (Grucza et al., 2008; Keyes et al., 2008; Steingrimsson et al., 2012). As recently as 2021, at least 20,270 women were experiencing a SUD (SAMHSA, 2022). Substance misuse in female-identifying populations is also increasing across illegal substance and prescribed medication use (SAMHSA, 2017); as of 2016, 6.6% of women in the U.S. 18 years of age or older identified as having misused a prescription medication (SAMHSA, 2017). Opioid use is of particular concern, especially in pregnant women, with the prevalence of women in labor and delivery presenting with opioid use disorder quadrupling from 1999 to 2014 alone (Haight et al., 2018).

In looking at sexual minority-specific substance use compared to heterosexual adults, nationally, sexual minorities (SM) have greater levels of substance use (Kerridge, 2017; Schuler & Collins, 2020), including binge drinking and tobacco use, meaning they subsequently meet the criteria for alcohol and tobacco use disorders (Boyd et al., 2019). This disparity in substance use between populations can include illegal drug (Schuler et al., 2018) opioid (Schuler et al., 2019) and marijuana use (Boyd et al., 2020). Notably, SMs often begin using substances at a younger age compared to heterosexual peers (Marshal et al., 2008), leading to increased risky use and negative health outcomes compared to heterosexual adolescents (Coker et al., 2010). When comparing SM men and women's use in adulthood, women demonstrate disparities regarding drug and alcohol use that can incur an increased likeliness of harmful use (S. McCabe et al., 2010; Trocki et al., 2009).

Specifically, within SMW's identities, results the 2015-2017 National Survey on Drug Use and Health found that within SM female populations, bisexual women demonstrated a higher risk for multiple substance use behaviors, including binge drinking, illegal drug use, opioid misuse, and alcohol use disorder compared to lesbian/gay women and heterosexual populations (Schuler & Collins, 2020); this disparity is historically supported (Feinstein et al., 2017). While these statistics are cause for concern, it is critical to remember the individuals and communities who represent these numbers. To better understand SMW's substance use, their unique factors regarding substance use will be explored next.

Developmental Factors in Substance Use Disorders

Women's Factors. In first looking broadly at women's factors surrounding substance use, women's use behaviors may differ from men's: women can experience "telescoping," in which they experience a faster path of initiating substance use and having use lead to dependency (C. Green, 2006; Greenfield et al., 2010a; Hernandez-Avila, 2004). This swift progression can result in women demonstrating more intensive negative symptoms of substance misuse (Greenfield et al., 2010a). Studies indicate that women typically begin using substances later in life compared to males (Greenfield et al., 2010b; Keyes et al., 2010), and obtain care within the course of their use earlier (Greenfield et al., 2010a), though they may access care services less often (C. Green, 2006; Greenfield et al., 2007). Women may have trauma experiences that lead to the development of substance use disorders (SUDs) given their higher tendency of historical and current sexual and physical abuse compared to men (Cottler et al., 2001; Wechsberg et al., 1998). Amongst women, difficulties with polysubstance use can often occur, and SUDs can lead to "significantly increased suicidality" in adult women (age 18 or older) (SAMHSA, 2020a).

Women also face distinctive challenges related to social perceptions and accessing services (Campbell et al., 2007; Elms et al., 2018; Gartner et al., 2018; Pinedo et al., 2020; Redmond et al., 2020; Robertson, 1988). Women may not seek resources for SUDs at comparable rates to men over concerns of being defined as having a substance "problem," given the prevalent stigmatic views surrounding women's substance use (Pinedo et al., 2020). The stigma women face regarding substance use has had repercussions within supportive programming, with women historically being excluded from services (Alcoholics Anonymous in particular) due to societal perceptions that women must behave in specific ways (e.g., being "nice" and not engaging in problematic drinking) (Robertson, 1988).

There is a critical intersection between race and gender when looking at women's substance use and substance misuse services as well (Davis & Ancis, 2012; J. Meyer, et al., 2019; Pinedo et al., 2020; Roberts et al., 2000). Pinedo and colleagues' (2020) qualitative study on substance misuse found that Black and Latina participants reported increased substance use-based social stigma, which may have played a role in the participants' low levels of perceived need for care. Such participants also felt that the services provided would not be as positively impactful compared to white peers' service reception (Pinedo et al., 2020). These experiences (Pinedo et al., 2020) are supported in other literature, with Black women receiving non-comprehensive care (Davis & Ancis, 2012) and experiencing racial gender-based stereotypes within substance misuse support services (Roberts et al., 2000). In recognizing the intersecting role that race can have with substance use and misuse experiences, J. Meyer and colleagues (2019) have recently called for specified studies that more directly focus on the role race plays in women's substance use. The intersection of race and sexual identity will be explored in later sections as well; next, however, substance use and pregnancy will be discussed.

Substance use during pregnancy is also an important health factor (Forray, 2016; United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration: Center for Behavioral Health Statistics and Quality, 2015), though such use may not be included in women's discussions with their care providers or screened for due to a lack of provider awareness (Gartner et al., 2018). Pregnancy and parenthood can impact women's relationship with SUD services, with mothers identifying societal and healthcare provider stigma as a barrier to obtaining care (Gartner et al., 2018). Gartner and colleagues' (2018) findings are supported by current research demonstrating healthcare provider's sustained negative perceptions surrounding their care for pregnant women with SUDs (Merritt et al., 2022). Women may also be fearful of the legal repercussions surrounding child custody if they seek treatment (Gilbert et al., 1997). These are but a few of the interlacing and complex factors that women with SUDs must navigate, warranting further examination and awareness when examining the available body of evidence surrounding woman's use of substances, experiences, side effects, and relationship with care services.

Sexual Minority and Sexual Minority Women's Factors

At the intersection of sexuality and substance use, SMW experience unique factors that impact the prevalence of use within this community and use behaviors (Schuler & Collins, 2020). Research has demonstrated the mixed effects that personal disclosure of sexual identity ("coming out") has on personal substance use behaviors; on the one hand, disclosing one's orientation can establish positive relationships with other minorities and supportive individuals, leading to decreased use of substances as a coping strategy, while for others who may experience stigma in coming and being "out," mental health challenges and substance misuse may occur (Feinstein et al., 2017). There are similar variable findings regarding the role of community

support in SM's substance use; personally connecting SMs to communities and institutions that support SM identities has been correlated with decreased substance use across various SM populations, serving as a protective factor (Heck et al., 2014; Johns et al., 2013). Despite this (Heck et al., 2014; Johns et al., 2013), SMs are often engaging in community spaces where heavy substance use (alcohol and tobacco) plays a prominent role in community-building (Baiocco et al., 2010; National LGBTQ Young Adult Tobacco Project, 2010). For SMs, financial and health access are additional risk factors for harmful substance use, with SMs with higher levels of socioeconomic struggle being at increased risk for harmful substance use compared to heterosexual peers (Rosner et al., 2021).

Feinstein and colleagues (2017) note that there are difficulties in determining what serve as protective factors versus risk factors for SMW who derive from varying SM identities (e.g., lesbian, bisexual, asexual, queer, etc.) given that SMW are often assessed across research as a homogenous group. In treating SMW as one population, scholars have noted that researchers risk making assumptions that women across differing sexual identities have the same risk and protective factors, despite their use behaviors differing (Feinstein et al., 2017; Schuler & Collins, 2020). As an example, community involvement and being out with one's sexual identity can serve as a protective factor for queer and lesbian women, while for bisexual women, this same openness in the community may result in discrimination and harmful substance use (Feinstein et al., 2017). This discrimination can come from within and outside of the LGBTQIA+ community and can be highly impactful for bisexual women's openness with their identity (Kuyper & Fokkema, 2011).

In briefly delving deeper, one hypothesis for the bisexual women's increased substance use compared to other populations relates to findings that bisexual women may use substances as

a coping mechanism in responding to the stigma they anticipate and experience when participating in LGBTQIA+ community programming (Feinstein et al., 2017); this leads to a cycle of seeking support for one's sexual identity and substance use, experiencing discrimination within and outside of one's community, and using substances to cope (Feinstein et al., 2017). In building from this theory, lesbian women may demonstrate decreased harmful substance use compared to bisexual women due to their greater acceptance in the LGBTQIA+ community and increased support and resource access (Feinstein et al., 2017). Sexual minority women have additional protective factors surrounding substance use behaviors, which can include spirituality practices (Lease et al., 2005) and religiosity (Drabble et al., 2016). Age may also play a role, especially for older SMW, who tend to demonstrate decreased harmful substance use compared to younger SMW (Rosner et al., 2021).

Minority Stress Theory

Minority stress and minority stress theory are often cited in understanding use behaviors (e.g., Dyar et al., 2022; Gorritz Fitzsimons, 2022; Kiekens et al., 2022; Lehavot & Simoni, 2011; Lewis et al., 2021; Schuler & Collins, 2020). Pioneered by Virginia Rae Brooks (1981) and Ilan Meyer (Meyer, 2003), Minority Stress Theory defines minority stress as distress deriving from racial violence, stigma, and discrimination that is generated from oppressive belief systems present in interpersonal environments (Childs, 1990). For sexual minorities, negative interpersonal interactions and stigma that lead to stress can include discrimination in public spaces (Dyar et al., 2022; Lewis et al., 2021; I. Meyer, 2003), structural stigma within policy (Hatzenbuehler & Link, 2014) and physical violence (Movement Advancement Project, 2015, as cited in Kerridge et al., 2017).

As described with bisexual women, this discrimination can even occur from *within* sexual minority communities (Feinstein et al., 2017). These ongoing stressors are linked to increased risk for mental health struggles, including depression (Hatzenbuehler, 2017) and harmful substance use (Dyar et al., 2022; Boyle et al., 2017). Social and religious stigma also has personal consequences for how SMs view themselves, with SMs experiencing decreased self-esteem due to stigma and discrimination related to homophobia (Lehavot & Simoni, 2011) and increased internalized homophobia because one's personal religious institution does not accept their sexual identity (Barnes & Meyer, 2012). These views of the self can directly be linked to increased alcohol use (Amadio, 2006; Lewis et al., 2021), mental health challenges, and other SUDs (Irwin, 2009; Lehavot & Simoni, 2011). Additionally, sexual minority women are more likely to experience abuse (verbal, sexual, physical) across their lives compared to heterosexual women (Moracco et al., 2007) and may hide their sexual orientation from others to prevent physical violence (D'Augelli & Grossman, 200l); SMW's substance use is tied to increased intimate partner violence (Eaton et al., 2008; Glass et al., 2008; Lewis et al., 2012). Such women may also forgo disclosing their sexual identity due to the fear of loss of employment (D'Augelli & Grossman, 2001).

Gender expression is also related to SM stress, with a study finding that lesbian women who identified as more "femme" or feminine (Rubin, 1992) in their gender expression experienced less discrimination compared to lesbian women who identified more as "butch," or a more masculine gender expression (Rubin, 1992). This social response (Rubin, 1992) to gender expressions can impact SMW's stress processing (Herek, 1995) and potentially lead to harmful substance use (Lehavot & Simoni, 2011). In considering SMW's use, it is critical to consider the role that stress (from discrimination (Hatzenbuehler & Link, 2014; I. Meyer, 2003), self-

internalized stigma (Lehavot & Simoni, 2011), abuse (Moracco et al., 2007) and more) has on substance use behaviors (e.g., Dyar et al., 2022; Irwin, 2009; Lehavot & Simoni, 2011) through a minority stress perspective (Brooks, 1981; I. Meyer, 2003). In considering SMW's substance use, there are other potential intersecting aspects which must be assessed.

Racial Factors

In re-visiting the role of race through the lens of minority stress theory, racial identity plays a distinctive role in individuals' experience with stress and the societal influences of substance use in the U.S. (e.g., McKnight-Eily et al., 2021). Non-white individuals experience increased stressors that interrelate with SUDs, including food insecurity and decreased healthcare access (Coleman et al., 2019, as cited in McKnight-Eily et al., 2021; McKnight-Eily et al., 2021). This difficulty with access to food and health care, a lack of adequate and available transportation, and discriminatory practices can have negative impacts on mental health, particularly during the COVID-19 era (Kim & Bostwick, 2020, Centers for Disease Control Foundation, 2020, Czeisler et al., 2020, as cited in McKnight-Eily et al., 2021). Additionally, recent studies examining the drinking behaviors in Black college students have found elevated levels of harmful drinking in the population due to acculturative stress (Pitteman et al., 2019), discrimination, and subsequent social anxiety and depression (Buckner et al., 2022; Pitteman et al., 2019).

Research has pointed towards a relationship between sexual identity, race, and substance use, with a 2014 study finding that SMW of color had a greater risk level for lifetime substance use struggles compared to white SMW and heterosexual women of color (Mereish & Bradford, 2014). These findings (Mereish & Bradford, 2014) have been corroborated across varying minority racial and sexual identities (Greene et al., 2020; Pérez et al., 2020). A recent study

examining bisexual Latina's racial and SM stress found ties to increased harmful substance use practices and mental health challenges (Cepeda et al., 2020). These experiences with stigma have negative consequences on health, with Black and Asian American SMs with greater internalized racism and stigma demonstrating increased psychological distress (Szymanski & Gupta, 2009). Latino and Black Americans are presenting with an increased risk for negative health outcomes such as binge drinking, difficulty sleeping, and strokes (Trinh et al., 2017), while in addition to these health challenges (Szymanski & Gupta, 2009; Trinh et al., 2017), Black lesbian women may have decreased routine healthcare-engagement behaviors given their expectations of receiving stigmatizing care (Brenick et al., 2017).

Notably, much of the available literature examining the relationship between race, sexual minority identity, and substance use is focused on risk factors and negative health outcomes (e.g., Cepeda et al., 2020; Mereish & Bradford, 2014; Pérez et al., 2020), though research on protective factors exists through works such as Shangani and colleagues (2020) work that found that higher socioeconomic status can serve as a protective factor. Scholars have noted gaps in current studies pertaining to the intersection of sexual identity and race regarding minority stress (Cepeda et al., 2020; Cyrus, 2017; Shangani et al., 2020), and discrepancies across research in demonstrating consistently significantly worse health outcomes and resultant mental health diagnoses for those with racial and SM identities when compared to heterosexual populations (Cyrus, 2017). Further studies are needed before establishing conclusions about SM's substance use behaviors and factors, including SMW (Cyrus, 2017). After examining the impact of racial stress experiences on substance use, we now turn towards our age-group of interest: emerging adults.

Emerging Adulthood

Emerging adulthood, or years 18-29 of the lifespan, is being recognized as its own unique period of life (Arnett, 2014); it is a time of significant change, with new engagement in employment and higher education, development of romantic relationships, and establishment of independent finances (Arnett, 2005). This is also the period in which substance use typically peaks (Chassin et al., 2014). Substance use within this period of life can be influenced by feelings of newfound independence and responsibility (Goodman, 2014; Stone et al., 2012), stress, and perceiving pressure to use given peers' behaviors (J. Andrews & Westling, 2016). For SMs, the age that one comes out regarding one's sexual identity can affect patterns of emerging adulthood substance use behaviors (Talley et al., 2010). A lack of familial support for one's sexual identity (Rosario et al., 2014), and identifying as a SM early in emerging adulthood have been linked to increased risk for harmful substance use behaviors compared to individuals who self-identify later in this period (Talley et al., 2010).

For SMW in this age-group, disparities in substance use compared to heterosexual peers begin in adolescence and persistently increase throughout emerging adulthood, with SMW using substances significantly more (Dermody et al., 2020). Theories regarding this growth in substance use have been posited, with focus placed on the role of emotional dysregulation (Hatzenbuehler, 2009; C. McCabe et al., 2021). Emotional dysregulation, or the difficulty in enacting emotional adaptations when responding to environmental stressors (Aldao et al., 2010) can be traced to minority stress theory (Hatzenbuehler, 2009), with the hypothesis that individuals who face discrimination (including sexual and racial discrimination) over time can experience challenges to their coping supports, eventually turning to substances as a management strategy (Hussong et al., 2011). Struggles with emotional regulation can appear as

rumination on events or interactions, and avoidance or suppression of an issue (Alao et al., 2010); current research has demonstrated that SMW can experience dysregulation that leads to substance use (Johnson et al., 2013) in emerging adulthood (C. McCabe et al., 2021).

Minority stress theory has been supported in research with SMs (e.g., Hatzenbuehler et al., 2008), and SMW (C. McCabe et al., 2021). Emerging adulthood is a time of increased stressors (Arnett, 2014; Arnett et al., 2014; J. Andrews & Westling, 2016; Goodman, 2014; Stone et al., 2012) and substance use (Chassin et al., 2014); as SMW in this age group can experience challenges to their coping skills and substance use patterns (Hatzenbuehler, 2009; Johnson et al., 2013; C. McCabe et al., 2021), addressing harmful substance use with SMW through prevention and early intervention efforts in emerging adulthood is critical. It is for this reason that I am focusing on this age group within my dissertation work (Dermody et al., 2020; C. McCabe et al., 2021).

In focusing on higher education student populations in emerging adulthood, students may experience increased amounts of substance misuse compared to non-collegiate peers (Skidmore et al., 2016), both within undergraduate (American College Health Association, n.d.) and graduate programs (Allen et al., 2022). Sexual minority students are not immune to this heavy use (Conner et al., 2023), particularly lesbian women (Eisenberg & Wechsler, 2003); SMs demonstrate increased harmful substance use behaviors when engaging on campuses in which verbal homophobic language is being used by peers (Winberg et al., 2019). Of note, student SMs may be more likely than heterosexual students to seek on-campus health services for substance use (Conner et al., 2023) but can report lower levels of satisfaction with provider communication regarding their needs (Addie et al., 2020).

Widespread campus resources are beneficial in addressing SM students' substance use-based needs (Eisenberg & Wechsler, 2003), as well as improved provider interactions and communication (Addie et al., 2020). There is notably a lack of recent research delving deeper into SM and SMW's specific experiences as students pertaining to substance use and campus support, pointing towards the need for additional research. Having described the population of interest (student SMW in emerging adulthood) and some of the many factors that can affect their substance use, we will now shift to explore the effects of societal views on substance use, including occupational science and therapy perceptions of, comfort with, and service approaches for SMW regarding substance use.

Exploring Societal, Professional Views, and Personal Perceptions of Substance Use and Sexual Identity

From a broad perspective, substance use is embedded in daily life in the U.S.: alcohol is a staple at sporting and social events (Erickson et al., 2011), cannabis retail shops are also available in states where use is legalized (Rup et al., 2020), and opioids are often a primary tool in treating chronic pain (Ballantyne, 2017). While individuals recognize that alcohol consumption at extreme levels can lead to negative outcomes, drinking, in specific, is largely done "for pleasure," and is viewed as a way to engage in camaraderie and social gatherings (Heath, 2000). Research has shown that individuals (in particular, women) can be strongly influenced to engage in harmful substance use such as binge drinking based on the "norms" established by other close social connections they hold (family, friends, etc.) (Ahern et al., 2008). This social theme around substance use is echoed when examining use in emerging adulthood, as research has shown that this population tends to associate drinking with creating important social connections (Niland et al., 2013; Vander Ven, 2011).

For many, occasional substance use is not viewed as causing long-term negative health and wellbeing outcomes (Heath, 2000; Hall & Pacula, 2003; Niland et al., 2013; Vander Ven, 2011). Substances can be used in celebrating an event (Heath, 2000), engaging in religious ceremonies (Doering-Silveira et al., 2005; Fuller, 1996), enhancing one's mood and recreational experience (Hall & Pacula, 2003), and for medicinal reasons (Jensen et al., 2015). Emerging adults and "non-dependent" substance users may have internalized hierarchies regarding which substances pose the greatest "risk"; these may be at odds with the U.S.' formal classification of drugs (Daniulaityte et al., 2012). A 2012 study found that participants viewed drugs such as mushrooms and LSD as "relatively low risk," compared to heroin, and also held similar views when comparing cannabis and alcohol, despite the U.S.' Controlled Substances Act categorizing alcohol, cannabis, mushrooms, LSD, and heroin in the same, "highest risk" category (Daniulaityte et al., 2012). This same study found that participants who were using opioids did not perceive an immediate threat to their health given their prescription by a medical professional, despite acknowledging that there were inherent risks to opioid use (Daniulaityte et al., 2012).

The multi-purpose use of substances (Doering-Silveira et al., 2005; Fuller, 1996; Hall & Pacula, 2003; Heath, 2000; Jensen et al., 2015; Niland et al., 2013; Vander Ven, 2011) and social perception of personal use (Daniulaityte et al., 2012) point to a socially-constructed view of substance use that may be defined in-the-moment, via context of use, and per the short-term outcomes experienced by an individual (Daniulaityte et al., 2012; Doering-Silveira et al., 2005; Fuller, 1996; Hall & Pacula, 2003; Heath, 2000; Jensen et al., 2015; Niland et al., 2013; Vander Ven, 2011). It is important to bear this in mind as we shift towards examining how the profession of occupational therapy views and response to substance use.

Occupational Science and Therapy Perspectives on Substance Use

In grounding how the U.S. OS and OT views and approaches substance use, Spiegel and colleagues (2015) explain that the U.S. is situated in the "Global North," with a societal health approach (and professional OT approach) that emphasizes remediation of an individual's health "risk factors" as opposed to enacting large-scale population-based structural changes (e.g., addressing housing, OT practices, and various occupational systems). While there have been calls for a shift in our professional approach to examining larger collective structures and how they impact health (e.g., a "social determinants of health" approach) (Godoy-Vieira et al., 2018; Spiegel et al., 2015), Godoy-Vieira et al, (2018) argue that the "social determinant," "northern" approaches to health may not address the heart of the inequities that purvey our society and lead to health challenges. These inequities (Godoy-Vieira et al., 2018) can include social factors like poverty (Hart, 2013, Soares, 2007, as cited in Godoy-Viera et al., 2018) and capitalist approaches to labor in which individuals are "alienated" from their own labor due to emphasis on "use-value" and "profit" (Antunes, 2013, as cited in Godoy-Vieira et al., 2018).

In embracing the need to expand beyond northern ideologies, the "emancipatory approach," can be employed (Godoy-Vieira et al., 2018; Spiegel et al., 2015). Godoy-Vieira and colleagues (2018) note that emancipatory approaches to substance use encourages a broader perspective and engaging in discourse on social "norms," which includes the prevailing influence and stigma around risk factors for substance use behaviors, such as poverty (Godoy-Vieira et al., 2018). The goal of the emancipatory approach according to Godoy-Vieira and colleagues (2018) is shifting the narrative away from a culture of blame and singular responsibility for harmful substance use and negative health outcomes to a focus on collective empowerment in collaboration across social entities in enacting expansive, structural changes. This effort (Godoy-

Vieira et al., 2018) is supported by the World Federation of Occupational Therapists (WFOT) (WFOT, 2006). My dissertation work looks to uphold and apply this emancipatory approach as an empowering, action-based method for engaging SMW in emerging adulthood affected by substance use in facilitating larger-scale change (Godoy-Vieira et al., 2018; WFOT, 2006; Spiegel et al., 2015).

Prominent OT scholars have pointed to OT practitioners' distinctive positioning and expertise in addressing an individual's multi-faceted experiences with substance use (Amorelli, 2016; Stoffel & Moyers, 2004), the effect of substance use on engagement in one's desired occupations (Stoffel, 1994), and the need to empower individuals with SUDs to explore a reality that is not dictated by substance use (Amorelli, 2016). Some in the profession have taken issue with the tendency we have had on centering approaches around occupations we deem "positive" and promotive of individuals' well-being (Hart, 2020; Hocking, 2020; Kiepek et al., 2014; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2013, 2020b, p. 1). These occupational therapy scholars argue both directly and through their work that this focus (Hart, 2020; Hocking, 2020; Kiepek et al., 2014; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2013, 2020a,b, p. 1) negates to acknowledge occupations (or the "dark side" of occupations (Hart, 2020; Twinley, 2013, 2020a,b) which might not be legal or those which are negatively perceived; this is important given that these occupations may serve a source of identity for individuals (e.g., an individual who identifies as a "smoker" (Haines et al., 2010. p. 242, as cited in Hocking, 2020; Hocking, 2020; Twinley, 2020b, p. 7), be rooted within daily realities and occupational pursuits (Hocking, 2020), and have multifaceted positive effects for users (Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Twinley, 2013, 2020a,b,

p. 7) (e.g., mood, cognition, and occupational "enhancement" (Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022)). This conversation initiates recognition in the profession that occupations that are not often recognized can have positive aspects to them (Hart, 2020; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2013, 2020a,b, p. 7; Wasmuth et al., 2014).

Occupational scientists, in exploring the many factors impacting occupation and individuals' positions as "occupational beings" (Yerxa et al., 1990) have worked to develop methods for the interpretation of SUDs through an OT lens, noting that substance use as an occupation, that can be embedded within one's life (Helbig & McKay, 2003; Hocking, 2020; Kiepek 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014). This has recently been manifested through critiques and new proposed lenses of understanding from scholars, including Rebecca Twinley (2013, 2020a,b) (creator of the concept of the "Dark Side of Occupation") and Niki Kiepek (2016; Kiepek et al., 2019; Kiepek et al., 2022). Occupational therapy scholars in the field call upon us as practitioners and researchers to develop a better understanding of the lived experiences of others and large-scale factors surrounding substance use (Helbig & McKay, 2003; Kiepek, 2016; Kiepek et al., 2019; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014). These works (Helbig & McKay, 2003; Kiepek, 2016; Kiepek et al., 2019; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014) serve as pioneering approaches in exploring OT's fundamental understandings of substance use; they provide a vision for future practice and apply a critical eye to our profession's perceptions and approaches to substance use. In taking the calls outlined in these

works (Helbig & McKay, 2003; Kiepek, 2016; Kiepek et al., 2019; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014) a step further, future scholarly energies could focus on treating and examining substance use simply as an "occupation" (Helbig & McKay, 2003; Hocking, 2020; Kiepek 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Wasmuth et al., 2014) (akin to other occupations such as social leisure, sleep, and the activities of daily living highlighted in our profession's Practice Framework ("Occupational Therapy Practice Framework: Domain and Process Fourth Edition", 2020)) or activity influencing other occupations (Helbig & McKay, 2003; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2020a), as opposed to a set of actions or an occupation that has a caveat attached to it, such as a "dark side," or an occupation that is "hidden" (Twinley, 2013, 2020a,b), and "illicit" (Kiepek, 2016). Debating the choice of terminology and deciding whether an occupation is inherently "bad" or "good" discounts what numerous scholars have concluded throughout OT literature: that at their core, all occupations have varying contexts, meanings, and implications for individuals that range between positive, neutral, and negative (Hammell, 2004; Ikiugu, 2005; Kiepek et al., 2014; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi & Galvaan, 2020; Twinley, 2013, 2020a,b, p. 7).

In centering on the discussions of terminology (Twinley, 2013, 2020b) regarding "negative" occupations or occupational outcomes that have traditionally held stigma (such as substance use (Cunningham et al., 1993; Earnshaw, 2020)), such deliberations risk purveying unearned and unnecessary judgement on what substance use (and occupations in general) are and ought to be (Kiepek et al., 2014; Kiepek et al., 2019; Kiepek et al., 2022). This may promote

stigma (whether deliberate or not (Twinley, 2020b, pp. 2-5)) through adjudication on all who engage in substance use as a desired occupation (Godoy-Vieira et al., 2018; Kiepek et al., 2014). These debates on jargon can evoke racially stigmatizing language, no matter what the intent (Twinley, 2020b, pp. 2-5); in continuing to attach such terminology to highlight substance use apart from other occupations, this can also unintentionally result in our profession continuing to pass judgement on what occupations are "positive," carry "worth", or are "normal" (Hart, 2020; Kiepek et al., 2014; Kiepek et al., 2022; Njelesani et al., 2015). Through labeling occupations as "positive," "negative," (Kiepek et al., 2014; Kiepek et al., 2019; Kiepek et al., 2022) "illicit" (Kiepek, 2016), or having a "dark side," (Twinley, 2013, 2020a,b), we become firmly positioned in a white, "Western" (Sholock, 2012; Kiepek et al., 2022) approach that takes away from scholarly expertise, time, research focus, and advocacy that could be used in critiquing larger societal structures that influence substance use and promoting social change (Godoy-Vieira et al., 2018; Spiegel et al., 2015) and more deeply exploring the spectrum of substance use (Kiepek et al., 2022).

Globally, OT has been widely recognized as a profession that has a valuable role in generating change at the societal level (Godoy-Vieira et al., 2018; Malfitano & Lopes, 2018; Picotin et al., 2021; WFOT, 2006). While outlining a plan for harnessing the profession's skillsets to enact systemic changes that prevent harmful substance use can seem overwhelming and resides somewhat outside the scope of this dissertation, a starting point is re-evaluating how we view substance use and approach it in our practice (Godoy-Vierira et al., 2018). We as OT practitioners must commit to empowering those we serve as the lead decision-makers regarding addressing systemic challenges to one substance use, and create opportunities for collaboration to enact social change (Godoy-Vieira et al., 2018). It is this step in leading to larger structural

transformations that I focus my dissertation work on in implementing a transformative (Mertens, 2009; Mills, 1959) occupational science (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) lens that grows our occupational imagination surrounding substance use (detailed in Chapter 4) (Laliberte Rudman, 2014, 2019). In initiating this process, I will detail broader social, personal, and practice factors that can influence service access and availability next, and tie this to implications OS and OT.

Access to and Implications in Attaining Substance Use Disorder Services

There are many interlacing factors regarding service access for substance misuse, including the availability and expense, the time required to receive care (and subsequent potential loss of income), and one's demographic and social disparities (Vaeth et al., 2016). An individuals' age also plays a role as well: teens and young adults may be less likely to seek services for SUDs (Christiana et al., 2000; Kessler et al., 1998, Wang et al., 2005, as cited in Blanco et al., 2015) and may look to parental figures to be familiar with symptoms and promote service access (Dakwar et al., 2014 as cited in Blanco et al., 2015). Education level also has an impact, with individuals who had not participated in college engaging in care services more frequently than those who attended school in a study by Blanco and colleagues (2015). Finances and insurance affect access to care for substances; prior to the 2014 Affordable Care Act (ACA) expansion of Medicaid, low-income earners experiencing substance use disorders were often unable to access needed care due to non-eligibility for Medicaid (Henry J. Kaiser Family Foundation, 2017, as cited in Olfson et al., 2018) or being uninsured (Ali et al., 2017). In states that saw expanded Medicaid services through the ACA, there was a decrease in the number of low-income adults with SUDs who were uninsured, though this did not lead to an increase in

persons with both a SUDs and lower income obtaining SUD-based services within a recent study (Olfson et al., 2018).

Stigma surrounding substance use (especially the type of substance) can factor into the personal decision to seek care (Teesson et al., 2006; Wu et al., 2017), with individuals with SUDs being a highly stigmatized group across the global spectrum (Ashford et al., 2019). Stigma surrounding SUDS can be societal (where one's identities are not considered important given their substance use, or one is thought to be untruthful) (Earnshaw, 2020). They can also be structural (in which public laws and organizations exercise discrimination against individuals with SUDs), and interpersonal (regarding personal views of those with SUDs) (Earnshaw, 2020). An individuals' SUD status can impact gaining employment (Earnshaw, 2020) and workplace experiences (Erickson & Goodstadt, 1979, Tootie, 1987, as cited in Cunningham et al., 1993). Importantly, the stigmatizing views on the part of healthcare providers may also prevent individuals from obtaining the critical care that they need for harmful substance use (Earnshaw, 2020), and can negatively impact individuals' perceptions of themselves and subsequent care participation (Mak et al., 2016).

From a psychological perspective, individuals who engage in substance misuse may not feel that they need care services or believe that such services will be impactful (Moeller et al., 2020). Additionally, individuals with a higher desire to pursue care services can experience decreasing levels of drive over time (Moeller et al., 2020). Those with less intensive symptoms or harmful outcomes from substance use may not be as likely to obtain services compared to those with more severe use and symptoms (Moeller et al., 2020). One may also simply not be ready to discontinue using (Han et al., 2015), given that substance use may itself become a form

of personal identity (e.g., Helbig & McKay, 2003; Hocking, 2020; Twinley, 2020b, p. 7; Wasmuth et al., 2014).

Current Service Engagement in the U.S., Service Focus, and the Role of Provider Competency

Substance Use. In examining the response to substance misuse in the United States (U.S.), within 2022, 13.1 million people received various forms of treatment for substance use, with 85.1% of those who qualified as having a SUD (12 years of age or older) not receiving treatment, demonstrating a notable care gap (SAMHSA, 2023). Traditionally, research regarding SUD intervention has focused on ending use and maintaining substance "cessation," though clinical thinking is evolving; newer treatment is focusing on reducing use, addressing the neurobiological underpinnings of addiction, implementing behavioral and modulational techniques, and creating care plans that are designed for individuals' specific needs (Volkow, 2020). Research and care directed at the unique experiences of women are also beginning to emerge, such as the 'Trauma Recovery and Empowerment Model' (Fallot & Harris, 2002), and the "Maternal Addiction, Treatment, Education, and Research Program" (Hand et al., 2021). While approaches specifically targeted towards SMs are available (e.g., Blume, 2016), it is difficult to find substance services and interventions directly tailored towards SMW.

Health care professionals, including occupational therapy practitioners, can both advertently and inadvertently play a role in whether a person chooses to seek care given providers' level of competence and experience surrounding substance use and targeted interventions (Amorelli, 2016; Blanco et al., 2015). In addressing SUDs and risky substance use with individuals, healthcare providers may present with a lack of extensive education and possess negative views of individuals who have SUDs (Earnshaw, 2020; Mak et al., 2016); these

have direct negative consequences for whether a person is referred to care services (Amorelli, 2016; Blanco et al., 2015). In addition, more broadly, OT providers may not have a clear understanding of the role that the profession has in addressing SUDs (McCombie & Stirling, 2018).

The ability to effectively define our scope of practice in mental health care and address harmful substance use starts at the educational and practice fieldwork levels (Egan & Cahill, 2017). As recently as (2017), a survey exploring the mental health curriculum of OT and Occupational Therapy Assistant programs across the U.S. showed that OT students often do not receive specified education and fieldwork experiences focused on mental health OT practice (Mattila & Provident, 2017). Mattila & Provident (2017) further discuss the issue of the deficiency of education regarding SUDs for occupational therapy practitioners, noting that up-to-date education on interventions is not readily available. These factors emphasize the current issues the OT profession is facing in applying our expertise in mental health care (and subsequently substance use care) (Amorelli, 2016; Blanco et al., 2015; Earnshaw, 2020; Egan & Cahill, 2017; Mak et al., 2016; Mattila & Provident, 2017; McCombie & Stirling, 2018).

In addition to the aforementioned professional challenges (Amorelli, 2016; Blanco et al., 2015; Earnshaw, 2020; Egan & Cahill, 2017; Mak et al., 2016; Mattila & Provident, 2017; McCombie & Stirling, 2018), there is also the issues of occupational therapy practitioners lacking awareness of individuals' experiences with SUD diagnoses *across settings* (including non-mental health settings) (Thompson, 2007) and implementing OT-specific assessment tools that can be incorporated into SUD services (Estreet, 2019). An OT survey found that most screenings and assessments of harmful substance use occur in mental health OT settings, with practitioners from non-mental-health settings reporting conducting SUD-specific assessments

less than 5% of the time; this means that SUDs are likely not being addressed in care service contexts, given that they are not being screened for (Thompson, 2007). Practitioners in non-mental health settings may also under-estimate the number of people they encounter with harmful substance use practices, meaning those who could potentially benefit from OT intervention or referrals to care specified substance misuse services who are being seen for another health factor may not be receiving the services they need (Thompson, 2007).

A gap also exists in OT literature regarding the role of the profession in treating individuals with co-occurring SUDs (McCombie & Stirling, 2018), and health providers report possessing limited knowledge regarding how OT practitioners can address recovery and occupational performance (Mattila & Provident, 2017). These issues facing the profession demonstrate a need for active efforts in defining how to better meet the needs of people (including women) with harmful substance use across our education (Amorelli, 2016; Blanco et al., 2015; Egan & Cahill, 2017), professional scope of practice (McCombie & Stirling, 2018; Mattila & Provident, 2017), research (McCombie & Stirling, 2018), and practice (Estreet, 2019; Thompson, 2007).

Sexual Minority Individuals. In returning to a focus on SMW's care services and their intersection with the OT profession, SMW' rate of service access for harmful substance use is higher than heterosexual women's (e.g., Grella et al., 2009), though it is difficult to find research that describes the prevalence of care access between specific sexual identities. Scholars have noted that this may be attributed to SMW having a greater need for services given more intensive mental health and substance use health impacts and prevalence (Hughes et al., 2014; Jeong et al., 2016). Sexual minority women's views on seeking care may also be tied to stigma, with K. Green (2011) finding that interestingly, SM individuals within their study reported decreased

concerns over stigma surrounding service access for substance use. For sexual and racial minority women (SRMW), service access differs, with SRMW engaging in care services less often than white SMW (Stanley & Duong, 2015). Additionally, SMW seeking care can face additional barriers including an increased likelihood of being underinsured/not having insurance and experiencing provider stigma (Hughes, 2011).

From an OT service perspective, occupational therapy provider (OTP) experience, competency, and comfort in working with SMW is important to explore. As recently as 2022, scholars within the profession noted that practitioners demonstrate a lack of confidence and knowledge in serving sexual minority individuals (Bolding et al., 2022). This is compounded by the fact that there is a dearth of education on working with SM individuals (Areskoug-Josefsson et al., 2016; Bolding et al., 2022), and often, when available training is incorporated into curriculum, it is in the contexts of cultural humility and does not include education on interventions, rapport-building, or population needs (Hammell, 2013). Compounding this lack of specified focus on SM health is the traditional assumption that when discussing cultural humility, the "majority group," is cisgender, heterosexual, and white; this further erases discussions of differing sexual (and gender) identity within professional content (M. Butler et al., 2016). For current practitioners, there is a lack of top-down information on the frequency in which OTPs are seeking continuing education to expand their competencies surrounding LGBTQIA+ care, or what continuing education resources are most commonly being accessed, despite the benefit of completing continued education on SM care in increasing adeptness and comfort (Bolding et al., 2022).

Occupational therapy providers' personal biases and stigma towards sexuality and gender can prevent their openness in addressing these in practice (McGrath & Sakellariou, 2016).

Additionally, little (if any) current research is available regarding best practices for substance use services targeted towards SM (including women (Mericle et al., 2018)) across care settings. Ultimately, these professional challenges have very real consequences for SMW, including care disparities resulting in negative health outcomes pertaining to mental health diagnoses, harmful substance use, homelessness, and more (Joint Commission, 2011). Researchers in this area of practice have called for OT engagement in continuing education on SM services and practice factors, active reflection on one's competency in providing care to this population and addressing where additional attention is needed to ensure the provision of best practices (Bolding et al., 2022). This research (e.g., Areskoug-Josefsson et al., 2016; Bolding et al., 2022; McGrath & Sakellariou, 2016) demonstrates that our profession has continued work in meeting our ethical duty to provide expert and compassionate care to SMs (American Occupational Therapy Association, 2020), including addressing harmful substance use (Amorelli, 2016; Blanco et al., 2015; Egan & Cahill, 2017; Estreet, 2019; Thompson, 2007).

Occupational Therapy Approaches to Substance Use Disorder Services

Occupational therapy practitioners can play a critical role collaborating with and empowering those we serve to address their substance use and engagement in other occupations that are needed and important for the individual (Stoffel & Moyers, 2004). Common OT evidence-informed approaches in addressing recovery from substance misuse have included motivational interviewing, cognitive behavioral therapy-based interventions, and promoting engagement in step-based programs (Doğu & Özkan, 2023; Stoffel & Moyers, 2004). Practitioners can work with individuals on honing "life skills" and activities of daily living training that can aid in preventing relapse (Amorelli, 2016; Stevens et al., 2003, as cited in Amorelli, 2016). Therapy can include relaxation activities, "didactic" group processing, hands-

on creative tasks (Peloquin 2010, as cited in Amorelli, 2016), and facilitating peer support groups (Boisvert et al., 2008, as cited in Amorelli, 2016).

Career development skill-building (e.g., interviewing for a job) (Darko-Mensah, 2011, as cited in Amorelli, 2016), and time management skills training (White, 2007, as cited in Amorelli, 2016) also serve as potential areas for OT intervention. Another significant approach to intervention is harm reduction, during which the practitioner collaborates with a person who is using substances to find ways to mitigate the negative effects of use in a person-informed way (Kiepek, 2016, pp. 95-130). Harm reduction interventions can include education on safer ways to use substances (e.g., sterilizing needles), and "alcohol maintenance programs" (Kiepek, 2016, pp. 95-130).

Calls for the implementation of SBIRT, or "screening, brief intervention, and referral to treatment" into training for rehabilitation providers (including occupational therapy practitioners) have been more common in recent years for the purposes of increasing practitioner comfort with screening for SUDs, addressing use, and referring individuals to care services (Brown et al., 2024; Mattila & Provident, 2017; Scudder et al., 2021). Scudder and colleagues' (2021) recent study found that training on the use of SBIRT resulted in increased positive feelings and perceived ability to screen for SUDs across OT and other health professions students (Scudder et al., 2021). Similar findings were corroborated in a 2024 study conducted by Brown and colleagues with Masters of OT students. A current barrier to implementation of SBIRT in OT practice is the limited understanding of the approach within the profession, leaving opportunities for increased education surrounding this method (Brown et al., 2024; Mattila & Provident, 2017). While it is a potential impactful tool for the OT profession (Brown et al., 2024; Mattila & Provident, 2017; Scudder et al., 2021) the focus of SBIRT is on addressing the needs of the

individual, as opposed to the larger social systems influencing substance use and SUDs (Scudder et al., 2021). That is not to say, however, that occupational therapy practitioners are not involved in movements seeking to change the healthcare system, poverty, legislature, and more (Stoffel, 2013).

When focusing specifically on the age group of interest in this dissertation, collegiate students, there have been recent calls for the need to better define and increase OT's role in on-campus care support for mental health needs and occupational engagement (Jalaba, 2022). Additionally, despite the availability of various profession-specific service avenues, there is little research available targeting OTPs' intervention approaches for those not formally diagnosed with a SUD who may be experiencing harmful use outcomes, or for those with a SUD who have chosen not to seek care, despite OTPs being uniquely situated in addressing this population through the skills previously illustrated (e.g., Amorelli, 2016; Davies, 2006; Doğu & Özkan, 2023; Kiepek, 2016; Stoffel & Moyers, 2004). This lack of research, practitioner's stigma surrounding sexuality (McGrath & Sakellariou, 2016), and concerns over practitioner SUD competency (Blanco et al., 2015) result in the need for research that explores the reasons that individuals (including SMW) choose to forgo services for harmful substance use and how OTPs (and other health professionals) can be of better service. Such research could help explore how providers can better address the individual, their occupations (including substance use), the role of sexual identity in substance use (Hicks, 2000), and the profession's position in purveying and changing the negative societal structures which influence substance use (Blanco et al., 2015).

For student SMW in emerging adulthood who are receiving substance use care, targeted therapy services are needed to infuse intervention with support for social and internalized stressors (e.g., homophobia, discrimination, and the coming out process), and enhancing

intimacy, family and social relationships, and supports such as spiritualty (Hicks, 2000). Given our scope of practice (AOTA, 2020), the roles of OT in substance use care (Stevens et al., 2003, as cited in Amorelli, 2016; Stoffel & Moyers, 2004), the potential for involvement in higher education settings (Jalaba, 2022), and the wide range of interventions we can facilitate across daily roles and occupations (e.g., Amorelli, 2016; Davies, 2006; Doğu & Özkan, 2023; Kiepek, 2016; Stoffel & Moyers, 2004), the profession is well qualified to provide specialized substance use intervention with SMW. To advance our knowledge and abilities as a profession, increased research surrounding the experiences of student SMW in emerging adulthood who are using substances is needed to understand how we might best serve this population across practice settings. Having established population factors and the profession's approaches to harmful substance use, current qualitative research on SMW in emerging adulthood's experiences with substance use and the study data methods will be detailed.

Exploring Qualitative Research on Substance Use in Female Populations

Historical Applications of Photovoice and Phenomenological Interviews. To explore the current research on student SMW in emerging adulthood's lived experiences regarding substance use, Photovoice methodologies and interviews were implemented within this dissertation work. Photovoice methodologies have been successfully used to examine the impact of substance use and obtaining mental health services within various populations (e.g., Brazg et al., 2011; D'Angelo & Her, 2019; Nair et al., 2016; Rosenthal et al., 2017; Valdez et al., 2019). Some studies have had a youth and emerging-adult-based focus, with a Photovoice-focused community based participatory research study by Brazg and colleagues (2011) examining community tools and areas for improvement regarding adolescent substance use through youth participation. Another study by Nair and colleagues (2016) examined nursing students' alcohol

use, and a 2019 study by Valedez and colleagues used Photovoice to explore the impact of living near the U.S. Mexico border on youth's substance use behaviors. Other studies have had similar specific geographic scopes, with D'Angelo & Her's (2019) research implementing Photovoice methods to better understand factors surrounding substance use and the impact of this misuse in the Hartford, Connecticut community, and a 2017 study by Rosenthal and colleagues exploring alcohol use factors on the community of Saint Vincent in the Grenadines.

Heery's (2017) research used Photovoice in a virtual (online) environment to examine the process of recovery for six adult individuals who identified as "addicts." Heery (2017) found that recovery takes time, and that while one recovers by oneself, the process is bolstered by support from others. A 2023 study by Smith and colleagues used digital Photovoice methods in working with numerous people receiving care services in the recovery process. Exploration into the isolation experienced by various participants and the need for interpersonal relationship opportunities in care services was detailed (E. Smith et al., 2023). While this is not an exhaustive list of research using Photovoice methodologies to examine various population's substance use, these studies demonstrate the variability and adaptability of Photovoice in exploring groups' lived reality surrounding substance misuse (Brazg et al., 2011; D'Angelo & Her, 2019; Heery, 2017; Nair et al., 2016; Rosenthal et al., 2017; E. Smith et al., 2023; Valdez et al., 2019).

Through an OT lens, Photovoice methodology has been used to explore the lived experience of student veterans (Dobson, 2017; Dobson et al., 2022; Tomar, 2013; Tomar & Stoffel, 2014), individuals with intellectual disabilities (Ausderau et al., 2019), the barriers to community participation for adults with intellectual or developmental disabilities (Heffron et al., 2018), community engagement struggles during the pandemic for younger adults on the autism spectrum during COVID-19 (Davidson & Preiffer, 2024) and exploring the need for OT

practitioners to address individuals who are homeless' engagement in self-care needs, leisure, group therapy, etc. (Van Oss et al., 2020). It has also been implemented successfully with LGBTQ college students on a midwestern campus in exploring their school experiences (Bardhoshi et al., 2018). Pertaining to substance use, a recent study by Dell and colleagues (2022) examined "safe" coping strategies for distress in individuals with co-occurring post-traumatic-stress-disorder and SUDs, finding that managing stress is a continued process, and mastering wellness skills can lead to feelings of agency. Participants also highlighted that healthy relationships are critical, and social and physical environments contribute to feelings of safety (Dell et al., 2022). Photovoice has also been described as an asset in gender and sexual identity exploration, as it opens the door to social and community engagement, self-expression, and alternate mediums for individuals to express themselves (Christensen et al., 2020). The variability of these studies and opportunity for self-exploration (Christensen et al., 2020) strengthens the wide applicability of Photovoice methodology as an exploratory method in OT within and across diverse populations and health factors, including substance use (Ausderau et al., 2019; Christiansen et al., 2020; Davidson & Preiffer, 2024; Dell et al., 2022; Dobson, 2017; Heffron et al., 2018; Tomar, 2013; Tomar & Stoffel, 2014; Van Oss et al., 2020).

Current applications of phenomenological interviews in substance use research, another qualitative method of inquiry, has been used with emerging adults (e.g., Pass et al., 2016), with a focus on collegiate populations (K. Andrews, 2023; Kimball et al., 2017; Kimball et al., 2022; Matsunaga, 2018). The use of this method of study has also been implemented within the OT profession as well (e.g., Cruz, 2019; Vegeris & Brooks, 2022; Wasmuth et al., 2014). Cruz's (2019) capstone research implemented interviews between an OT and individuals who had received substance use services in delineating the role of the profession in substance use care and

identifying individuals' occupational needs. The study findings support that individuals desire services that target meaningful leisure occupational exploration, highlighted occupational therapy practitioners' role in promoting leisure engagement, and demonstrated our ability to collaborate with those who we serve to develop communication, interview, and assertiveness skills (Cruz, 2019).

Wasmuth and colleagues' (2014) study implemented interviews with individuals with varying dependencies (e.g., alcohol, marijuana, methamphetamines, sex, food) in examining addiction as an occupation, with participants exploring the various effects of their substance use on their daily lives. Aspects that influenced participants' substance use behaviors included feeling social inhibition and connection; the effects of addiction had varying levels of "penetration," on participants' lives, with some describing experiencing use habitation, which made the occupation feel like a "background activity" within their daily schedule (Wasmuth et al., 2014). Vegeris & Brooks' (2022) research examined the occupational lives of individuals maintaining sustained recovery from harmful alcohol use. Participants described addiction as an occupation that can cause social isolation while providing meaning as a coping strategy (Vegeris & Brooks, 2022). While there are not a wide variety of phenomenological interview-based studies through OT on substance use, this research illustrates the usefulness of the method in generating rich data surrounding individuals' substance use as it relates to their occupational functioning (Cruz, 2019; Vegeris & Brooks, 2022; Wasmuth et al., 2014).

Women's Substance Use. Research that examines the lived experience of women in which substance use, while not the primary focus of the studies, is an aspect explored, are available and provide a better understanding of the role of substance use as an occupation (e.g., Bukowski & Buetow, 2011; Fitton, 2019; Miller et al., 2021). While research specifically using

Photovoice methodologies to explore the lived experiences of women with SUDs is not as commonly available, a study by Howard & Colvin (2021), involved the use of Photovoice and coding processes outlined by Wang & Burris (1997) in exploring motherhood through the lens of women with opioid use disorders. Participants called for compassionate care and support across services, including the need for promotion of care on behalf of mothers (Howard & Colvin, 2021). Research by Van Steenberghe and colleagues (2021) explored the experiences of women in active recovery from drug use, noting the applicability of Photovoice as a method for addressing barriers to recovery and negative social norms that impact women's recovery journeys. Halprin (2017) applied Photovoice in collaborating with pregnant women regarding their experiences with substance use and described the complexities of the decision-making surrounding use. The study also included discussion of the strengths and challenges that intersected with substance use centered related to stigma, housing insecurity/security, use patterns, program accessibility, and familial support (Halprin, 2017).

There are numerous studies using varying phenomenological, interview-based approaches with female-identifying populations, including research on Black women's experiences (Blount et al., 2021; Rawat et al., 2021; Redmond et al., 2020; Wright, 2001, 2003), the intersection between substance use and sex-work (Sallman, 2010), women's service experiences regarding interventions provided by male healthcare professionals (Bennett, 2019), and exploring the relationship between childhood traumatic occurrences and substance use (Hunter, 2016). A 2018 study by Suarez and colleagues used interviews to explore the challenges and resources available to mothers in opiate recovery and highlighted the stigma healthcare providers can hold regarding pregnancy and addiction. Rawat and colleagues' (2021) study examined the impact of SUDs on women's roles and occupations in the context of harmful

substance use using semi-structured interviews, finding that women experienced decreased engagement in activities of daily living, alterations in sexual libido, risky sexual practices, difficulty maintaining performance within employment, and the replacement of previously enjoyed leisure activities with substance use (Rawat et al., 2021).

This research offers a rich set of data that tell the stories of women from unique populations who have experienced harmful substance use (Bennett, 2019; Blount et al., 2021; Hunter, 2016; Rawat et al., 2021; Redmond et al., 2020; Sallman, 2010; Wright, 2001, 2003). It should be noted that there is not a wide expanse of qualitative, interview-based studies on women's lived experience with substance use, nor, to my knowledge, qualitative interview-based research focused explicitly on women's experience with substance use and SUDs through an OT lens. A study by Narain and colleagues (2017), stands out for this reason, as it implemented qualitative semi-structured interviews with individuals in better understanding women's occupational performance as it is affected by substance use and peer-based program engagement. The study concluded with numerous themes, including, importantly, that the women participating perceived that substance use significantly negated their ability to engage in their daily lives (Narain et al., 2017). The lack of available research using such a rich method, findings from studies like Narain et al. (2017), and calls for broader-scale, societal-based addressment of substance use (Godoy-Vieira et al., 2018) underscores the need for further literature through an OS and OT lens to improve provider understanding of this health experience across a spectrum, from personal, occupational performance perspectives (Narain et al., 2017) to broader sources of social inequities that affect substance use patterns and behaviors (Godoy-Vieira et al., 2018).

Sexual Minority Women's Substance Use. Just as there is a lack of OT literature on the use of phenomenological interviewing and Photovoice methods in women's substance use, this

gap extends to student SMW in emerging adulthood. Research on SMW's substance use using these methods exists outside the OT profession (e.g., Bochicchio et al., 2021; Creighton et al., 2019; Goodyear et al., 2023; Gorritz Fitzsimons, 2022; Helminen et al., 202; Ioannides, 2021; Mericle et al., 2018) though it is difficult to come by. Ioannides (2021) recently conducted interview methods with SMW regarding their behaviors surrounding alcohol use and reduction intake, with participants emphasizing pressure from peers to use and the need to build personal coping tools to address stressors. Factors influencing participants in decreasing their use included prior familial history of alcohol misuse, the desire to have healthier mental, physical, and relational outcomes, and concerns over becoming dependent on alcohol as a coping strategy (Ioannides, 2021). Finally, participants discussed breaking out of LGBTQIA+ social settings altogether given the lack of sober venues, showing how embedded substance use may be in LGBTQIA+ community social spaces (Ioannides, 2021).

Research on New York SMW's PTSD symptoms and substance use behaviors during "heightened societal stress" (e.g., living in one of the first COVID-19 city epicenters, through racism-related police violence, etc.) included semi-structured, qualitative interviews, and detailed participants' higher prevalence of hazardous drinking behaviors and PTSD symptoms compared to general and trauma-exposed SMW (Helminen et al., 2021). Bochicchio and colleagues (2021) study used phenomenological qualitative interview methods via phone and Zoom to detail the alcohol and marijuana use behaviors of SMW during COVID-19. For participants, the pandemic led to disruptions to personal schedules and previously applied substance use boundaries (Bochicchio et al., 2021). Substance use was tied to stress and boredom relief, including both social connection (with partners, friends, and work colleagues) and disconnection (Bochicchio et al., 2021).

In examining a final phenomenological interview study, Mericle and colleagues (2018) interviewed substance use service program directors regarding sexual-identity-sensitive care for SMW, with participants describing the measures they took through the evaluation and care processes to provide individuals with a safe, welcoming environment; this included emphasis on respecting individuals' sexual and gender identities and promoting program members' ability to choose a preferred provider. Connecting women with services outside of the substance use programs and providing trauma and gender-informed care were also critical aspects of SMW's care experiences (Mericle et al., 2018). Lack of staff who are sexual minorities, inadequate funding and personnel, and a limited consistent number of SMW participating in the programs served as barriers to providing the comprehensive care to SMW that program coordinators desired (Mericle et al., 2018).

From the lens of Photovoice methods, research on sexual minority individuals' (including women) substance use that focuses on youth populations exists, with Goodyear et al. (2023) using the method in examining sexual and gender minority youth's experiences with opioid use (Goodyear et al., 2023). In focusing on adult sexual minority populations, more broadly, Photovoice has been applied in examining sexual minority individuals of color's experiences in receiving SUD counseling (Gorritz Fitzsimons, 2022). This research was focused on sexual minority people of color and their experiences receiving counseling; participants' experiences with counselors' visible discomfort when discussing sexual and racial minority factors and a lack of authenticity impacted participants' comfort level with personal disclosure (Gorritz Fitzimons, 2022). Participants also felt "unseen" by their counselors, particularly regarding their minority stress experiences (Gorritz Fitzimons, 2022). The individuals who engaged in the study voiced the importance of counselors connecting sexual and racial minority individuals with others in

their community, sexually and racially affirming services, demonstrating acceptance and care regarding one's identities and disclosures of trauma experiences, and having diverse voices involved in the care process (Gorritz Fitzimons, 2022). Finally, of note, participants had recommendations for counselors, including the need for increased sexual and racial minority representation in service settings, improved collaborations with community supports, increased recognition and education on sexual minority care amongst counselors, and access to counseling services that are affordable and easy to engage with (Gorritz Fitzimons, 2022).

Another Photovoice study indirectly examining SMW's experiences with substance use include a recent study from Creighton and colleagues (2019) working with female survivors of childhood trauma and suicidality, which involved participants' discussion of personal harmful substance use. Creighton et al.'s (2019) work represents the most commonly accessible research on SMW and Photovoice methods that includes discussion of substance use. While there are not a great deal of studies implementing Photovoice with SMW, let alone in targeting substance use, these studies (Creighton et al., 2019; Gorritz Fitzimons, 2022; Goodyear et al., 2023) demonstrate the applicability of Photovoice as a valuable method in exploring sexual minorities' experiences with substance use.

With specific regard to SMW's experiences with substance use and care services, though there are OT-based studies using Photovoice methodology to explore various aspects of mental health and substance use across populations (e.g., Birken & Bryant, 2019; Greco et al., 2017, Howard & Colvin, 2021, etc.), to my knowledge, there are no studies that examine SMW in emerging adulthood's lived experience with SUDs' lived experiences around personal substance use and care access/experiences. There are no Photovoice studies available on this issue through an OT lens, including none that implement the intersecting application of the PEO model (Law et

al., 1996, Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011), Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sholock, 2012) and Queer Theory(ies) (J. Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020).

Qualitative Methodological Limitations

While the practical limitations of both Photovoice and phenomenological interview methods from the perspective of this study are explored in greater depth in Chapter 5, it is worth noting here that there are historical limitations to these methods (and qualitative research as a whole) that must be considered (Bonisteel et al., 2021; Hannes & Parylo; Kaiser, 2009). Initial challenges with qualitative study recruitment can arise due to ethics committee's requirements regarding the recruitment process (Bonisteel et al., 2021). One's recruitment population matters, with the potential for challenges in recruiting individuals who are emerging adults, as they are in a period of life transition (Bonisteel et al., 2021). In pertaining to methods of qualitative data gathering, there is a risk for co-researchers to potentially be identifiable to others given the specific attributes they possess and describe through the research (Kaiser, 2009). Ethical challenges can also arise within qualitative health research regarding co-researcher disclosure of personal information (including one's sexual identity) that might be helpful for one's healthcare providers to be knowledgeable about in providing the most optimal care (Kaiser, 2009). Additional challenges regarding confidentiality come into play with photo-based qualitative methods such as Photovoice, which place the responsibility of taking ethical and confidential photos with the study participants (Hannes & Parylo, 2014). The inclusion of these limitations (Bonisteel et al., 2021; Hannes & Parylo, 2014; Kaiser, 2009) is not to say that qualitative

methods such as Photovoice and phenomenological interviews are not worth implementing; these limitations are merely meant to stoke our awareness of these impacting factors on the research process in considering how they might be accounted for within this dissertation work and future research.

Given that the OT profession has a unique set of clinical perspectives and skills within the field of mental health (and substance use) (Amorelli, 2016; Doğu & Özkan; Stoffel & Moyers, 2004) along with an understanding of the interaction between one's person factors, environment, and occupations (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011), our profession is well-equipped to better meet the needs of those we serve. While being mindful and addressing the potential limitations of qualitative research methods (Bonisteel et al., 2021; Hannes & Parylo, 2014; Kaiser, 2009), we can address the needs of SMW in emerging adulthood who use substances through exploratory Photovoice and phenomenological interview-based qualitative studies that explore substance use and the mental, physical, and environmental barriers/supports to seeking supportive services. This study contributes to the literature surrounding SMW in emerging adulthood and provides critical recommendations for improving women's well-being and healthcare encounters.

Discussion and Looking Ahead

Substance use plays a significant role in the lives of U.S. citizens (SAMHSA, 2022), including women, specifically (Grucza et al., 2008; Keyes et al., 2008; SAMHSA, 2020a; Steingrimsson et al., 2012). Women experience unique factors around substance use that differ from that of mens,' including specific forms of stigma (Pinedo et al., 2020; Robertson, 1988) trauma factors (Cottler et al., 2001; Wechsberg et al., 1998), and the experience of motherhood (Gartner et al., 2018). Support service access for SUDs is a complex issue, with numerous

factors influencing individuals' ability and decision-making when seeking care for substance use, including education level (Blanco et al., 2015), socioeconomic and demographic disparities (Vaeth et al., 2016), age (Kessler et al., 1998, Wang et al., 2005, as cited in Blanco et al., 2015), and insurance coverage (Ali et al., 2017; Henry J. Kaiser Family Foundation, 2017, as cited in Olfson et al., 2018). Sexual minority women have an increased rate of substance use compared to their sexual minority male peers and heterosexual peers (S. McCabe et al., 2009; Feinstein et al., 2017; Schuler & Collins, 2020; Trocki et al., 2009). Women in this population have distinctive factors that impact their substance use (Schuler & Collins, 2020). Personal disclosure of sexuality, stigma (Feinstein et al., 2017; S. McCabe et al., 2010) and challenges to community support (Heck et al., 2014; Johns et al., 2013) can serve as barriers to healthy substance use behaviors or care supports. Sexual minority community social spaces can center on substance use, making it difficult to establish relationships and experience support from others in the community without engaging in such use (Baiocco et al., 2010; National LGBTQ Young Adult Tobacco Project, 2010). While differentiating between supports and barriers for non-harmful substance use behaviors can be difficult (Feinstein et al., 2017), being "out," social support (Feinstein et al., 2017) and spirituality can all be critical supports for SMW (Drabble et al., 2016). Minority Stress Theory has also commonly been applied in examining sexual minority substance use as well (Brooks, 1981; I. Meyer, 2003), all of which contributes to substance use (Dyar et al., 2022; Gorritz Fitzsimons, 2022; Kiekens et al., 2022; Lehavot & Simoni, 2011; Lewis et al., 2021; Schuler & Collins, 2020).

Occupational therapy practitioners have skillsets that make them critical members of SUD care teams (Amorelli, 2016; Doğu & Özkan; Stoffel & Moyers, 2004); the profession, as one based in healthcare, regards substance use disorders as a disease-based health issue (Hyman,

2014; Spiegel et al., 2015). Despite this, OT has also taken new approaches, looking at substance use as an occupation (Helbig & McKay, 2003; Hocking, 2020; Kiepek 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014), and calling for an "emancipatory" approach (Godoy-Vieira et al., 2018) to misuse services that address the societal systems that contribute to the development of SUDs (Godoy-Vieira et al., 2018). It is also important to understand that OT practitioners report feeling that they lack the educational competencies, required training, and experience needed to comprehensively treat individuals with SUDs (Amorelli, 2016; Blanco et al., 2015; Mattila & Provident, 2017) *or* varying sexual identities (Areskoug-Josefsson et al., 2016; Bolding et al., 2022; McGrath & Sakellarious, 2016). Practitioners may also not be assessing substance use in persons who are seen in non-behavioral health-based settings, leading to gaps in identifying substance misuse (Thompson, 2007).

These issues, coupled with healthcare provider stigma surrounding substance use (Earnshaw, 2020; Gartner et al., 2018; Mak et al., 2016), and a potential lack of comfort and competency surrounding LGBTQIA+-affirming care (Areskoug-Josefsson et al., 2016; Bolding et al., 2022; McGrath & Sakellarious, 2016) garner the need for research that explores these factors and SMW's experiences. To accomplish this, Photovoice methodology, which has historically proven to be a valuable method for exploring individuals' relationships with mental health substance use service access (Brazg et al., 2011; D'Angelo & Her, 2019; Heery, 2017; Nair et al., 2016; Rosenthal et al., 2017; E. Smith et al., 2023; Valdez et al., 2019) and sexual minorities' substance use (Gorritz Fitzimons, 2022; Goodyear et al., 2023) will be implemented. Phenomenological interviewing methods, which have also shown to be effective tools in eliciting knowledge regarding substance use (Bochicchio et al., 2021; Helminen et al., 2021; Ioannides,

2021; Mericle et al., 2018) were also used to evoke further personal reflection from the co-researchers regarding their experiences with substance use.

In building from our exploration into the prevalence of SUDS, SMW's personal factors surrounding substance use and SUDs, societal/professional views on SUDs, service factors, and available research on qualitative methods that can be used to study SMW's substance use and SUDs, we now move forward to the reflexive study practice and study methods. The study's purpose was to explore the lived experiences of student SMW in emerging adulthood who are at risk for or have been harmed by substance use, or those who are evaluating their substance use. The study used Photovoice pieces, identified themes, field notes, and co-researcher interviews and recommendations to inform policy recommendations for the occupational science and therapy fields to improve wellbeing outcomes for SMW who use substances.

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Chapter 4: Theory and Model Guiding Approaches

Abstract

A transformative research paradigm has been applied within this study to expand occupational science and therapy's surrounding sexual minority women's (SMW's) substance use. Details on how this transformative philosophical approach, which emphasizes further development of our occupational imagination surrounding sexual minority women's experiences with substance use, will be outlined as it was applied across the study. "Queer'ed" Women's Standpoint Theory and the Person-Environment-Occupation (PEO) Model were used in conjunction with one another to guide my positionality practices and the study methods across this dissertation research, though there was a shift away from using the PEO model within the data analysis process due to a lack of applicability. Women's Standpoint Theory acknowledges that each person has experiences and characteristics that can come together to form a personal standpoint, including sexual and gender identities. These factors may be shared (and differ) from others identifying with the same standpoint and can affect the way we view the world and generate experiential knowledge. This theory critiques traditional sources of "knowledge" and upholds the voices of the oppressed in defining new understandings of women's' lived experiences and engaging in critical discourse.

Queer Theory (or "theories") was also applied within the dissertation approach and recognizes similar tenants with Women's Standpoint Theory in critiquing power hierarchies and oppression across sexuality, sex, gender, and other intersecting identities. Finally, the Person-Environment-Occupation (PEO) model was incorporated within the study in structuring Photovoice workshop materials and crafting interview questions given its holistic view of how personal, environmental, and occupational factors impact one's occupational performance (in

this case, substance use and other desired occupations). The applicability of these underpinnings to the study's findings was assessed through the data analysis process and co-researcher member check feedback on the resulting themes and recommendations.

Philosophical Underpinnings of the Research

In coming to this dissertation work with a reflexive heart (and mind), I needed to first critically assess the paradigmatical, philosophical, and epistemological lenses through which I viewed the research, as these ultimately form my "worldview" and understanding of reality and knowledge production across SMW's experiences with substance use (Creswell, 2014; Davies & Fisher, 2018). If there is something that I have come to understand about myself through my PhD program, it is that I eschew positivism in its assertion that knowledge is strictly constructed from measurable, reproduceable phenomenon and that the researcher can (and should) be fully objective and removed from the individuals who engage in the research process (Park et al., 2020).

When reflecting on my ultimate goals for the study, I wanted to choose methods that recognized the "critical realist" ascription (Redman-MacLaren & Mills, 2015) that knowledge and understanding of a phenomenon can be collectively constructed (Hockey, 2010, p. 366), are contextually (and historically) "situated" (Redman-MacLaren & Mills, 2015) and change over time, never being fully complete (Altheide & Johnson, 2011, p. 581); in applying this belief within the study I upheld this view through promoting collaboration, reflection, and empowerment between myself and the co-researchers and creating opportunities for the co-researchers to share their lived experiences, all of which are

simultaneously aspects of participatory action research (McIntyre, 2008). The purpose for this approach (Altheide & Johnson, 2011, p. 581; Hockey, 2010, p. 366; McIntyre, 2008; Redman-MacLaren & Mills, 2015) was to meet my personal goals for the study: to use the findings to increase opportunities and spaces for discussing SMW's substance use across occupational science, therapy practice and potential additional health professions. I also wanted to increase practitioner, scholar, researcher, and advocate awareness surrounding SMW's lived experiences and needs in the contexts of substance use.

Given my belief in critical realist beliefs and goals surrounding knowledge construction (Altheide & Johnson, 2011, p. 581; Hockey, 2010, p. 366; Redman-MacLaren & Mills, 2015), my philosophical perspectives are in line with the transformative research paradigm (Mertens, 2009; Mills, 1959). This paradigm recognizes that common paradigmatical approaches in the field may not provide the ability to explore and take action regarding the social issue being researched, leading to the need for new and innovative approaches (Kuhn, 1962). These approaches (Kuhn, 1962) can include collaboration with individuals who have been on the margins of research pertaining to their social contexts and issues (Mertens, 2009). Transformative research often includes common assumptions and practices, including the following:

- Emphasizing the inclusion of community members across the research process (creating multi-sourced knowledge (Hockey, 2010, p. 366)).
- Establishing trust with transparency through the aims of the research (Mertens, 2009).

- Challenging systemic social practices that hegemonize peoples (Mertens, 2009).
- Implementing findings from the work to further justice and abilities for peoples (Mertens, 2009).

In further detailing my desire to improve the care we are providing to sexual minority women surrounding substance use through this work, transformative researchers such as C. Wright Mills (1959) and Debbie Laliberte Rudman (2014) describe the ethical responsibility we have as scientists to seek ways to change the world around us; we cannot fall back on the positivist assumption that knowledge is linearly built from previous establishing work, and that large scale change is not capable for or the responsibility of the researcher (Lincoln et al., 2011; Laliberte Rudman, 2014, 2019). In her work on transformative occupational science, Laliberte Rudman (2014, p. 375) includes a quote from Denzin & Giardina's (2009, p. 29) work that with our research, we can work towards significant change in being "...unruly, disruptive, critical, and dedicated to the goals of justice and equity"; in upholding this sentiment in the study, I sought to disrupt the current lack of research we have on SMW and their lived experiences surrounding substance use and anticipated that this would lead to critical practice assessment and critique in pursuit of equitable care for all women. While positivist and post-positivist academics and scientists may feel it is naive to suppose one's research will better the world beyond the local spectrum, this assumption does not absolve us of the duty to aim for large-scale change (Lincoln et al., 2011; Laliberte Rudman, 2014, 2019). In coming to the study from a transformative research perspective, I affirmed my commitment to the responsibility of enacting social change (Lincoln et al., 2011; Laliberte Rudman, 2014, 2019), and working towards expanding our occupational

science (detailed later), practice, compassion, and understanding surrounding SMW's substance use factors.

In returning to the application of the transformative research paradigm from the perspective of the research approach, rather than simply taking a broad procedural process in viewing one's understandings of reality, knowledge, and the community they are engaging in research with, the transformative paradigm provides scaffolding for approaching research, from the initial recruitment of participants to the dissemination of the study findings (Mertens, 2009). Transformative research approaches recognize the notable power differential between the researcher and those with whom they conduct research (Mertens, 2009); the paradigm includes the call for reflexive practice and trust building in addressing this inherent imbalance. The transformative approach upholds my reflexive practices (including the use of "voice" (Morris, 2012; Perryman-Fox, 2020) across the study and can be applied in understanding the use of Queer (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) and Women's Standpoint Theories (Andersen, 1983; Carastathis, 2014; Collins, 1986; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) within the study, which are detailed shortly (Mertens, 2009).

Occupational Science as Informed by Transformative Research

In building from Mills' (1959) foundational work on the "Sociological Imagination" of transformative research, Laliberte Rudman (2014) calls for the synthesis of transformative approaches in future thinking with the exploration of occupational engagement in creating "occupational imagination" within occupational science. In her (2014) work, Laliberte Rudman

applies Mills' (1959) conceptualizations in describing the steps needed to engage in occupational imagination, including:

- 'Thinking outside the box' of traditional approaches and perspectives regarding a social issue.
- Acknowledging the political, moral, and ethical lenses through which we engage in our scientific social exploration.
- Committing to transformational change through the interrelationship of scientific inquiry and advocacy.
- Viewing occupations as, "a product of history, society and agency, and as continually shaped in relations of power (p. 381)."

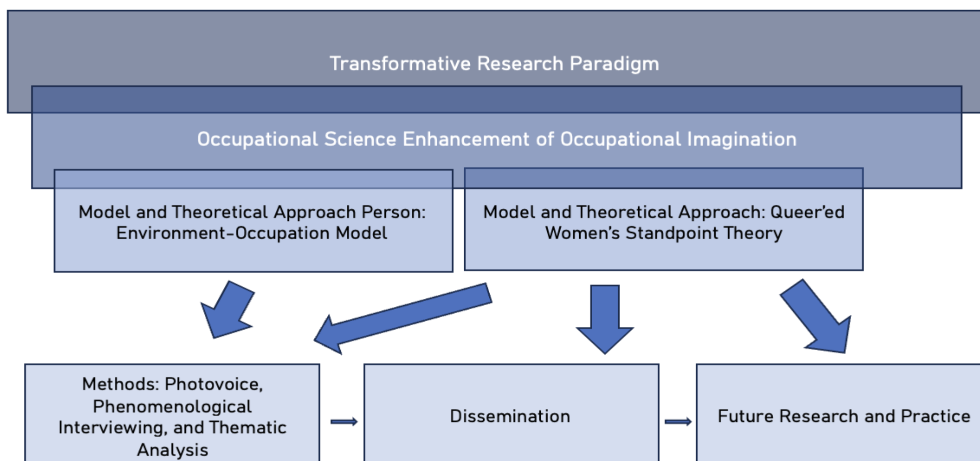
Occupational science is grounded in our understanding of how our engagement as "occupational beings" in tasks (including substance use) within our personal environments plays a role in our everyday lives (Yerxa et al., 1990). This field emphasizes a focus on individuals' assets and what is possible in approaching care, rather than seeing a person as their diagnosis (Yerxa et al., 1990). With the use of occupational imagination in contributing to our profession's science surrounding substance use assessment and treatment, we are challenged to boldly explore not just social and personal factors that underly substance use, but broader systems (Laliberte Rudman, 2014, 2019). These factors and systems include where and how power operates and our personal perspectives and morals surrounding substance use (Laliberte Rudman, 2014, 2019). Through occupational imagination, this dissertation research can move beyond supporting the need for and benefits of occupational therapy services for those experiencing harmful use (Hocking & Whiteford, 2012; Laliberte Rudman, 2014, 2019) and address the intricate systems, dynamics, and personal factors that influence those who use substances, including the impact of

ourselves as service providers and our practice approaches (Farias & Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990). In enhancing the occupational science surrounding substance use and its intersection with sexual identity, the tenets of occupational imagination inform each aspect of this study (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Mertens, 2009; Mills, 1959; Yerxa et al., 1990). Practices incorporating these tenets included my engagement in personal reflexivity, the coverage of systemic factors related to substance use in the study literature review, and the co-researcher informed methods, data analysis, and dissemination processes (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Mertens, 2009; Mills, 1959; Yerxa et al., 1990).

In recognizing the influence of a transformative research paradigm (Mertens, 2009; Mills, 1959) on enhancing occupational science (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) through occupational imagination (Laliberte Rudman, 2014, 2019) and in visualizing the approach to this research, and we can conceptualize the flow of influencing underpinnings from a layered colored lens approach, seen in Figure 4.1.

Figure 4.1

Study Theoretical Flow Chart



Across the study, the transformative lens (Mertens, 2009, Mills, 1959) underlies the goal of enhancing occupational science (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) through occupational imagination tenets (Laliberte Rudman, 2014, 2019), which in turn influence the application of specific theoretical and model approaches used in creating the study methods and analyzing and reflecting on the findings. Of note, however, is that there is not a complete overlap in the graphic of the chosen paradigm and impact of occupational science, models, and theories on the study methods, dissemination processes, and future research and practice implications. This means that I recognized the opportunity for new discoveries, approaches, and techniques, driven by the co-researchers and others who come to this work that may challenge these applied approaches. Having described the initial overlaying paradigm that guides the research, the subsequent guiding theoretical and model approaches are detailed next.

Guiding Theoretical and Model Approaches

Three strategically chosen theories and models were used to guide the study in providing opportunities for co-researcher collaboration and personal sharing; these include Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012), Queer Theories (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020), and the Person-Environment-Occupation model (Law et al., 1996; Strong et al., 1999; Strong, & Rebeiro-Gruhl, 2011). Application of Women's Standpoint Theory across the study will first be outlined, with its intersection with Queer Theories and the PEO model described subsequently. As previously illustrated in Chapter 2, a Queer'ed Women's Standpoint

Theory-based approach was also used in guiding my personal positionality and reflexivity practices across the study methods (Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Finlay & Gough, 2003; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012).

Women's Standpoint Theory

In understanding the role of Women's Standpoint Theory across the proposed study, it is first worth examining the literature surrounding the broader application of feminist theories to substance use. Historically, feminist scholars have correlated the formulation of substance use disorders (SUDs) (in particular, alcohol-based SUDs), as a patriarchal tool of power and control, driven by capitalistic intentions (Travis, 2009). The theory has grown and influenced approaches to substance use research, with previous studies exploring the impact of gender (Miller & Carbone-Lopez, 2015; Grant, 2008), race (Miller & Carbone-Lopez, 2015), racism (Ehrmin, 2002) and homophobia (Bobbe, 2002; Staddon, 2005) on women's experiences with substance use and recovery. Feminist theories have included recognition that individuals possess internal and experiential factors that carry mutable influence on systems of inequity (Andersen, 1983; Carastathis, 2014; Reid & Frisby, 2008); in acknowledging this, feminist theorists have placed continued emphasis on involving women at the center of research queries as investigators (Andersen, 1983; Carastathis, 2014; Reid & Frisby, 2008) akin to Wang and colleagues' (1996) description of the "nothing-for-us-without-us" approach used across their Photovoice research (Bandauko & Arku, 2023).

While to my knowledge, Women's Standpoint Theory has not explicitly been used in examining substance use disorders (SUDs) in SMW's populations, the theory's recognition of individualized factors, or "standpoints" that both unite women and result in unique and diverse experiences presents a critical lens that was applied within this study, as I looked to uphold SMW's voices in directly affecting the healthcare they receive surrounding substance use (Harding, 1983; Harding, 1991; Harding, 2004b; Harding, 2004c; Heldke, 1998; Jaggar, 2004; Lugones & Spelman, 1983; Sandoval, 2004; Sholock, 2012). This theory's tenets are in keeping with this study's goals of empowering individuals who are at risk for harm, engaging in harmful substance use, or who have SUDs in identifying their needs and recommendations for health care system and occupational therapy (OT)-specific practice-based changes (Harding, 1991; Harding, 1983; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; Jaggar, 2004; Lugones & Spelman, 1983; Sandoval, 2004; Sholock, 2012).

Women's Standpoint Theory actively scrutinizes the relationship between power and knowledge production; the theory recognizes that those who are a part of the historically dominant standpoints (e.g., white, male, cisgendered, heterosexual, middle-class, etc.) have controlled much of what we consider to be "knowledge" (Harding, 2004a; Harding, 2004b, pp. 129-133; Harding, 2004c; Sandoval, 2004; Sholock, 2012). Jaggar (2004), a standpoint theorist, provides the critique that persons with power often seek to maintain their influence through domination and exploitation, leading to analyses of reality that are partisan and ignorant of the experiences of the oppressed. These narrowed lenses of understanding can lead to ascriptions of oppressed peoples' struggles as "freely chosen, deserved, or inevitable" (Jaggar, 2004, p. 56). The healthcare community continues to struggle with this pitfall (Jaggar, 2004) including with meeting women's needs surrounding substance use (e.g., Chrisler et al., 2016; Cochran et al.,

2007; Davis & Ancis, 2012; Green & Feinstein, 2012; Roberts et al., 2000; Senreich, 2009). There is a plethora of examples of this, such as the clinical guidelines for substance not including older women's use as the result of not involving older women in clinical research trials, leading to negative health outcomes; this highlights ageist and sexist healthcare and research practices (Chrisler et al., 2016).

Another example includes that Black women may be less likely to complete care services due to having their ethnic, cultural, and gender-specific needs unaddressed across the care process (Davis & Ancis, 2012). Black women also face an overabundance of racialized gender stereotypes that negatively impact the care they receive from healthcare providers for substance use (Roberts et al., 2000). Research on substance use service outcomes for women who are sexual and gender minorities (homosexual, bisexual, asexual, transgender, etc.) is incredibly lacking (Green & Feinstein, 2012), with individuals in this population historically reporting decreased positive experiences and fulfillment within substance use services (Senreich, 2009). Finally, substance use counselors may lack comprehensive education regarding approaching care with sexual minorities and carry negative stereotypes that impact the services provided (Cochran et al., 2007). These factors (Chrisler et al., 2016; Cochran et al., 2007; Davis & Ancis, 2012; Green & Feinstein, 2012; Roberts et al., 2000; Senreich, 2009) are just a handful of the numerous challenges that women with intersecting standpoints and identities face when accessing healthcare and addressing substance use.

In exploring these challenges through Standpoint Theory, reality can be redefined by the oppressed through engagement in collective "struggle" across both historically dominant and non-dominant standpoints to examine current factors such as substance use, and substance misuse services (Jaggar, 2004, p. 57). Emphasis on the voices of the oppressed in generating new

realities within Standpoint Theory comes from this theory's posit that the oppressed have experiences and understandings of reality that represent a more whole view of the world and its social systems (Collins, 1986; Haraway, 2004; Harding, 2004a, p. 7-8; Harding, 2004b; Harding, 2004b, p. 128-130; Jaggar, 2004; Sandoval, 2004). This makes their perspectives more epistemologically applicable than dominant groups' when working towards structural change (Collins, 1986; Haraway, 2004; Harding, 2004a, p. 7-8; Harding, 2004b; Harding, 2004b, p. 128-130; Jaggar, 2004; Sandoval, 2004). Standpoint Theory (Collins, 1986; Haraway, 2004; Harding, 2004a, p. 7-8; Harding, 2004b; Harding, 2004b, p. 128-130; Jaggar, 2004; Sandoval, 2004) upholds the similar perspectives to the transformative research paradigm in engaging the voices of the marginalized for social change and addressing power imbalances within the research (Mertens, 2009). These very imbalances have been purveyed within feminist literature and critique as well, with white, heteronormative voices often controlling the space (Harding, 2004a; Harding, 2004b, p. 131; Sandoval, 2004). Women's Standpoint Theory calls for recognition of the "historical," and "social" locations of knowledge (in keeping with my critical realist beliefs (Hockey, 2010; Redman-MacLaren & Mills, 2015; Sandoval, 2004) and the need to collectively work across groups of individuals who have traditionally not been included in the generation process to transform oppressed peoples' experiences into "knowledge" and determine what constitutes this knowledge (Collins, 1986; Haraway, 2004; Harding, 2004a; Harding, 2004b; Harding, 2004b, p. 128-130; Harding, 2004c; Sandoval, 2004). Ultimately Women's Standpoint Theory creates knowledge that is "for" women rather than about them (Harding, 2004a, p. 4; Harding, 2004c). In doing so (Harding, 2004a, p. 4; Harding, 2004c), Standpoint Theory is often noted as multiples theories, or "Women's Standpoint Theory," in recognizing the broad spectrum of women's many sub-standpoints and experiences (Harding, 2004a, p. 12;

Harding, 2004c). Given this, I have and will continue to refer to Standpoint Theory as "Women's Standpoint Theory," recognizing the immeasurable number of standpoints that one can maintain (Harding, 2004a, p. 12; Harding, 2004c).

Under Women's Standpoint Theory, knowledge created "for" women (Harding, 2004a, p. 4; Harding, 2004c) must start (Harding, 2004b, pp. 128-129) with deriving from diverse groups of women who explore women's questions (Harding, 2004a). In pursuit of creating this knowledge Harding (2004a), describes in her work that care must be taken to avoid the same historical patterns of preferencing certain voices over others and creating a singular "truth" (Harding, 2004a, Harding, 2004b). Addressing this potential (which is a common critique of Women's Standpoint Theory) can lead to critical discussions on deconstructing broad definitions about what and who constitutes a "woman" (hooks, 1989; Kronsell, 2005). Standpoint theorist Donna Haraway (2004, p. 91) argues that in generating understandings of the world, we must constantly be aware of "positioning," or:

> "…the key practice of grounding knowledge organized around the imagery of vision...Positioning implies responsibility for our enabling practices. It follows that politics and ethics ground struggles for the contests over what may count as rational knowledge."

Haraway (2004) notes that all knowledge (which would include the exploration of women's experiences surrounding substance use) is produced by individuals who possess specific locations, situations, and positioning that impacts their vision of reality; given this, what constitutes true knowledge must not be presented as objectivity. The pursuit of knowledge must provide opportunities for constant interpretation with no absolutes, including the understanding that all material and "truths" are generated by individuals with their own "vision" (Haraway,

2004). In Haraway's line of thinking, all "knowledge" is situated (Haraway, 2004; Harding, 2004b, p. 133) and incomplete (which Collins, 1986 similarly posits), with knowledge building being a continuous process of critique and transformation (Haraway, 2004). These posits (Collins, 1986; Haraway, 2004; Harding, 2004b, p. 133) are further grounded by critical realist interpretations (Altheide & Johnson, 2011, p. 581; Hockey, 2010, p. 366; Redman-MacLaren & Mills, 2015).

This thinking (Altheide & Johnson, 2011, p. 581; Collins, 1986; Haraway, 2004; Harding, 2004b, p. 133; Hockey, 2010, p. 366; Redman-MacLaren & Mills, 2015) is in direct conflict with our common positivistic scientific premises and practices that stipulate that there is a quantifiable way to measure an issue and determine a correct source of action through evidence-based findings (Park et al., 2020). For qualitative research (including this dissertation) that upholds that there are many "truths" in addressing care with SMW (Haraway, 2004), you as the reader may find yourself feeling frustrated when engaging with the findings in determining how to apply them to your practice. I ask that in the spirit of reflexivity, rather than dismiss those feelings, you sit with them for a while, and consider where that frustration might emanate from, what "truth" in practice and engaging with others means to you, and what adaptable, evolving practice for SMW might look like for you in your service to others (Haraway, 2004).

While healthcare tends to deal in rules and replicable methods, (e.g., meeting criteria for a diagnosis, surgical protocols, diagnostic measurements), Standpoint theorist's perspective that all knowledge is situated can be applied to our work, as demonstrated within this dissertation research (Haraway, 2004, Harding, 2004b, p. 133). In regarding this study and the usefulness of its findings to the healthcare community and other interested parties, rather than becoming

frustrated with the thought that one can never determine a singular "truth" (Haraway, 2004) about SMW's lived experiences with substance use that can be applied to practice, I have instead felt invigorated. This excitement comes from the study having brought together the voices of individuals across situated experiences to create the knowledge that Haraway notes as critical in birthing transformational change (Haraway, 2004). It is my hope that with continued inquiry into SMW's experiences, building from this study, we as providers can more deeply examine the impact of our own views on the care we are providing and determine ways to better meet the needs of those we serve (Haraway, 2004).

Scholar Nancy Campbell (2015) notes that the use of Standpoint Theory in exploring women's lived experiences surrounding substance use (including harmful use) is lacking, despite the well-established understanding that substance use behaviors can differ across gender identities (Campbell, 2015). Campbell explains that while studies on women's experiences with substance use that implement reflexivity practices are becoming more common, additional research examining this issue is needed given the purveyance of social structures, violence, and stigma that surround women who use substances and are deemed to be living "risky" lives (Campbell, 2015). Current research examining women's substance use within differing populations using Standpoint Theory exists; Sarinic (2022) noted the importance of the theory in centering rural women's voices regarding substance use. Allen and colleagues (2010) also used a standpoint approach in studying the societal structures surrounding poverty and detention for mothers who were incarcerated for drug-related offenses. Despite these available studies, to my knowledge, no current research exists that implements Women's Standpoint Theory with SMW in examining substance use, despite its previous applicability (Allen et al., 2010; Campebll,

2015; Sarinic, 2022) and other social issues that SMW face (e.g., Smoyer et al., 2021; Walker & Melton, 2014).

I seek to chart a course for the use of Women's Standpoint Theory (Andersen, 1983; Carastathis, Collins, 1986; 2014; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Love, 2011; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) in studying student SMW in emerging adulthood's experiences with substance use. I will next discuss how the theory guides my study methods and positionality practices, my personal reflective work, the dynamics of power and knowledge within healthcare and communities regarding gender, sexuality, age, and substance use, and the purposeful incorporation of participatory action-research-based methods intertwine with one another. Through practicing positional disaffiliation across the study methods, I have the opportunity and duty to critique my role as a researcher, academic, and healthcare provider and the impact my positionality has on these roles (Haraway, 2004). I wanted to also create an initial 'blueprint' for those interacting with my work to do the same in critiquing the knowledge and care we possess surrounding SMW's substance use experiences (Haraway, 2004).

In recognizing that my standpoints differ from the women who I collaborated with across the dissertation given my effort to reach populations who are traditionally underserved and oppressed, I used the tenants of Women's Standpoint theory and call to "know the text" (Lugones & Spelman, 1983)

by focusing my literature review efforts on exploring the experiences of SMW and centering the voices of women from diverse socioeconomic, educational, racial, ethnic, geographical positions, and social backgrounds throughout the study methods (Harding, 2004a; Harding, 2004b; Harding, 2004b, p. 128-130; Harding, 2004c; Sandoval, 2004). Given the healthcare community's gaps in approaching substance use with women (Chrisler et al., 2016; Cochran et al., 2007; Davis & Ancis, 2012; Green & Feinstein, 2012; Roberts et al., 2000; Senreich, 2009), in applying Women's Standpoint Theory within this dissertation research, women who have experienced oppression and marginalization carried out the study methods alongside me and defined their reality (Jaggar, 2004). These women had control over the stories they shared, the recommendations they generated for healthcare providers, and the study conclusions (Jaggar, 2004). While highly applicable within this dissertation study, Women's Standpoint theory is not without its detractors, with one such issue being theorists' traditional analysis of sexual and gender as being static (hooks, 1989; Krane, 1997). The intersection of Queer Theory(ies) with that of Women's Standpoint Theory helps in addressing and preventing such a narrowed perspective within this research (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020).

Queer Theory(ies)

Much like approaching Standpoint Theory as "Women's Standpoint Theory," as opposed to "Feminist Standpoint Theory" and recognizing that Standpoint Theory is made up of multiple interconnected theories (Harding, 2004a, p. 12), Queer Theory is also built on differing and similar perspectives, making "Queer Theories" more applicable (McCann & Mohaghan, 2020, p. 1-3, 6-7). In the contexts of my dissertation work, the working application and understanding of

Queer Theory(ies) included the view of the theory(ies) as a call to dismiss the binaries of sex, sexuality, and gender, and critique the structural power hierarchies and oppression surrounding these factors (McCann & Mohaghan, 2020). According to Queer theorists, Queer Theories recognizes that sex and gender are socially constructed and are worthy of critical examination and deconstruction (Butler, 1999) across "norms", "normativity", and "normalization" practices (Butler, 1999; McCann & Mohaghan, 2020, p. 12-13) (including those of Queer Theories (Love, 2011)). The practice of resistance to "fixed" categorizations and engagement in active discourse includes doing so with a plethora of factors such as race, class, disability, performativity, pedagogy, etc. (Butler, 1999; Love, 2011; McCann & Mohaghan, 2020, p. 4). Queer theorists, much like Standpoint theorists (Harding, 2004a; Jaggar, 2004) recognize that personal standpoints (or identities) intersect with one another, with increased focus placed on breaking down the overlap of these identities under the term "queer" (Love, 2011; McCann & Mohaghan, 2020, p. 4).

Within these theories, "queer" can be understood as a noun, an identity, and a verb; my emphasis in applying this theoretical approach in tandem with Women's Standpoint Theory is in using queer in its verb form (e.g., we need to "queer" the way we approach substance use); viewing queer as an active state of critique and resistance, rather than just an identity (Jakobsen, 1998). Jakobsen (1998, p. 526) describes taking action through Queer Theory:

> "…just as making different connections to articulate various norms differently enables action, so also does making alliances among those differently positioned in relation to the norms that make up a normativity. Such a shift decenters the norm-deviant relation by making alliances that focus on relations among various "deviants." Thus, the move to

solidarity, rather than simply opposing or even resisting the norm, also shifts the network of power relations."

Personal reflection on substance use through a queer lens in exploring addiction and its interrelatedness to disability has already proven to be a powerful and impactful approach (Macuch, 2017). Jakobsen (1998, p. 526) also describes how collaborating across individuals who are affected differently by social norms to identify such norms and normativity results in powerful "relations" that can lead to change. This (Jakobsen, 1998, p. 526) was the exact goal of my dissertation work in connecting with SMW in emerging adulthood from varying backgrounds and standpoints to discuss their lived experiences surrounding substance use and healthcare access. It is only through critiquing the social (including healthcare) norms surrounding substance use and its intersection with gender, sexuality, race, socioeconomic status, etc. that we can begin to identify what steps must be taken to improve the healthcare we are providing women (Jakobsen, 1998, p. 526).

In "queering" the study methods, I collaborated with co-researchers to evaluate the influence that societal norms and practices, and sexuality and gender have on our standpoints, personal identities, and experiences, including how these interlace with substance use (Butler, 1999; Jakobsen, 1998; Love, 2011; McCann & Mohaghan, 2020; Macuch, 2017). This exploration occurred through the Photovoice workshops, interviews, recommendation generation process, and in member-checking the study findings. Questions incorporated into the Photovoice workshops and one-on-one phenomenological interviews promoted discussions not only on differing and shared standpoints (Collins, 1986), but conversations surrounding what co-researchers considered their "communities," their experiences of the intersection between their sexual identity and substance

use, their experiences surrounding healthcare, and more. The goal of incorporating these forms of queries was to evaluate the social norms that SMW interact with every day through a queer lens (Butler, 1999; Jakobsen, 1998; Love, 2011; McCann & Mohaghan, 2020; Macuch, 2017).

While it is difficult to identify current research that explicitly uses Queer Theories in assessing SMW's substance use, Queer Theories have been applied in better understanding the lived experiences of sexual and gender minority populations whose characteristics can intersect with substance use, such as trans and gender non-conforming inmates (Cavagnini, 2022). Researchers have also called for the implementation of theories such as Queer Theories in addressing substance misuse with SMW to generate impactful interventions (Stevens, 2012). In facilitating additional research that enhances the application of Queer Theories to sexual minority populations using substances, the incorporation of this theoretical approach furthers discussions on SMW' lived experiences for the purposes of enacting structural change at the healthcare (and potentially other social entities) level.

Person-Environment-Occupation Model

In pivoting to the underlying model that was used to guide the generation of the data collection tools, the Person-Environment-Occupation (PEO) model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) will be explored next. Established by Law and colleagues in 1996, the model posits that there is an interrelationship between one's environments, occupations, and the person that influences one's functioning within their desired occupations (Strong et al., 1999). The person is made up of numerous factors, including one's physical abilities, sensory perception, personal experiences and principles, cultural background, and spiritual beliefs (Law et al., 1996). An individual's affect and cognitive processing are also considered (Strong & Rebeiro-Gruhl, 2011). The environment can best be defined by physical

features, and institutional, socio-economic, societal, and cultural influences (Law et al., 1996). Occupation is comprised of activities that meet one's needs and provide fulfillment and self-expression (Law et al., 1996). These occupations can include basic activities of daily living (ADLs) (e.g., bathing, dressing), instrumental activities of daily living (IADLs) (e.g., cooking, house cleaning), play, participation in desired leisure activities, rest/sleep, and social engagement (Strong & Rebeiro-Gruhl, 2011). The PEO model is optimal for examining substance use and SUDs, as it not only considers the relationship between these three concepts, but the impact of time (Strong & Rebeiro-Gruhl, 2011). Through this model, there is an understanding that individuals evolve over time and differ in their occupational performance locations, all of which play a role in mental health (and subsequently substance use behaviors) (Strong & Rebeiro-Gruhl, 2011).

The PEO model has successfully been used to examine a wide scope of mental health (e.g., Edgelow et al., 2020; Larivière et al., 2015; Patil & Jaywant, 2019) and substance use factors (including studies focused on recovery and women) (e.g., Peloquin & Ciro, 2013; Stone, 2017). Recent work applying PEO across study processes includes Larivière and colleagues' (2015) thematic analysis of mental health recovery experiences for women with borderline personality disorder, which used PEO as a thematic organizer, and Peloquin & Ciro's (2013) assessment of the perceived satisfaction of women who were engaging in substance use recovery-based programs with group sessions. Stone (2017) used the PEO model in better understanding the negative experiences and personal decision-making surrounding substance use across male and female-identifying participants and found that substance use impacts individuals' occupational performance within personal, environmental, and occupational contexts. These studies highlight the applicability of PEO in structuring and organizing study approaches that explore mental health

and substance use factors (Edgelow et al., 2020; Larivière et al., 2015; Patil & Jaywant, 2019; Peloquin & Ciro, 2013; Stone, 2017).

In structuring my study methods, the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) was used in tandem with “Queer'ed” (Butler, 1999; Jakobsen, 1998; Love, 2011; McCann & Mohaghan, 2020; Macuch, 2017) Women’s Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012), including in guiding the interview questions, and facilitating discussion and personal reflection within the Photovoice workshops. As an example, within the one-on-one phenomenological interviews, the blending of the theories and model just cited (Women’s Standpoint Theory, Queer Theory(ies) with the PEO model) can be seen in type and order of questions asked (see Appendix G); queries probed into personal aspects of one’s substance use, their environments, and occupation(s), as well as the impact of familial and interpersonal relationships, and community views on substance use. Questions also included focus on the effects of personal substance use on occupations, and one’s experiences with care services, personal strengths, and recommendations for providers.

The Photovoice workshop facilitator prompts were similarly designed to engage co-researchers in reflecting on how they view substance use, what is important to them, and what they wish to share with the healthcare community ((Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Law et al., 1996; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011). I

intentionally avoided including any questions in the interview script or within the Photovoice workshop materials that asked co-researchers to denote their personal identities to emphasize the importance of trusting co-researchers to define their own standpoints (including their sexual and gender standpoints) through personal reflection and collective collaboration across the study methods (Anderson & Jack, 2002; Collins, 1986; Lugones & Spelman, 1983). In using the study methods to develop unifying (and differing) standpoints through personal reflection, I sought to promote the co-researcher-driven nature of this research and create knowledge that was defined by co-researcher and is *for* women of similar and differing standpoints, rather than *about* them (Harding, 2004a, p. 4; Harding, 2004c).

While I had initially intended to use the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) in intersecting with Queer'ed Women's Standpoint Theory (Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) when analyzing the co-researcher's data and lived experiences (detailed in Chapters 6 and 7), I felt that the model was too restricting in exploring co-researcher themes and shared experiences given my desire to expand our "occupational imagination" (Laliberte Rudman, 2014, 2019) surrounding substance use through a broader, occupational science lens (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990). Further

implications of this shift within the analysis and dissemination of the findings are explored in the chapters just mentioned.

A Synthesis of Foundational Study Approaches

With this dissertation work, I sought to expand the field of occupational science through exploring SMW's lived experiences surrounding substance use as they contribute to and shape our occupational imagination (Laliberte Rudman, 2014, 2019). I approached this study from the perspective that individuals' personal standpoints (e.g., sexuality, race, socioeconomic status, dis(ability) status, etc.) intersect with one another; for example, one's educational status may be tied to their profession and subsequently, their interrelationship roles. As an example, for me, as an individual who holds a master's degree and training in occupational therapy, I was able to become an occupational therapist, and subsequently take on the intermittent role of caregiver in some of my personal relationships (Collins, 1986). These intersecting standpoints influence one another and carry differing meanings for each person (Collins, 1986). In applying Queer'ed Women's Standpoint Theory (Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) through a transformative (Mertens, 2009; Mills, 1959) , occupational science lens (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990), we can examine the influence that women's standpoints (including sex, gender, and sexual identity (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) have on aspects of

substance use and other occupations across historical, social, and power-balance-based perspectives (Collins, 1986; Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019).

Within the data analysis and dissemination process, the intersection of occupational imagination (Laliberte Rudman, 2014, 2019) and Queer'ed Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway. 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Love, 2011; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) are used to organize and present the data, given that co-researcher engagement in the study shaped the analysis process and conceptualization, including shifting the analysis away from the PEO model structure (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011). In exploring these intersecting standpoints (Collins, 1986) and better understanding the influence of systemic structures on them, we (including OT students and practitioners, SMW, community members, and readers of this work) must critique the impact of our social structures on our standpoints (including sexuality), and describe the norms, practices, and expectations, and power hierarchies in which we operate (Butler, 1999; Jakobsen, 1998; Laliberte Rudman, 2014, 2019; McCann & Mohaghan, 2020; Macuch, 2017). In imagining all that substance use is and can be for ourselves and the people we serve, and conceptualizing our role in addressing substance use and sexual identity across the care spectrum (Laliberte Rudman, 2014, 2019), I encourage readers to engage in personal reflection on these guiding approaches to the study. I also recommend that readers continue to seek out resources regarding occupational science (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) the study of substance use, and potential intersection with Queer Theories (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) and Women's Standpoint Theories

(Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012).

Discussion

As illustrated, in enhancing occupational science through the practice of occupational imagination (Laliberte Rudman, 2014, 2019) the study approach and methods are structured via application of the a transformative research paradigm (Mertens, 2009; Mills, 1959), Queer'ed (Butler, 1999; Jakobsen, 1998; Love, 2011; McCann & Mohaghan, 2020; Macuch, 2017) Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) and the Person, Environment, Occupation Model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011). The synthesized utilization of these approaches is innovative within the field of occupational science and, therapy and the study of SMW in emerging adulthood's lived experiences surrounding substance use and healthcare, as the field of occupational theory (and my knowledge and field) has not used these approaches in conjunction to explore this critical issue.

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Chapter 5: Methods

Abstract

As substance misuse continues to increase across the United States (U.S.), and particularly in student sexual minority women (SMW), the need for research that examines this populations' healthcare and occupational therapy-based needs is critical. This chapter details the use of qualitative Photovoice and phenomenological interview methods in exploring student SMW in emerging adulthood's lived experiences surrounding substance use. A diverse sample of emerging adulthood SMW students who identified with varying sexual identities, educational, racial, socioeconomic, cultural, and experiential backgrounds were recruited through academic sites and social media. Numerous confidentiality and safety measures were designed and implemented throughout the study, with co-researchers also being compensated for their engagement. The co-researchers engaged in the study methods virtually rather than in-person given their preferences, location, and due to recruitment flow. The study activities included attending Photovoice workshop sessions, engaging in an individual phenomenological interview, and providing feedback on the study data via virtual meeting or emailed member checks.

Amendments were made to the study to increase the trustworthiness of the data gathered and to direct recruitment. The dataset includes the Photovoice workshop transcripts, Photovoice pieces, interview transcripts, and my field notes, all of which were iteratively analyzed using Braun and Clarke's thematic and reflexive thematic analysis steps. As part of the dataset, the co-researchers also provided actionable practice recommendations for OT and other healthcare providers regarding SMW in emerging adulthood's needs pertaining to substance use. Member checking was conducted across the findings, with the co-researchers confirming and enhancing the themes and recommendations.

Introduction

The reach of substance use disorders (SUDs) across the U.S. is growing (Centers for Disease Control (CDC), 2021; Substance Abuse and Mental Health Services Administration (SAMHSA), 2022; 2023). As a subset of the U.S. population, the prevalence of women's SUDs are nearing men's rates (Grucza et al., 2008; Keyes et al., 2008; Steingrimsson et al., 2012). Women's unique experiences and personal factors regarding substance use warrants attention in relation to provider interactions and women's varying spectrum of substance misuse service experiences (Elms et al., 2018; Gartner et al., 2018; Greenfield et al., 2007; Greenfield et al., 2010a; Greenfield et al., 2010b; Keyes et al., 2010; Pinedo et al., 2020; Redmond et al., 2020; Robertson, 1988; SAMHSA, 2020). Notably, SMW (lesbian, bisexual, pansexual, asexual, queer, questioning, etc.) demonstrate elevated substance use compared to their heterosexual peers (Kerridge, 2017; Schuler & Collins, 2020), particularly bisexual women (Schuler & Collins, 2020), and SMW in emerging adulthood (ages 18-29 (Arnett, 2014)) (Dermody et al., 2020; McCabe et al., 2021). Sexual minority women have distinctive factors that influence their substance use practices, justifying the need for further research (e.g., Dyar et al., 2022; Feinstein et al., 2017; Gorritz Fitzsimons, 2022; Rosner et al., 2021); this research is particularly important in examining SMW's substance use factors during emerging adulthood (ages 18-29 (Arnett, 2014)), and heavy substance use patterns (Chassin et al., 2014) in targeting a pivotal life period for early intervention (Dermody et al., 2020).

In addressing substance use, occupational therapy practitioners (OTPs) report that they do not feel they possess competency with screening for and treating SUDs (Amorelli, 2016; Blanco et al., 2015; Mattila & Provident, 2017), despite possessing the skills to do so (e.g., Amorelli, 2016; Doğu & Özkan, 2023; Kiepek, 2016; Stoffel & Moyers, 2004). Occupational therapy

practitioners may also be lacking in their comfort and competency in addressing sexual identity (Areskoug-Josefsson et al., 2016; Bolding et al., 2022; M. Butler et al., 2016; Hammell, 2013). Given these factors, research targeting SMW in emerging adulthood's experiences with SUDs and exploration into their relationships with healthcare professionals (including OTPs), is imperative to increase occupational science (OS) and therapy's (OT) body of knowledge and aptitude surrounding substance use with SMW in emerging adulthood. Across the rest of the chapter, the order and structure of presenting the study methods has been informed by my faculty mentor Dr. Virginia Stoffel's (2007) dissertation "Research Design" chapter formatting (pp. 48-77).

Purpose and Aims of the Study

The aim of this study was to examine the lived experiences of student sexual minority women in emerging adulthood who use substances, with an additional sub-aim exploring co-researcher recommendations regarding preferred approaches in serving SMW who use substances through healthcare interactions. To address this aim and sub-aim, the study implemented Photovoice methodologies and phenomenological interviews.

Lived experiences were defined within this study as "retrospection" on one's "immediate" lived reality, "where meaning is recovered and reenacted, for example, in remembrance, narration, meditation, or more systematically, through phenomenological interpretation and "inscription"" (Burch, 1990, p. 134). Emphasis within this "retrospection" on one's "immediate" lived reality (Burch, 1990, p. 134) through the aim and sub-aim of the study was placed on exploring the impact of substance use, sexual identity, and healthcare access on co-researchers' lived experiences.

Overarching Study Approach

A general phenomenological approach was used to guide the study methods in addressing the purpose, aim, and sub-aim. Phenomenological approaches to qualitative research generate themes that acknowledge the unique individualistic experience of a person within their reality (Giorgi, 1997). Phenomenological research seeks to explore the meaning of things by encouraging the researcher to "enter the lifeworld" of the co-researchers as opposed to conducting removed, clinical surveillance methods (VanManen, 1990, p. 69). The approach identifies the distinct role of one's "consciousness" in viewing and understanding one's reality and the world; it calls upon the researcher to remove their judgements, professional drivers, and assumptions from data collection to encourage an openness to the methodological process and data (Giorgi, 1997). This appeal to recognize the impact of one's self as a researcher on the study process and active reflexive practices within the methods (Giorgi, 1997) is directly in keeping with the participatory action research tenets influencing this dissertation (McIntyre, 2008), and my applied reflexive framework (Andersen, 1983; J. Butler, 1999; Carastathis, 2014; Farias & Laliberte Rudman, 2016; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; Jaggar, 2004; Jakobsen, 1998; Laliberte Rudman, 2014, 2019; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Mills, 1959; Mertens, 2009; Morris, 2012; Perryman-Fox, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012). This study was unique in that, to my knowledge, this population, age group, and focus on substance use have not previously been explored in tandem in OT literature (and more broadly in the health science community), including the application of these chosen study methods, which will be described within the contexts of the broad phenomenological basis of the study (Gallagher, 2012; Giorgi, 1997; VanManen, 1990).

Applicability of Phenomenological Methods Within the Study

A phenomenological thread was suffused within the study process (Gallagher, 2012; Giorgi, 1997; VanManen, 1990) through Photovoice methods (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) and phenomenological interviews (Gallagher, 2012; Giorgi, 1997; VanManen, 1990). Photovoice methods are nested within phenomenological styles of research given the method's focus in exploring individuals' lived experiences (Plunkett et al., 2013). Phenomenological one-on-one interviews were used as another primary source of data on the co-researchers' lived experiences (VanManen, 1990). Reflexive thematic analysis (Braun et al., 2018; Braun & Clarke, 2019, 2020; Byrne, 2022) informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014a,b), another phenomenological data analysis tool (VanManen, 1990), was used to analyze and capture the lived experiences of the co-researchers (Giorgi, 1997).

Study Methods

Recruitment

A diverse group of student SMW in higher education were recruited through convenience and word-of-mouth sampling. Physical posters presented at in-person recruitment, emailing, and word of mouth in two Midwestern University's LGBTQ Centers and various commonly trafficked university spaces served as recruitment methods. Additional recruitment through social media posts in queer spaces (e.g., LGBTQ Facebook groups) on Facebook, Instagram, and eventually LinkedIn were also used. Prior to recruiting in physical spaces, I engaged in initial outreach with faculty and center staff in providing a background on the study, my goals, position in the community, and desire to recruit. Permission to recruit across each space was obtained in

writing prior to posting materials, unless they were being posted in said highly trafficked public spaces (e.g., student unions).

Recruitment took place across late spring of 2023 into fall of 2023, with the bulk of data collected in summer of 2023. The majority of those who reached out with interest in the study participated in the recruitment process and went on to be co-researchers within the study. Given that many of the co-researchers wished to complete the interview solely, an Institutional Review Board (IRB) amendment in early fall 2023 was submitted and approved for targeted recruitment for just the Photovoice workshops, however, no potential co-researchers came forward with interest. While I had initially posted my recruitment materials to my personal Instagram and Facebook accounts at the start of each week in spring and summer of 2023, about halfway into the summer, I discontinued these weekly postings due to concerns regarding scamming. From there, I began to solely focus my efforts on email and drop-in recruitment to academic centers and common social spaces (e.g., LGBTQ centers, announcement bulletin boards in a student union, etc.), emails to faculty, and in posting on LinkedIn.

Sample

The study sample included SMW students of varying ages (between 18-29), races, socioeconomic statuses, education levels, and geographic locations. While I initially planned to recruit 20-25 co-researchers to ensure study saturation, data collection was finalized prior to engaging 20 co-researchers in the study in determining that saturation across the interviews and a diverse set of Photovoice pieces had been obtained. The original recruitment number goal was informed by previous research and dissertation committee feedback, as out of 560 studies examined in a literature review of PhD students' qualitative interview research (Mason, 2010), the mean number of co-researchers was 31. In recruiting a slightly smaller population than this

average (Mason, 2010), my goal was to be able to devote the time needed to conduct quality research that adequately served the co-researchers in exploring their lived experiences, promote co-researcher engagement in the data analysis process, generate detailed study findings, and support my ability to create a comprehensive final dissertation. This goal was still accomplished in decreasing the number of recruited co-researchers moderately.

Ethical Considerations

There were multitudinous, critical ethical factors requiring consideration and careful planning for across the study. Within the recruitment and consent process, there was a potential that co-researchers may have recently used substances prior to completing the informed consent form, which could impact their ability to understand the implications of study participation and their ability to choose to participate (Aldridge & Charles, 2007). To promote inclusive participation, I reviewed the consent form with the co-researchers during the screening process, with inclusion criteria requiring that co-researchers not engage in the study should they need medical immediate medical assistance; I also used my practice experience across the screening and study process in determining whether the co-researchers were acutely intoxicated, which did not occur (Bennett, 2000, Deehan & Saville, 2003, as cited by Aldridge & Charles, 2007).

Co-researcher compensation also served as another ethical topic, which has been debated across numerous other studies examining substance use (Draus et al., 2005; Seddon, 2005; Striley et al., 2008); compensation may be viewed by some as “rewarding” co-researchers for their substance use (Seddon, 2005). Researchers who engage with populations who use illegal substances have recommended the use of money-based compensation as a way of respecting the co-researchers and demonstrating a lack of researcher judgement (Draus et al., 2005). In keeping

with this (Draus et al., 2005), the co-researchers in this study were provided with compensation in the form of staggered Amazon gift cards to thank them for their time and engagement.

Substance use disorders carry stigma with significant repercussions (Ashford et al., 2018; Ashford et al., 2019), including impacting one's ability to secure employment (Tootie, 1987, Erickson & Goodstadt, 1979, as cited in Cunningham et al., 1993). Additionally, given the continued discrimination and stigma that sexual minorities experience, how and when one shares their sexual identity matters (Brooks, 1981; Feinstein et al., 2017; Meyer, 2003). In recognizing and responding to the impact of such discrimination and stigma, various steps were taken across the study to ensure that the co-researchers had autonomy in determining their level of engagement (Aldridge & Charles, 2007; McIntyre, 2008) including:

- Co-researchers had a private space in which they could share their experiences had they chosen to participate in-person and via the virtual meeting formats (Hughto et al., 2021).
- Co-researchers had the ability to determine where, when, and to whom co-researcher Photovoice pieces and direct quotes from interviews were presented (Aldridge & Charles, 2007; McIntyre, 2008).
- Co-researchers were asked about their sexual identity during the demographic survey and were notified at the start of the demographic intake process that they did not have to answer any question that they were uncomfortable with.
- Co-researcher identifying information collection was kept to a minimum and was not attached to other study data (McIntyre, 2008).
- Limited numbers of individuals had varying levels of dataset access, including my faculty mentor and the student transcript cleaner.

These practices, in addition to the protocol amendments noted later in the study, were implemented to establish a safe and respectful study environment for the co-researchers.

Study Inclusion and Exclusion Criteria

Inclusion criteria for the study required the following: co-researchers had to be between 18 and 29 years of age, identify as a woman, be an active student in secondary/higher education (college, technical college, university, etc.), identify as a sexual minority (lesbian, bisexual, pansexual, asexual, queer, questioning, etc.), have experience using a substance or substances (alcohol, tobacco, opioids, illegal substances, etc.) that may or may not currently present harm to the individual, have access to reliable transportation if engaging in the study in-person, and have consistent internet and email access. Exclusion criteria included individuals who were unwilling to sign the informed consent form, were active students in high school, those who were unable to fluently speak and read English, individuals with cognitive disabilities (e.g., intellectual disability, dementia, etc.) that would make fully informed consent impossible, and anyone who was experiencing acute medical needs (due to substance use or otherwise).

In choosing to conduct the study with SMW in emerging adulthood who are in higher education, I excluded the experiences of female youth who use substances, and women who are above the age of 29. The decision to focus the scope of this study on SMW in emerging adulthood was made intentionally, as youth have specific, unique factors surrounding substance use and SUDs that deserve qualitative inquiry devoted entirely to exploring their lived experiences (Dow & Kelly, 2013; Newcomb et al., 2020); this extends to women who are in periods of life beyond emerging adulthood (Greenfield et al., 2007; Kelpin et al., 2019). The inclusion criteria regarding substance use were purposefully structured to include a broad definition of use and qualifying substances to encourage the participation of a diverse sample of

women who use varying substances at differing levels, including women who identify as trans. The goal was to encourage the co-researchers to share about a wide variety of experiences with substance use and harmful substance use, leading to rich co-researcher reflection and recommendations for OTPs, healthcare practitioners, and potentially other community persons of interest (e.g., academic staff, healthcare administrators, community center staff, etc.).

As I looked to contribute to the health and well-being of my community, inclusion criteria requiring that the co-researchers were willing to verbally share about their substance use was not be included; it was my hope that any co-researcher who chose to attend the study sessions without verbally engaging in the Photovoice workshops and interviews would still benefit from observing the study methods and could reflect on their relationship and experiences regarding substance use. All co-researchers, however, participated verbally consistently across the study.

Regarding the exclusion criteria, fully informed consent was required to participate in the study for ethical and IRB purposes. The study materials were written in English, with the methods also conducted in English given that this is my primary language. These practices required individuals to be able to read, understand, speak, and write fluently in English. Individuals with cognitive disabilities were excluded from the study to minimize ethical issues regarding consent and autonomous decision-making. Finally, the choice to exclude individuals with acute medical needs (including extreme substance use or overdose) was implemented to encourage those who may be experiencing emergency or critical health symptoms to prioritize seeking medical care. A few months into the study, as concerns over the trustworthiness of the co-researchers' participation arose, I completed an IRB amendment that added an additional

inclusion criterion requiring co-researchers to be living in the U.S. while engaging in the study. This was done for the purposes of preventing fraudulent participation, which will be highlighted in more detail later in this chapter.

Consent and Confidentiality

After screening the co-researchers via the inclusion and exclusion criteria and reviewing the consent form, informed consent was obtained via a signed digital consent form with a separate consent form focused solely on engaging in the Photovoice workshops prepared (though not implemented) later in the recruitment process (see Appendix A for the full consent form). The consent form outlined the purpose and aim of the study, co-researcher compensation, study tasks, data management and security, mandatory reporting requirements, benefits and risks of participating, time requirements, and the funding source. The co-researchers were encouraged to attend all sessions; however, this was identified as not mandatory to promote flexibility.

The co-researchers were informed in the consent form confidentiality section and verbally across workshop sessions that they were not to share what was disclosed by other members of the study, though the co-researchers were alerted that others may not adhere to this request. As with man participatory action research studies (McIntyre, 2008), data breaches were also a potential risk; steps to prevent the breach of data included using password-protected devices, limiting access to the data, separating identifiable data from de-identified data, and destroying identifiable data after the conclusion of the study were also implemented. The consent form notified the co-researchers that sessions were being recorded for transcript and data analysis purposes, and that co-researcher data that was electronically written by myself (e.g., researcher field notes) would be stored in password protected device. The co-researchers were informed that any virtual data (e.g., transcript recordings, virtual Photovoice pieces, field notes)

would be maintained through password protected sites (OneDrive files, school email, all accessed through a password protected laptop). Details on the secure storage of physical materials were also provided to the co-researchers, as well as information regarding how long their data would be kept. Special care was taken to denote that the co-researchers could revisit confidentiality regarding their Photovoice pieces and when/where they would be displayed as they engaged in the Photovoice workshops.

The confidentiality form highlighted that the co-researchers were able to leave the study at any time, and that should they choose to do so, only their material up to their point of withdrawing from the study would be included in the data analysis and dissemination processes. Study co-researchers were informed that their names would be de-identified within publications and presentations to protect personal confidentiality. Finally, the consent form included information regarding how the study findings would be disseminated.

Co-Researcher Privacy and Protection. Given the societal stigma surrounding SUDs (Ashford et al., 2018; Ashford et al., 2019) and minority sexual identities (Brooks, 1981; Feinstein et al., 2017; Meyer, 2003) as well as the sensitive nature of discussing substance use (which could potentially be harmful to the co-researchers and illegal), great care was taken throughout the study methods in preserving confidentiality. The co-researchers received information in the informed consent form informing them that they did not have to share their name or any other personal identifying details throughout the study apart from their preferred methods of contact (phone, email, etc.) and in completing the consent form. The co-researchers were assigned a study ID number that they used throughout the workshops and interview to promote confidentiality. The co-researchers were also asked to use this ID when speaking and when assigning a name to themselves on Zoom.

The confidentiality factors noted in the consent form, and the overall study steps and goals were verbally repeated to the co-researchers at the start of each workshop session, in keeping with Aldridge & Charles' (2007) recommendations, and participatory action research (PAR) (which will be discussed in greater detail later in the chapter) considerations (McIntyre, 2008). The co-researchers were also consistently reminded of the mental health resources form, as well as their ability to leave sessions at any time should they feel uncomfortable or unsafe. The co-researchers were informed of my responsibility in escalating certain disclosed factors (posing a threat to oneself and/or others, child or elder abuse and suicidal ideation) that the co-researchers may have chosen to share, given my role as a mandatory reporter. Finally, the co-researchers were given a copy of the consent form, which had my contact information, and were consistently verbally reminded that they could contact me at any time to withdraw from the study or to review the consent form (Aldridge & Charles, 2007).

During the Photovoice methods and interviews, I collected co-researcher preferences regarding confidentiality, with individuals indicating if they consented to having their Photovoice pieces and direct interview quotes included in manuscripts, presentations, stakeholder outreach, etc. The co-researchers could also denote whether they would like these materials presented as "anonymous" or through a pseudonym (see Appendices H and I for preferences forms) and learned how to obtain informed consent from anyone included in their photos (see Appendix J for consent form). Emphasis was placed on safety, particularly in creating the Photovoice pieces. The co-researchers were instructed to avoid taking photos of themselves or others engaged in illegal, risky, or unsafe behaviors. Safety across the Photovoice "mission" was addressed through education on photo-taking ethics.

Individual autonomy and confidentiality were consistently evaluated in collaboration with the co-researchers (Aldridge & Charles, 2007; McIntyre, 2008) to ensure they had control of their experiences and disclosures. The study was offered in both virtual and in-person format options. While all of the co-researchers engaged in the study virtually, had any wished to complete the workshops and interviews in-person, I had planned to work with local universities to locate private spaces in which the study workshops could be carried out in promoting confidentiality. These spaces would include factors such as not being highly visible/trafficked and possessing soundproofing (e.g., conference rooms in various buildings across a campus).

Autonomy and choice were emphasized within the research methods to emphasize safety. The co-researchers had the ability to choose whether they wanted to complete the one-on-one phenomenological interview or the Photovoice workshop sessions first and were able to engage in each as little or as much as they liked (including describing their sexual identity, type and amount of substance use, potential traumatic experiences, etc.). The study methods allowed for co-researchers to join the Photovoice workshop sessions after they were underway and receive a review from me on previous workshop materials prior to accessing their first session (though these steps were not needed across the study). Co-researchers were also accommodated if they could only complete the interview concurrently during the week(s) of their Photovoice workshop sessions. Additionally, co-researchers were given the option to engage in only the interview or the Photovoice workshops, which the co-researchers exercised across the study.

Compensation

The co-researchers received $50 in Amazon gift cards as compensation for participating, which was disbursed across 3 payments. Ten dollars were disbursed after completing the second Photovoice session, $15 dollars were disbursed after participation in the final Photovoice

workshop session, and $25 were disbursed after completing the interview. Co-researchers who only completed a portion of the study (e.g., the interview) were provided with the compensation associated with that portion of the study, rather than the full $50. The co-researchers were notified of the compensation at the start of the study within the consent form, which included informing the co-researchers that they could receive the appropriate compensation for the activities they had completed should they choose to leave the study at any time. The gift cards were provided to the co-researchers by sending the gift card electronically via email.

Co-Researcher Communication

Communication regarding the meeting times and locations for the Photovoice sessions and interviews was conducted via the co-researcher's identified preferred contact method (email, phone, etc.) (see Appendix D for communication form). While no co-researcher required them, preparations were made for accommodations that might be needed to ensure accessible study engagement, including closed captioning, increased font and/or contrast on physical study handouts, etc. Study material language also avoided the use of medical jargon, complex wording, and exclusionary language to promote engagement.

Study Method, Sequence, and Approaches

The study employed an overall qualitative, phenomenological approach to the methods, which included researcher observations and field notes, Photovoice workshops (including Photovoice pieces and workshop transcripts), and individual, detailed interviews (Gallagher, 2012; Giorgi, 1997; VanManen, 1990). Qualitative methods are powerful tools for generating preliminary understandings of topics that often lack research; they create a platform for under-researched and marginalized individuals to engage in exploration of issues which are important to them (Levitt et al., 2018), which is in keeping with the aim and sub-aim of this study.

Photovoice Methods

Applicability of Method and Method Process Within the Study. Recruitment across the study was very sporadic. While I had intended to establish "cohorts" of co-researchers who would complete the Photovoice workshops together to encourage inter-collaboration and discursive exploration, to respect their schedules, availability, and preferences, co-researcher engagement in the interview or initial Photovoice sessions occurred individually. The co-researchers who chose to participate in the Photovoice portion of the study methods first partook in four structured workshop sessions (with a fifth optional session available in which they could present to identified interested community parties).

Photovoice methodologies use community member photos and active involvement in the Photovoice creation process to enact societal change (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). Centering community-driven voices as the main creators of "knowledge" within the study to increase OTP's awareness of SMW's unique substance use factors and experiences was a primary goal of mine within the study. Using Photovoice methodology, co-researchers have the freedom in choosing what aspects of their lives, communities, and personal experiences they wish their pictures and narratives to convey in telling others of their story and creating this critical knowledge (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). Photovoice methodologies have a rich history that emphasizes improving populations' lives through co-researcher engagement in the research process (Dobson, 2017; Dobson et al.,

2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000).

Photovoice uses a participatory action approach in engaging individuals in the research methods (Wang, 1999; Wang et al., 2000; for other examples, see: Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang & Burris, 1997; Wang et al., 1998). Participatory action research, "aims to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health" (Baum et al., 2006, p. 854). Photovoice methodologies can be used as a valuable qualitative method for examining the lived experiences of individuals with SUDs, as this tool places emphasis on person-centered research outcomes, and co-researchers, not study facilitators, describe specific facets of their lived experience through photos and accompanying narrative (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). Co-researchers then use these pieces to interact with persons of interest and drive community-level changes (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). Photovoice was an appropriate methodology given the purpose of the study in using co-researcher data to improve OS and OT practice, education, and policy surrounding SMW's substance use (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000).

While the exact process of creating Photovoice pieces have differed across foundational Photovoice studies (e.g., Wang, 1999; Wang & Burris. 1997; Wang et al., 1998; Wang et al., 2000), there are critical aspects that define the methodology, including co-researchers' use of

cameras and the display of photos to tell their desired stories (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). Studies have also included other critical factors, including education on the ethical considerations and process of taking photos that might include others (Dobson, 2017; Dobson et al., 2022; Tomar, 2013; Wang, 1999; Wang et al., 2000), group discussions on the Photovoice pieces and the co-researchers' reflections on their lived experiences (Wang, 1999; Wang et al., 1998), and presentation of the study findings to community changemakers (e.g., Selingo & Stoffel, 2021; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). Numerous studies have had co-researchers craft a narrative following the SHOWED prompt that accompanies their photo; this was implemented in this study in guiding the co-researchers through the narrative-writing process (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wallerstein, 1987, as cited in Wang et al., 1998; Wang et al., 2000) as co-researchers were asked to explore:

What do you **S**ee here?

What is really **H**appening here?

How does this relate to **O**ur lives?

Why does this problem or strength exist?

How could this image **E**ducate the community or policy makers?

What can we **D**o about it?

Coding of the Photovoice workshops and pieces has been conducted within foundational Photovoice studies as part of the data analysis process, in which individuals identify critical codes, themes, and “issues” that came to light within the Photovoice pieces (Wang, 1999; Wang

& Burris, 1997; Wang et al., 1998), and discussion sessions (workshops) (Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). Broadly, Photovoice methods facilitate a process in which the co-researchers explore, create, and present their lived experiences in a visual, powerful way (Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000).

To carry out the study, I drew from the aforementioned foundational historical studies to inform the Photovoice methods (Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). The workshop sessions were also based on the configurations and materials implemented across recent Photovoice studies facilitated by my faculty advisor, Dr. Virginia Stoffel (e.g., Dobson, 2017; Dobson et al., 2022; Tomar, 2013; Tomar & Stoffel, 2014), including our research on OT students' lived experiences surrounding COVID-19 (Selingo & Stoffel, 2021). Please see Appendix E for workshop flow and Appendix F for materials and discussion items covered. Wang and colleagues' (1998) steps for engaging in Photovoice research were also used for guiding the methodological flow, and included:

1. Selection: The co-researchers chose photos which they felt portrayed their lived experiences and shared them with me as they engaged in discourse over the images and how they created their Photovoice piece(s). Some co-researchers generated their entire Photovoice piece(s) and *then* shared it/them as opposed to sharing the picture(s) first, creating their narrative(s), and then returning to discuss their completed piece(s).

2. Contextualizing: The co-researchers and I explored their conveyed significance within their finalized pieces.

3. Codifying: I organized the workshop session transcripts, Photovoice pieces, interview transcripts, and my field notes into various codes, given common phrases, topics, and ideas that

occurred throughout the workshops, interview, and field notes; I then translated these codes into larger overarching themes using the reflexive thematic analysis process (Braun et al., 2018; Braun & Clarke, 2019, 2020; Byrne, 2022) as informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014a,b).

All Photovoice workshop sessions were carried out virtually given co-researcher preference and recruitment timing. The four to five sessions varied from one in a half to two hours in length (with some sessions combined, given the co-researcher's preferences, and verbalized desire to present to persons of interest). Sessions included the following:

1. The initial workshop included the co-researcher's orientation to OS and OT and the study flow, provided time to discuss any questions regarding the informed consent form, and explored how to use Zoom if needed.

2. The second session included education on the Photovoice process, with discussions on barriers and supports that the co-researcher might wish to explore through their Photovoice pieces. Education on ethical photo taking, obtaining informed consent, and identification of a potential audience for the pieces were also included.

3. The third session was conducted individually by the co-researchers outside of the group, during which individuals took pictures and generated initial narratives.

4. The fourth workshop focused on photos and narrative presentations, including discussing and carrying out edits, and determining potential next steps for sharing the co-researchers' pieces.

5. The three co-researchers who engaged in the entirety of the Photovoice workshop sessions portion of the study determined that they wished to present their pieces during a fifth "workshop" or "gallery", with two able to attend the gallery event (which was held virtually in

early January 2024). I assisted the co-researchers in conducting the initial outreach to persons of interest and finding a time for tall to meet. The co-researchers had the ability to engage in the presentation as much or as little as they would like, whether that included conducting initial outreach, attending but not presenting, attending and presenting with one's camera off, etc. Please see Chapters 6 and 7 for more details regarding the gallery event.

Had numerous co-researchers wished to complete the Photovoice (and phenomenological interview) methods in-person, I would have provided them with written and verbal directions for parking and accessing the rooms. Emphasis would have also been placed on ease of access and privacy across the spaces implemented in the study. The same approach would have been applied in conducting the study interviews with co-researchers who chose to complete the interview in-person. If co-researchers had not had access to a camera (e.g., via a cellphone, personal camera, etc.), I planned on purchasing disposable cameras to give to them, which they would have been able to keep after using. I would also have paid for and developed the photos through Walgreens and upload co-researcher photos to the computer if assistance had been needed. Given co-researcher preferences, some workshop sessions were combined (e.g., Sessions 1 and 2) to promote flexibility regarding personal schedules.

Photovoice Methodological Limitations. Photovoice methods are not without historical issues; an important challenge in the use of the approach as a qualitative tool is that it is used incongruously across studies, with no concrete methodology consistently applied (Catalani & Minkler, 2010; Sanon et al., 2014). A recent review of available studies using Photovoice has also uncovered a lack of co-researcher involvement in establishing themes and the choice of which pieces should be displayed within various publications and exhibitions (Evans-Agnew & Rosemberg, 2016). While Photovoice approaches may result in various populations gaining

increased alertness to the social issue being studied (community persons of interest, administrators, etc.), they may not address or result in positive, systemic, large-scale change needed to explore the phenomenon being researched (Catalani & Minkler, 2010; Sanon et al., 2014), which coincidentally, is a recurring theme in our profession's care surrounding SUDs (Godoy-Vieira et al., 2018). Photovoice studies may also not involve co-researchers in taking measures to address the study-identified issues (Catalani & Minkler, 2010).

Current scoping Photovoice study reviews have also illuminated that researchers are rarely identifying the impacts of the methods on their personal understanding and practices surrounding the study topic (Sanon et al., 2014). They may be lacking in addressing the effect of the potential power differentials between the researcher and the study co-researchers, or highlighting what personal steps they can take to address the needs that became apparent within their research (Sanon et al., 2014). When carrying out Photovoice sessions virtually, specific factors such as consistent co-researcher internet access, additional time and care needed for rapport building, and innovative sharing platforms for social change all require consideration (Breny & McMorrow, 2022). Finally, Photovoice-based research lacks adequate discussions on study limitations pertaining to the "rigor" of the methods (Sanon et al., 2014). These limitations are all worth considering in structuring a dissertation study that includes Photovoice methodologies (Breny & McMorrow, 2022; Catalani & Minkler, 2010; Evans-Agnew & Rosemberg, 2016; Godoy-Vieira et al., 2018; Sanon et al., 2014).

Establishing the Trustworthiness and Rigor of the Methods. In speaking to some of the study limitations previously noted (Breny & McMorrow, 2022; Catalani & Minkler, 2010; Evans-Agnew & Rosemberg, 2016; Godoy-Vieira et al., 2018; Sanon et al., 2014), and to establish the trustworthiness of the virtual Photovoice methods (Breny & McMorrow, 2022), I

used historical, foundational studies (Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) and current, well-established Photovoice studies in guiding the current study's workshop sessions formatting (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014). In carrying out workshops that are similarly formatted to the previous studies (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014), with emphasis on my work with Dr. Stoffel on creating virtual Photovoice methods (Selingo & Stoffel, 2021), I aimed to contribute to the body of Photovoice literature in demonstrating consistency in methodological application (Catalani & Minkler, 2010; Sanon et al., 2014).

The reflexivity practices outlined in Chapter 2 were critical in critiquing and addressing the role of who I am in my research (e.g., England, 1994; Farias & Laliberte Rudman, 2016; Haraway, 2004; Harding, 1991; Harding, 2004c; hooks, 1989; Laliberte Rudman, 2014, 2019; Rose, 1997) and the potential power imbalances between myself and study co-researchers in addressing previously noted issues with current Photovoice research (Sanon et al., 2014). To speak to issues regarding co-researcher engagement in the data analysis process, (Evans-Agnew & Rosemberg, 2016) and enacting systemic changes in collaboration with the co-researchers (Catalani & Minkler, 2010; Sanon et al., 2014), I completed the initial thematic analysis of the study materials and returned to the co-researchers to conduct a member check (Birt et al., 2016) using email outreach; I also supported co-researchers in holding the fifth, optional Photovoice workshop. The member check (Birt et al., 2016) was a particularly important step given that, due to co-researcher preference and recruitment flow, the Photovoice methods within this study were carried out in a somewhat modified form, as co-researchers went through the Photovoice process individually with myself; Photovoice methods are typically carried out in a group format to

include shared knowledge building surrounding group members' lived experiences (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000).

During these member checks, the co-researchers could refute or concur with the findings to ensure they were driving and directly informing the study results and recommendations (Birt et al., 2016). Co-researchers were also able to determine if they wanted to conduct outreach to share their pieces, perspectives, and experiences with substance use with community and healthcare persons of interest, which demonstrated collaboration with the co-researchers in creating structural change (Catalani & Minkler, 2010; Evans-Agnew & Rosemberg, 2016; Sanon et al., 2014). These efforts across the Photovoice methods and study were implemented to strengthen the body of research on replicable Photovoice methods (Catalani & Minkler, 2010; Sanon et al., 2014) and reflective processes (Sanon et al., 2014).

Phenomenological Interview Methods

Applicability of Method and Method Process Within the Study. The initial interview questions were piloted with two friends informally for the purposes of a course project earlier in my PhD program, prior to their implementation into the phenomenological interviews in this study. At that time, I had not yet determined that my dissertation research would focus on SMW, and as such, the interviews focused on the questions surrounding substance use and did not include questions related to sexual identity. Through this project, I received feedback from the course instructor and my faculty mentor, Dr. Stoffel, regarding adjusting questions to be more open-ended, and had the opportunity to practice applying the questions with others who could request clarification and provide feedback from the perspectives of interviewees. Through this

project and my dissertation proposal defense, the questions for the interview were finalized for this study.

The co-researchers who engaged in the study met with me privately and virtually (given their preferences and recruitment flow) to engage in the variably timed phenomenological one-on-one based interviews. The co-researchers were asked open-ended questions pertaining to their substance use (e.g., when they began using substances, how their substance use has been influenced by societal and personal factors, etc.) and were encouraged to share only what they were comfortable with disclosing (see Appendix G for interview questions). While focus group interviews can promote open co-researcher sharing that builds from other individuals' disclosed statements and experiences (Leung & Savithiri, 2009) and generate data on factors such as co-researchers' body language, or "non-verbal cues" and tone (Sagoe, 2012), I chose to conduct these interviews in a one-on-one format for numerous reasons.

Had the co-researchers had the opportunity to connect with one another through the Photovoice workshop sessions (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) this could have had similar benefits and opportunities for interpersonal growth and observation when compared to focus-group style phenomenological interviews (Leung & Savithiri, 2009; Sagoe, 2012). In shifting to one-on-one interviews, the co-researchers were asked to build from the understandings they had developed within the Photovoice workshop sessions to delve more deeply into their relationship with substance use as it intersects with their views of themselves, their occupations, and personal environments, leading to a deeper comprehension of the co-researchers' lived realities and identities (Law et al., 1996, Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011). Rapport building is critical in conducting qualitative

research, particularly surrounding such an intensive topic (Kawulich, 2011; Liamputtong, 2007; Watts, 2011) discussed in a virtual format (Breny & McMorrow, 2022). To promote co-researcher safety and comfort in discussing their substance use experiences, I provided the women with the opportunity to choose whether they completed the one-on-one interview with me first, or the Photovoice workshop sessions. The co-researchers were informed at the start of the interview that they could leave the interview at any time and did not have to answer any questions they might be uncomfortable with responding to. Breaks across the interviews were also promoted.

My goal in creating a one-on-one environment throughout the interviews was to promote co-researcher comfort, as given the personal nature of the questions, disclosure of highly personal information regarding sensitive topics (e.g., familial substance use, community views, negative and positive results from substance use, etc.) was possible. These interviews gave the co-researchers the ability to reflect on their experiences and share what they felt was most important, without having to balance feedback and commentary from other group members. Using this structure, we were able to take breaks as needed and discuss at the co-researchers' preferred pace; I could also engage in shared reflection with each person. In conducting these interviews in a group format, the co-researchers may have felt the need to refrain from speaking to allow others to share, feel uncomfortable disclosing personal factors regarding their substance use, or have been unable to discuss every topic covered in the interview questions.

The interview questions were designed and ordered in a way that used a phenomenological approach to explore and better understand the "personal life stories" of the co-researchers surrounding substance use (VanManen, 1990), in keeping with the purpose of the

study. Similar to the experience of conducting the initial pilot of the study questions, I found that many of the semi-structured questions incorporated into the interview were answered by the co-researchers as they shared their stories, without my prompting, in keeping with the phenomenological approach that promotes exploration of one's "life stories," (VanManen, 1990).

Phenomenological Interview Considerations. While not necessarily a limitation to the phenomenological approach to interviewing, when carrying out phenomenological research, authors such as Gallagher (2012) have urged caution in concluding that a study is successful in capturing the lived experiences of its studied population if the interview questions are not thoughtfully generated. If conscientiousness is lacking across the interview questions and process, the co-researchers may provide data that are more focused on emotions pertaining to non-pertinent factors (Gallagher, 2012). VanManen (1990) too, has recommendations for structuring and carrying out phenomenological interviews that were implemented, including that the researcher must have a clear understanding of their research question prior to conducting the interview(s) (as this question informs the interview(s)), and must ensure that their queries evoke rich, detailed responses from the co-researchers. These responses in turn provide a well-bodied dataset to analyze, preventing an interviewer from having to imbue the study results with their perspectives on the data (VanManen 1990). According to VanManen (1990), this is a balancing act, as the researcher does not want the interviews to be unstructured and open to the point that they result in a dataset that is so vast that the researcher finds themselves struggling to organize their analysis of the data and come to conclusions about the findings.

To address these potential pitfalls of conducting interviews as a data collection method within the study (Gallagher, 2012; VanManen, 1990), I drew on my personal interviewing skills

as an occupational therapy practitioner who has worked in behavioral health settings and other practice areas in which detailed interviewing is required to obtain a person's health history and engage the person in therapy interventions. I also limited the number of interview questions and structured the queries to gather a wide range of information on the women's lived experiences and perceptions surrounding substance use, without branching off into various paths of inquiry. The goal with this was to create a cohesive narrative within the data analysis and dissemination processes. To ensure that the questions were appropriate to the study, led to data that directly pertained to the research aim (and sub-aim), and explored the intersection of the co-researchers' personal factors (e.g., socioeconomic status, education level, etc.), their substance use, and their environment (physical, temporal, and community contexts) I used the study's guiding approach (Queer'ed Women's Standpoint Theory (Andersen, 1983; J. Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) and the Person-Environment-Occupation (PEO) model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) to inform the interview questions that were asked.

I ordered the interview questions in a way that promoted the co-researchers' reflection on the many factors in their lives and identities that could potentially intersect with substance use, from larger environments and societal systems to personal factors. The interview began with a broad question about one's upbringing to promote co-researcher comfort and their ability to share their story, after which the co-researcher defined what substance use is and means to them. This question was specifically included as it prompted the person to assess what harmful

substance use might look like in their life or the lives of others; their definition then served as a reference point regarding substance use throughout the rest of the interview. From there, questions that approached substance use through both an environmental and personal-factor lens were included. Throughout the interview, the co-researchers were asked increasingly directed questions that encouraged individuals to reflect on how substance use may have positively and negatively affected them.

The interview then pivoted to questions about substance use as it pertains to health, wellness, and care access. The purpose of this was to evoke co-researcher sharing regarding the potential positive and negative roles/patterns/responses individuals have experienced when interacting with individuals in healthcare professions through the substance use service lens. Targeted questions regarding treatment were placed towards the end of the interview, as some co-researchers may not have categorized their substance use to be problematic, could be in various stages of evaluating their use, or may not have felt that the treatment question pertained to them. Given this, I wanted to ensure these questions were placed towards the end to maintain co-researcher engagement in the discussion. As the interview drew to a close, the queries emphasized identifying personal strengths surrounding substance use and potential recommendations for healthcare providers to promote co-researcher autonomy and end on a positive, hopeful note. Across the interview and initial Photovoice workshop sessions, the co-researchers were asked to explore why they chose to engage in the first study method of their choice over the other method to explore the decision-making surrounding co-researcher study engagement.

Establishing the Trustworthiness and Rigor of the Methods. I have a multi-year history of practice as an occupational therapist, including working in an inpatient behavioral

health setting, which often requires the use of interviewing techniques within the evaluation process and throughout intervention, particularly in group structures. My skillfulness in building a trusting relationship with each of the co-researchers (Kawulich, 2011; Liamputtong, 2007), and in conducting interviews (Gallagher, 2012; VanManen, 1990) was truly integral to the study's success, building rapport with the co-researchers, and ensuring the accuracy of the findings.

Researcher Observations and Field Notes

Applicability of Method and Method Process Within the Study. Author Anne Mulhall (2003) describes the value of using observations as a data source in informing study findings, noting that observation (when paired with record keeping) aids in providing a holistic picture of group dynamics, results in valuable information regarding the study environment, and is a tool in documenting nuanced study factors such as interpersonal contexts. In translating observations to field notes (Mulhall, 2003), the incorporation of the notes into the qualitative research data collection process has been noted as an essential, historical piece by authors writing on qualitative methods, including Emerson and colleagues (2011) and Phillippi & Lauderdale (2018). Such field notes enhance the data analysis (and potential resulting future analyses) through the provision of thorough descriptive text surrounding a study's methods (Phillippi & Lauderdale, 2018). Phillippi & Lauderdale (2018) go on to comment:

> "Field notes situate qualitative studies within a larger societal and temporal context. In addition, they provide nontextual or auditory information about interviews and focus groups, useful in understanding participant meaning. When field notes are disclosed with other study information, they allow for transmission of the full depth of the study context."

Given the utility of field notes (Phillippi & Lauderdale, 2018) and their consistent implementation within qualitative research (Emerson et al., 2011; Phillippi & Lauderdale, 2018), this qualitative practice of data collection was carried out using in a Microsoft Word document (which is password protected).

Per Mulhall (2003), observations can be understood as "structured" and "unstructured"; "structured" observations require the researcher to actively differentiate between their role within the study compared to the study co-researchers' and to ensure that their experiences and beliefs are not impacting the study. An "unstructured" observational approach sees the researcher enmeshed with the co-researchers, open to observing unexpected co-researcher factors and actions, with their perceptions of predicted observations being molded across the study by the co-researchers (Mulhall, 2003). Within this study, in the spirit of phenomenological methods' goal to "enter the lifeworld" of co-researchers (VanManen, 1990, p. 69), I followed the "unstructured" approach to observing the co-researchers across the study interviews and workshops (Mulhall, 2003).

I translated my observations across my reflexivity practices, the Photovoice workshops, and phenomenological interviews using electronic, written field notes, and journaling. Techniques can vary in notation style, platform (including written and digital methods), and formatting, with some researchers choosing to use "keywords," and others using drawings (Phillippi & Lauderdale, 2018). For this study, I used a brief, "keyword" style of note taking during workshop and interview sessions to generate live, in-the-moment observations in ensuring that the field notes accurately reflected each session (Phillippi & Lauderdale, 2018). These keywords were used with the other data sources to generate the qualitative themes (detailed later).

Establishing the Trustworthiness and Rigor of the Methods. I used “unstructured” observational field notes to maintain an openness to the co-researchers' lived experiences, engage with the co-researchers in the study process, and our interpersonal dynamics, the study environment, and other factors that stood out as noteworthy; these were used in establishing the rigor and trustworthiness of the methods (Mulhall, 2003). In using an “unstructured” approach, it was critical to consistently engage in reflexivity practices to address my influence on the study process given my own experiences and biases (Andersen, 1983; Carastathis, 2014; Crew, 2021; England, 1994; Finlay & Gough, 2003; Haraway, 2004; Harding, 1983; Harding, 1991; Heldke, 1998; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008). Across the study, I worked to consistently assess and acknowledge my experiences, perspectives, and biases, and address the influence of these on the study through my journaling and synthesis of my reflections, which is explored further in Chapter 7 (Andersen, 1983; Carastathis, 2014; Crew, 2021; Finlay & Gough, 2003; Harding, 1983; Harding, 1991; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Laliberte Rudman, 2014, 2019; Morris, 2012; Perryman-Fox, 2020; Rose, 1997; Reid & Frisby, 2008).

Study Procedural Changes

As reflected on in Chapter 7, there were numerous rounds of amendments and adaptations to the study procedures to protect the co-researchers’ confidentiality, ensure the trustworthiness of the data, focus recruitment efforts, and create a more standardized way of reporting co-researcher's/other individual’s safety concerns (per mandatory reporting requirements). Changes included adding a waiting room to each virtual Zoom meeting (including screenings) to prevent multiple co-researchers from entering a meeting simultaneously or for the co-researchers to enter with their full name entered as their Zoom username, and an additional

requirement to have one's camera on for some or all of the screening process. Further adjustments through amendments included changes to the language used in recruitment regarding compensation, implementation of a checklist for detecting fraudulent/non-valid participation and removing co-researchers from the study, an addition to the inclusion criteria to include living in the U.S., and an application of recruitment materials that focused on Photovoice workshop session recruitment.

In providing additional details for a few of these alterations, a waiting room configuration was added to all Zoom meetings with co-researchers as early in the study, while completing a screening process with one co-researcher, another co-researcher whose screening meeting was scheduled for an hour later entered the meeting (one hour early), thus posing a potential confidentiality breach. In my discussions with our IRB staff, we came to learn that despite generating unique meeting links for each individual meeting, Zoom sends all meeting accessors to a singular "room" that is owned by the Zoom account holder who created the meeting; this means Zoom does not generate separate, unique "rooms" for each meeting. Including a waiting room allowed me to ensure that should a co-researcher mistake the time they needed to attend their scheduled meeting with me, they would not be immediately admitted to an ongoing meeting I was having with another co-researcher.

In conducting the study through virtual means given co-researcher preferences and timing, challenges in ascertaining the co-researcher's identity and trustworthiness occurred (please see Chapter 7 for examples), similar to other virtual research studies (e.g., Pellicano et al., 2023; Ridge et al., 2023; Roehl & Harland, 2022). Given these concerns, multiple steps were taken across the study amendments to further strengthen the data collection process and subsequent trustworthiness of the data. These changes, as highlighted above, were instituted

across the summer and fall of 2023 as data collection occurred. Most potential co-researchers were comfortable with the new requirement to turn on their camera for some or part of the initial screening process, however, there were a few who described issues with their camera not working, etc., or who did not reach out to me after subsequent outreach to re-connect. Alternative social media recruitment materials with compensation information removed were made to encourage potential co-researchers who were sincere in their desire to participate in the research study to reach out to initiate the screening process. Additionally, as time went on across the data collection process, I decreased the amount of social media recruitment I conducted across Facebook and Instagram, and solely focused on LinkedIn outreach. While the study had an amendment that approved Reddit recruitment, I did not use this platform for recruitment out of caution regarding the potential for scamming.

A new screening checklist was used across potential co-researchers after the approvement of the amendment in July of 2023. ChatGPT 3.5 was used in formulating updated language regarding valid participation for the study consent form, as it was difficult to find examples of such language in publicly available consent forms (OpenAI, 2023). ChatGPT created the language surrounding ensuring and reinforcing legitimate co-researcher study engagement within the consent form (OpenAI, 2023). The screening checklist data was stored for co-researchers who did not meet the fraudulent/non-valid criteria. Co-researchers had to meet three or more criteria to be removed from the study (see Appendix B for the study screening script and Appendix C for the implemented checklist), and would have been notified in writing of this decision, with the option to discuss the reason for their withdrawal with me. Any of the co-researchers who were asked to step down from the study for any reason were compensated up

until the point of the request to discontinue participation to demonstrate appreciation for their time, and their data was removed from the dataset included in the data analysis.

Given co-researcher preferences to engage in only the interview process, focused recruitment efforts and materials were implemented in October of 2023 to ensure that an adequate saturation of Photovoice pieces were present within the study. Finally, a mandatory reporting protocol and template script was created (though not added as an active amendment due to completion of the data collection process) for the study to be used during Photovoice workshop sessions and interviews given concerns over the need to report co-researcher's disclosures after a co-researcher shared a case that warranted a report. These materials and processes were created to ensure that had data collection continued, I as the researcher could have adequately responded to disclosable events, had practices in place to inform the co-researchers, and could follow up in interfacing with IRB and reporting to the appropriate authorities.

Demographics Collection

The co-researchers engaged in a verbal demographics collection at the end of the phenomenological interviews. Given the stigma surrounding substance use disorders (Ashford et al., 2018; Ashford et al., 2019) and sexual identity (Brooks, 1981; Feinstein et al., 2017; Meyer, 2003), and the sensitive nature of discussing substance use (Clapp et al., 2021), the demographics data collection portion was conducted upon completion of the interview to provide the co-researchers with the autonomy to self-identify through open-ended questions related to age, sexual identity, zip code, income level, ethnicity, race, substance use type and frequency, etc. (see Appendix K for questions). My ultimate goal in this placement was to build rapport with the co-researchers and develop a respectful, trusting relationship prior to asking them these

detailed questions about their substance use and personal factors (Kawulich, 2011; Liamputtong, 2007).

The demographic questions were included to provide a well-rounded view of the co-researchers' backgrounds and contexts and to approach the person from the intersecting and holistic perspectives of the Person, Environment, Occupation model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011), and Queer'ed Women's Standpoint Theory (Andersen, 1983; J. Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012). The co-researchers were given the option to not answer any demographic questions that they did not feel comfortable in answering to further promote rapport, co-researcher comfort, and safety (Kawulich, 2011; Liamputtong, 2007), with some choosing this option across varying prompts.

Finally, while not a factor in co-researcher confidentiality or study dataset trustworthiness, an amendment to include fewer potential co-researchers to aim for through recruitment was passed (with a decrease from 25 to 20 intended recruited co-researchers). An amendment focusing on specified Photovoice-based recruitment was also made given the preference of initial co-researchers to complete only the interview portion of the study; this amendment focused on ensuring an accurate saturation of Photovoice data within the dataset. Demographic information that was collected from the co-researchers was analyzed and presented in a descriptive statistics table in Chapter 6.

Data Analysis Methods

To ensure that the data collection and analysis processes were iterative and manageable timewise, data analysis was initiated as the first round of Photovoice workshops concluded and occurred throughout the study. Braun & Clarke's thematic analysis approach steps (2012; Clarke & Braun, 2014a,b) and reflexive thematic analysis (Braun et al., 2018; Braun & Clarke, 2019, 2020; Byrne, 2022) guided the analysis process in presenting co-researchers' lived experiences and recommendations regarding substance use. Braun and Clarke's note in their 2019 call for reflexivity within the thematic analysis that this method of data analysis recognizes the researcher's need to question their analyses across the process, as the themes are not "hidden" and "emerging" from the dataset, but rather, are generated because of the researcher, including their interpretations and applied theories. This recognition and need for consistent self-reflection on behalf of the researcher was incorporated into the analysis process and is explored in the results and final reflection (Braun et al., 2018; Braun & Clarke, 2019).

Braun and Clarke's earlier 2012 work outlined processes for analysis (and steps for the initial analysis process within this study) includes notating the data and "familiarizing" oneself with it. This process occurred throughout the study as I observed, wrote field notes, completed the Photovoice workshops, conducted the interviews, and reviewed these materials across the analysis process (Braun & Clarke, 2012). The co-researchers' verbal recommendations for healthcare providers, including OT practitioners, were included in the thematic analysis and as separate results presented Chapter 6. Prior to analysis, session transcripts were cleaned by a student transcript cleaner or myself, after which I worked with the data across physical printings and digital copies of workshop and interview transcripts, Photovoice pieces, and fieldnotes in

highlighting initial codes, or common topics, phrases, and ideas that arose (Braun & Clarke, 2012).

Within this process, analysis and coding started as the first rounds of co-researchers progressed through the study (Braun et al., 2018). As I continued to collect data with the co-researchers, I re-examined the identified codes and worked to build broader themes, which were then checked against the original codes (Braun & Clarke, 2012) and personally critiqued through the lens of transformative (Mertens, 2009; Mills, 1959) occupational science (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) imagination (Laliberte Rudman, 2014, 2019) and subsequently Queer'ed Women's Standpoint Theory (Andersen, 1983; J. Butler, 1999; Carastathis, 2014; Collins, 1986; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012).

This cyclical process, based on the initial steps outlined by Braun & Clarke (2012), included personal electronic journaling, in which I assessed the impact of my study's guiding theoretical underpinnings and my personal experiences and biases on the data analysis process (see Chapter 7 for further details) (Braun et al., 2018; Braun & Clarke, 2019, 2020; Byrne, 2022). The purpose of this (Braun et al., 2018; Braun & Clarke, 2019, 2020; Byrne, 2022) was to avoid generating generalizations across the co-researchers who had varying sexual identities, and paying attention to detailing differences in opinions and experiences (Feinstein et al., 2017). After creating the final set of themes from the study data, I discussed the findings with my faculty mentor, Dr. Virginia Stoffel, and subsequently concluded the analysis process with

member-checking through email outreach or virtual meetings depending on the co-researchers' preference (Birt et al., 2016).

In providing a bit more detail about my analysis approach, Braun and Clarke (2012, 2019, 2020) and Clarke & Braun (2014a,b) call for recognition and analysis of numerous philosophical "assumptions" (Byrne, 2022). The following approaches were taken within this study:

Byrne (2022) notes that outlining a timeline for determining epistemological underpinnings across the course of a study is needed; consideration regarding these underpinnings within my study was, while non-specifically articulated within my dissertation proposal, designated as I chose my guiding theoretical approaches and subsequent study methods. Within reflexive thematic analysis, Braun & Clarke (2020) urge researchers to avoid assigning either a "realist/essentialist" (where the language used is directly resultant in creating meaning of our experiences (Widdicombe & Wooffitt, 1995)) or "experiential/phenomenological" (in which the language is used reciprocally, while influencing and is affecting by our experiences (Schwandt, 1998)) epistemological approach in analyzing data and determining themes. They note that thematic analysis can be "flexible" in blending these approaches (Braun & Clarke, 2019, 2020; Braun et al., 2018; Byrne, 2022; Clarke & Braun, 2014a). Through my choice in using a transformative (Mertens, 2009; Mills, 1959), occupational imaginative philosophical epistemology to approach the work through (Laliberte Rudman, 2014, 2019) that was grounded in critical realist beliefs (Altheide & Johnson, 2011, p. 581; Hockey, 2010, p. 366; Redman-MacLaren & Mills, 2015), I was able to apply a fusion (Clarke & Braun, 2014a) of these epistemological approaches in recognizing that the language used by the co-researchers was a result of their experiences as a queer woman (Widdicombe &

Wooffitt, 1995) as well as a tool used in defining their experiences and various standpoints (Schwandt, 1998).

Another decision needed to be made within the analysis regarding whether the data and thematic detailing would come from an experiential orientation in showing how SMW experience substance use and influencing factors (Byrne, 2022, Clarke & Braun, 2014a) or a critical orientation in focusing on the social factors that contribute to the understanding and meaning that the co-researchers assigned to their experiences (Braun & Clarke, 2012; Clarke & Braun, 2014a; Byrne, 2022). As I reflected on my goals for the study and desire for the co-researchers to drive the study findings given my PAR-based lens (McIntyre, 2008), I applied an experiential orientation in generating the themes and emphasizing co-researcher quotes (informed by co-researcher language (Terry et al., 2017) via interview and workshop session summaries (Byrne, 2022; Clarke & Braun, 2014a; Terry et al., 2017)). That is not to say, however, that a critical orientation (Braun & Clarke, 2012; Byrne, 2022; Clarke & Braun 2014a) is not explored within this work, as within the final chapter (Chapter 7) and the literature review (Chapter 3), co-researcher experiences are held up to current findings regarding SMW's experiences and needs surrounding substance use, sexual identity, and more, in determining whether the experiences shared concur or deviate from current hypotheses and social phenomenon.

Through the experiential lens (Braun & Clarke, 2012, 2020; Byrne, 2022; Clarke & Braun, 2014a; Terry et al., 2017), a blend of deductive and inductive analysis processes was used in examining the data and creating the codebook (Braun & Clarke, 2012, 2019, 2020, Byrne, 2022; Clarke & Braun, 2014a,b). The initial process of coding included inductive emphasis on identifying co-researcher's shared and differing experiences and the language used they used to

explore their various standpoints (Bryne, 2022). This was carried out first, without the direct application of my chosen guiding theories and application of my knowledge of substance use from a practice perspective (Bryne, 2022). After creating the initial codes, my chosen theoretical underpinnings and knowledge of substance use from a current, evidence-informed OT lens were deductively held up to the data and initial codes in seeing where these theories and knowledge might be present (or deviate) within co-researcher's shared experiences and descriptions of their identities (Byrne, 2022). Ultimately, this study was PAR-based and carried out with the goal of having co-researchers determine the study's results to the greatest extent possible (McIntyre, 2008). Given this, the thematic analysis process emphasized more of an inductive lens (Braun & Clarke, 2012; Byrne, 2022) in structuring the themes based on co-researcher's direct reports, rather than my underlying guiding frameworks (Byrne, 2022).

Finally, within reflexive thematic analysis, themes may be “explicit,” “semantic,” or “conceptual,” and “latent,” (Braun et al., 2018; Byrne, 2022) and come from an iterative, detailed process of analyzing and codifying the data (Braun & Clarke, 2012; Braun et al., 2018). Semantic codes can be understood as the “surface meaning” and direct representation of what a co-researcher states (Braun et al., 2018; Byrne, 2022); this form of coding can result in “contradictions” across what is shared by various individuals (Braun et al., 2018). When using latent coding approaches, “underlying assumptions, ideas, or ideologies that may shape or inform the descriptive or semantic content of the data” (Byrne, 2022) are used to deeply analyze the data (Byrne, 2022).

Given the flow of my decision making across the aforementioned approaches to the analysis process, a blend of semantic and latent coding was used (Braun et al., 2018; Byrne, 2022). On the one hand, I upheld and summarized the language and descriptors used by the co-

researchers thematically, while also assessing how the language used and disclosed lived experiences did or did not agree with my study's guiding theoretical framework and my knowledge of current OT practice (Braun et al., 2018; Byrne, 2022). Latent coding assessment was pertinent, particularly when co-researcher experiences and subsequent codes were found to be in explicit agreement (or disagreement) with the chosen guiding resources for the study (Braun et al., 2018; Byrne, 2022).

Applicability of Analysis Method Within the Study. Through this method of data analysis, both the findings regarding the broader lived experiences of those who engage in the research work can be analyzed, as well as the specific underlying and impacting constructs that influence the research issue being studied (Braun et al., 2018). This hybrid method (Braun et al., 2018) blends with the large-scale goals of transformative (Mertens, 2009; Mills, 1959) occupational science and imagination (Farias & Laliberte Rudman, 2014; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990), and can be used in recognizing the intersecting standpoints and knowledge generation of Queer'ed Women's Standpoint Theory (Andersen, 1983; J. Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011l; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012).

Given the many nuanced factors that impact the lived experiences of SMW surrounding substance use, the flexibility of this analysis method felt appropriate (Braun et al., 2018). Various approaches to thematic analysis have commonly been used within phenomenological methods (Giorgi, 1997) and Photovoice-based studies (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang

et al., 1998; Wang et al., 2000), strengthening its appropriateness as a data analysis method for this study. The use of qualitative, reflexive thematic analysis resulted in highly personal data that can be used to engage and motivate the OS and OT community (including other healthcare providers and persons of interest) to enact changes to better meet the needs of this population (Braun & Clarke, 2012, 2019, 2020; Braun et al., 2018; Byrne, 2022).

Triangulation

Methodological triangulation was addressed in numerous ways, including the use of multiple methods of data collection (my field notes, phenomenological interview transcripts, Photovoice session transcripts, and Photovoice pieces), in keeping with a transformative research paradigm (Mertens, 2009). To ensure that the study's findings and conclusions accurately represented the co-researchers' experiences, personal statements, and recommendations, multiple theoretical approaches were used to examine the data (or "theory triangulation") and engagement of the co-researchers in member checking was conducted (Birt et al., 2016). These triangulation methods were used to assess the consistency of the co-researchers' data, and work towards upholding their "voice" within the study findings (Patton, 1999).

Positionality Reflections and Reflexivity as a Personal Research Tool

While not a data analysis tool, I used the outlined positionality framework to personally journal over the course of the study (see Chapter 2) via Microsoft Word on OneDrive as an assessment tool in confronting the potential influences of my experiences, perspectives, and biases on the study methods, through active reflection and adjustment (Andersen, 1983; Carastathis, 2014; Crew, 2021; Finlay & Gough, 2003; Harding, 1983; Harding, 1991; Heldke, 1998; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008); this practice is in keeping

with the tenants of reflexive thematic analysis (Braun & Clarke, 2019, 2020; Braun et al., 2018; Byrne, 2022).

Study Timeline

Data was collected between May 2023 and December 2023, with a final Photovoice gallery held in January 2024. Data coding and analysis was an iterative process across the research, with codes consistently updated with additional data from each co-researcher. Initial themes were generated in late fall of 2023, and member checking was conducted across January 2024. Study amendments related to increasing the scope of recruitment spaces, decreasing recruitment numbers, and creating study protocols that supported legitimate data collection were passed across July and August 2023. An amendment regarding Photovoice-workshop session-specific recruitment materials was approved in October 2023.

Data Collection and Management Resources

Qualtrics and emailing served as places in which the co-researchers could upload copies of their various consent forms and Photovoice pieces, engage with mental health and Photovoice resources, and access the Zoom workshop session meetings. The first Photovoice workshop included a tutorial on how to use Zoom and the opportunity for co-researchers to ask questions about the study platforms. The co-researchers were also provided with a physical resources on how to use Zoom (see Appendix L). The use of Qualtrics and email allowed for easy study data management and meeting organization. While Canvas was considered for an organizational platform across the study, given IRB feedback on increased barriers to access given co-researcher's potential inexperience with the platform and confidentiality concerns, I pivoted to emailing and Qualtrics.

Zoom was implemented for hosting the Photovoice workshop session meetings and the one-on-one interviews as it is a commonly used video-conference platform that has established video and audio recording and transcript capabilities. The co-researchers also had the ability through Zoom to modulate their participation, as they could choose to attend a session with their camera or audio turned off. Had the virtual sessions been conducted in groups, co-researchers would have also been able discuss session topics with one another in the Zoom chat feature available throughout meetings. Zoom would have also been used in recording any in-person Photovoice or interview sessions via my computer. For virtual meetings, the co-researchers were asked via their preferred method of outreach to enter this number as their Zoom "name" upon entering each workshop session and the interview to promote co-researcher confidentiality.

The Microsoft OneDrive suite offered through the University of Wisconsin-Milwaukee (UWM) was used to store data, in Microsoft Excel sheets (demographic data), PDFs, and Word documents. My faculty advisor, Dr. Stoffel, had access to the anonymous data (Photovoice pieces and interview transcripts) through OneDrive, with a student transcript cleaner having access to the session and interview audio recordings and transcripts. I was the only individual with access to identifiable information and the demographics (the co-researcher's consent forms, preferences for communication and contact information, payment tracking, and co-researcher dentification number). Any physical materials from the study (e.g., printed session and interview transcripts) were maintained in a locked lock box in my place of residence that was only accessible to me. OneDrive provides a password secured storage location for the study materials and served as an ideal data management resource.

Transcript Cleaning

Transcript cleaning was conducted by me and a graduate OT student. There were numerous transcripts that I needed to clean individually, as some co-researchers verbalized their name aloud during Photovoice sessions or the interview, which prevented the student cleaner from being able to clean these transcripts given potential breaches in confidentiality via the audio recordings. The transcript cleaning process involved separation of the transcripts and audio recordings that included co-researchers' names into folders that only I could access, versus folders with transcripts that did not include confidential information that the student cleaner could access and clean.

Verbatim transcription was used, with notes needing to be included in the transcripts to highlight when the person speaking was non-discernable due to poor internet connection, speaking softly, etc. A transcript log was kept to chart formatting and confidentiality decisions made across the cleaning process that both I and the student cleaner adhered to (see Appendix M). Transcript cleaning took place over the summer and fall of 2023, during which I regularly met with the student transcript cleaner to discuss progress and questions that might have arisen, including cleaner notes on similarities between co-researchers' stories and voices, and other factors of concern throughout the transcripts.

Funding

Funding for the study was obtained from application to and receipt of UWM's Chancellor's Graduate Student Award across 2020-2023. This funding was used to provide compensation to the co-researchers and to the student transcript cleaner. Total costs associated with the study across co-researcher participation and transcript cleaning equaled $693.00 out of a $3,000 allotted initial budget.

Discussion

Within the chapter, this dissertation's various study methods and procedures were explored. Across these study procedures, methods, platforms, and data analysis processes and tools, intentional choices were made to facilitate exploration of the co-researchers' lived experiences while upholding safety, autonomy, confidentiality, respect, and personal reflexivity. Photovoice (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) and phenomenological (Gallagher, 2012; Giorgi, 1997; VanManen, 1990) methods were chosen as the primary study methods given their ability to explore lived experiences through numerous mediums. Data collection took place primarily across summer 2023 and fall 2023, which included a fifth Photovoice workshop gallery in January of 2024. Data analysis and member checking and were carried out during late fall of 2023 and early winter of 2024 using Braun and Clarke's reflexive thematic analysis (Braun et al., 2018; Braun & Clarke, 2019, 2020; Byrne, 2022), informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014a,b). Various amendments were made to the initial study protocol to ensure the trustworthiness of the dataset, and co-researcher confidentiality. Transcript cleaning was carried out by me and a student cleaner. Next, the results of the study will be explored and discussed.

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"...I thought that it [substance use] *was helping me. And still looking back on it, at times I do think that it was, but at the end of the day it...I needed to help myself, I couldn't depend on something else to get me through the day. But truly...I don't know where I would be if it wouldn't have helped me get through those hard times...that I've developed the proper skills and thought processes and things like that. I can obviously get through without it, but at times I am just a little bit thankful, cuz mentally, I was just not doing okay. And like I said, I don't know where I would be if I hadn't gone through that."* - Caroline (pseudonym)

Chapter 6: Results

Abstract

This chapter explores the results of this dissertation work, including a breakdown of the co-researcher flow across the study activities, and descriptive statistics. A brief description of the member check process is included. Themes identified from the co-researcher's interview transcripts, Photovoice workshop session transcripts, and Photovoice pieces are explored, with themes addressing the intricate personal and systems-levels influencers of substance use as it intersects with one's sexual identity and healthcare access. An initial thematic framework is also included to assist readers in making connections between co-researcher themes. Co-researcher recommendations for practitioners ground the rest of the chapter, and include emphasis on creating safe spaces, respecting personal choices regarding substance use and sexual identity, not being discriminatory in practice, and more. Further assessment of the findings with regards to the underlying study aim (and sub-aim) and guiding philosophical and theoretical scaffolds are explored in Chapter 7.

Introduction

This dissertation study examined the impact of sexual minority women (SMW) in emerging adulthood's lived experiences with substance use using Photovoice (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) and phenomenological interviewing methods (Gallagher, 2012; Giorgi, 1997; VanManen, 1990). In interacting with the study results, I urge readers to use this as an opportunity for personal reflection regarding the co-researchers' shared experiences and recommendations, and how our personal experiences with substance use, and our identities, privileges, and biases influence the way in which we engage

with the findings. We can take these reflections and consider how they in turn impact our approaches to and comfort with addressing substance use in practice, and what actions we can take and apply from the study findings to our future service to others to who use substances, including SMW.

As you engage with the findings, I have included some reflective questions informed by the underlying approach of transformative (Mertens, 2009; Mills, 1959) occupational science (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) and imagination (Laliberte Rudman, 2014, 2019), and Queer'ed Women's Standpoint Theory (Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012):

- What subjectivities (Gorman-Murray et al., 2010), experiences, biases, and privilege do I bring with me in interacting with these findings?
- How am I emotionally and physically responding in engaging with the findings? Do I feel energized? Uncomfortable? Why might I be feeling the emotions I am feeling?
- Do I identify with any of the lived experiences or recommendations shared by the co-researchers?
- What are my views on substance use and sexual minority identities? How do they affect the way I synthesize the readings and engage in everyday practice?

- How do I see these shared lived experiences and recommendations fitting into large scale societal systems, including healthcare?
- How might I incorporate these findings and recommendations into my practice and how I view substance use going forward? How might I initiate a conversation regarding the findings with my colleagues?
    - What is one action I can consistently commit to going forward in applying the findings to my life and work?

While reading, try to be as present as possible. Put away other work, phones, the television, your email; anything that pulls you away from fully immersing yourself in the stories and recommendations shared here.

The co-researchers across the study could denote if they were comfortable with their direct quotes being used in the dissertation and subsequent publications. The also had the ability to determine whether they would like their quotes and Photovoice pieces to be noted as created by "anonymous" or a pseudonym. All names you see listed in the chapter and beyond are pseudonyms for those whose preference was using a name other than theirs, therefore, the denotation of (pseudonym) will not be used going forward. I would also like to highlight a trigger warning, that the topic of familial and sexual-identity-based trauma will be discussed, including sexual assault and suicide. In taking care of yourself, please take breaks when engaging with the results as needed.

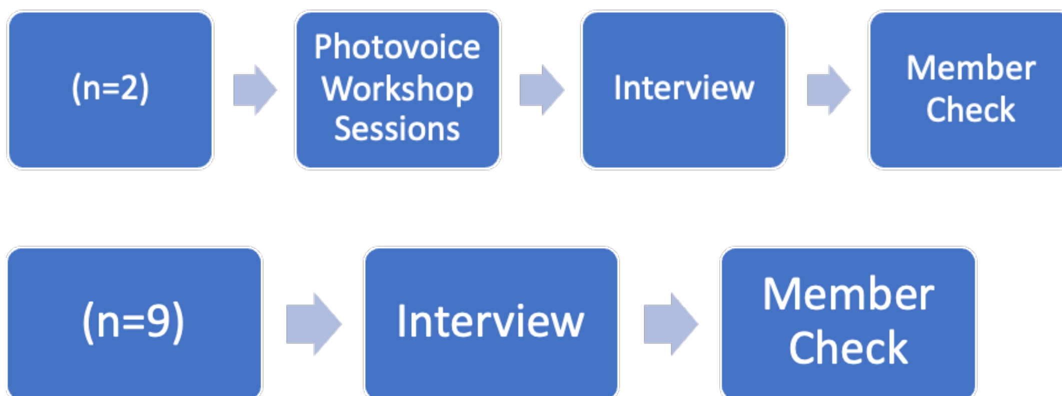
Study Trajectories

In upholding participatory action researcher (PAR) principles including autonomy and flexibility for community members who participated (McIntyre, 2008), the co-researchers were given the option to initiate study engagement with either the Photovoice workshop sessions or

the interview; they were also notified that they could complete only the Photovoice workshop sessions or interview. To illustrate the potential study trajectories the co-researchers chose, please see Figure 6.1.

Figure 6.1

Co-Researcher Study Progressions



Of note, there was one co-researcher who initially engaged in the Photovoice workshop sessions, though discontinued participation in the sessions and requested to move to the interview as they reached the third Photovoice workshop session. Nine women chose to complete the interview singularly, with none engaging in just the Photovoice workshop sessions. Two co-researchers were withdrawn from the study by me given trustworthiness-based concerns. Additionally, at least 16 women went through the screening process, though given the concerns about potential recruited women attempting to engage in the study multiple times, an exact screening number cannot be ascertained.

The variance of co-researcher engagement in the study affected how co-researchers viewed the study methods and reflective process. For Alexis, who completed the Photovoice workshop sessions prior to the interview, the interview was viewed as a way to reflect on what

was explored in the Photovoice workshop sessions without having the interview discussion impact her Photovoice process:

> "I thought having the interview second would be kinda like an exit interview kind of vibe…'Okay, I can see why, other things that I did during the Photovoice sessions came out in the way that it did,' …because I can see having the interview before it could shape it a lot more like, you know, like, 'Oh, I've been thinking about these things that were going on during the interview, as opposed to attaching meaning to it afterwards'…" - Alexis

In providing the option for co-researchers to engage in the study in the order they wished, consideration regarding how this ordering of participation may have influenced women's reflections and understanding of the study processes should be considered.

Demographics

Co-researchers from across the United States participated in the study, with many having differing backgrounds, racial and ethnic identities, physical locations, socioeconomic tiers, and sexual identities. Tables 6.1 and 6.2 detail co-researcher demographic descriptive statistics. Data has been aggregated for co-researcher confidentiality. The co-researchers were provided with the choice to decline answering any demographic queries they did not wish to answer. For questions that one or multiple co-researchers chose not to provide answers to, no data for these individuals are included in the aggregated answers. As these questions were asked in an open-ended format, the co-researchers provided the categories shown below in their responses and could classify themselves as multiple identities. The descriptive demographic statistics have been included in Times New Roman font as opposed to Sitka text for easier viewing.

Table 6.1

General Descriptive Demographics

Demographic Variable	Number of Co-researchers
Age	
18-20	1
21-23	3
24-26	6
27-29	2
Living Environment	
Suburban	2
Urban	10
Region	
Northeast	7
South	0
Midwest	2
West	2
Sexual Identity	
Lesbian	11
Pansexual	1
Homoromantic	1
Gender Identity	
Female	9
Woman	2
Queer	1
Loose Gender Expression	1
Lesbian	1
Annual Income Range	
Less than $20,000	1
Between $20,000 and $25,000	1
Between $25,000 and $35,000	3
Between $35,000 and $45,000	2
Between $45,000 and $55,000	2
Between $55,000 and $65,000	2
Between $65,000 and $75,000	0
$75,000 or more	1
Racial Identity	
Black American	6
African American	2
Black	2
White	2
Ethnic Identity	
Black	3
Black American	2
African American, Hispanic	1

Nigerian, American	1
Catholic	1
Non-Hispanic	1
White	1
Highest Level of Education	
Bachelor's	6
High School	2
College Student	1
Online Undergraduate	1
GED	1
Marital Status	
Single	11
Single, Living with Partner	1
Number of Children Living with Co-researcher	
None	11
1	1

Note. Co-researcher region is based on U.S. census regions per the United States (U.S.) Census Bureau (U.S. Department of Commerce Economics and Statistics Administration: U.S. Census Bureau, n.d.).

Table 6.2

Substance Use Descriptive Statistics

Substance Use Variable	Number of Co-researchers
Substance Use	
Alcohol	11
Marijuana	9
Tobacco/Nicotine	3
Cocaine	1
Heroin	1
Opioids	1
Prescription Medications	1
Per Week Frequency of Use	
Every Day/Daily	3
Almost Every Day to Daily	1
6 Days a Week	1
5 Days a Week	2
4-5 Days a Week	1
4 Days a Week	1
3 Days a Week	1
2 Days a Week, On the Weekends	1
1 Time per Week, for Alcohol	1

Per Month Frequency of Use	
Every Day/Daily	3
Almost Every Day to Daily	1
24 Days per Month	1
20-25 Days per Month	1
20 Days per Month	2
2 Weeks per Month	1
10-15 Days per Month	1
6 Days per Month, on the Weekends	1
4 Times per Month for Alcohol, 2-3 Times per Month for Marijuana	1
Has Received Occupational Therapy Services for Any Need	
No	9
Yes – General Health	1
Yes – Mental Health	1
Yes, Likely – Mental Health	1

Note. It should be noted that some co-researchers were sober or not using substances at the time of the interview and provided responses to questions regarding substance type and amount used based on previous use. Additionally, the co-researcher who reported using prescription medications did not indicate whether this use fell within the bounds of prescribed use or misuse of the medication.

Member Checking

Member checking was carried out via email, with co-researchers having the option to provide feedback in writing (through email) or meet virtually individually with me to assess the study themes, sub-codes, and practitioner recommendations. While multiple co-researchers emailed to ask about aspects of the member check process, including compensation, two co-researchers completed the member check process in total. One co-researcher provided feedback both in person and via email, with the other providing feedback through email alone. Across the two co-researchers who engaged, both women reported being in general agreement with the themes, sub-codes, and recommendations. The two co-researchers also added feedback that is highlighted across the findings. This feedback includes additional responses to member check

prompts I requested from the co-researchers that asked them to define what constitutes safe spaces and interactions with providers, including what love looks like when applied by practitioners in their interactions with the women. The responses to these queries are included in enhancing the themes and recommendations shared in this chapter.

Photovoice Gallery

Two co-researchers engaged in the fifth, optional Photovoice workshop session, which was held as a virtual gallery on Zoom in early January of 2024. Numerous interested community members attended, including occupational therapists. In presenting their pieces, both co-researchers reflected on their continuously developing understanding of their perspectives shared through their Photovoice pieces, with one co-researcher describing their evolving process of working towards self-acceptance. Both co-researchers affirmed the experiences of one another that were shared through their Photovoice pieces and subsequent conversations. Discussions regarding the internalized pressure to feel that one is “queer enough” in queer spaces also arose, with co-researchers describing external expectations from the queer community as to how one should present, as well as internal personal assessment, and the resulting strain this might cause. Both co-researchers and attendees alike conversed over factors contributing to feeling accepted, safe, and comfortable with their personal sexual and gender identity presentation in queer and non-queer spaces, with factors such as supportive signage, engaging with a “younger” group, and having another queer friend present discussed. Co-researchers described the positive impact of experiencing love from others, though highlighted that they may feel loved and safe to “come out,” though responses from others when disclosing their sexual identity may lead them to feeling a resulting lack of love.

Frustrations with the lack of available queer community spaces that do not involve substance use was explored across the co-researchers and attendees, including the impact of this dearth of space on how one navigates engaging in with in the queer community.

Study Thematic Findings

This study's aim focused on examining the lived experiences of student sexual minority women in emerging adulthood who use substances. In addition to this aim was a sub-aim focused at exploring co-researcher recommendations targeting preferred approaches to healthcare interactions with SMW who use substances. Themes across the co-researchers' data (Photovoice workshop session transcripts, interview transcripts, and Photovoice pieces) and my field notes taken during Photovoice sessions and the interview were generated using Braun and Clarke's (2019, 2020) reflexive thematic analysis approach (Braun et al., 2018; Byrne, 2022) informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014a,b). As the themes are explored next, an emphasis is placed on the co-researcher's voices and experiences in exploring each overarching theme (which were further supported by my field notes). Further analysis of the applicability of the philosophical, theoretical, and model underpinnings is provided in Chapter 7.

Thematic Organization

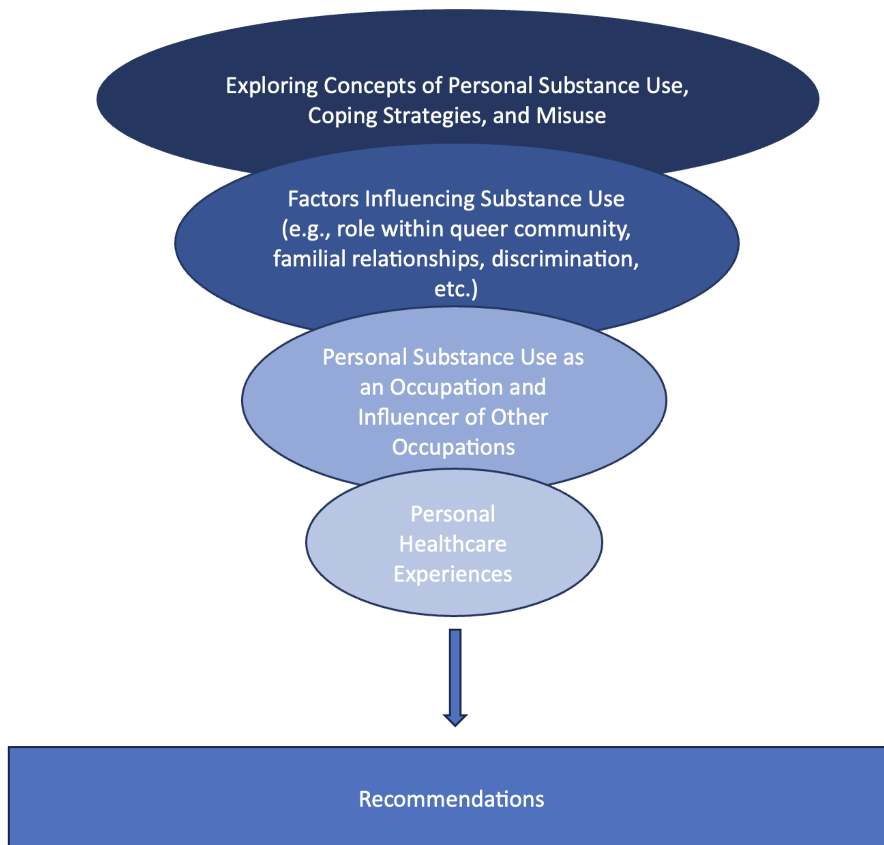
I came to recognize through the reflexive thematic analysis process (Braun & Clark, 2019, 2020; Braun et al., 2018; Byrne, 2022) (informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014a,b), that applying the PEO model (Law et al., 1996; Strong et al., 1999 Strong & Rebeiro-Gruhl, 2011) was not applicable given the co-researchers' shared experiences and perspectives. Given this, the thematic findings are not structured around the

PEO model and are based on the intersecting topics and concepts highlighted as important by the co-researchers.

Presentation of the resulting study themes has been strategically organized, as shown in Figure 6.2.

Figure 6.2

Presentation of Study Themes



The themes start with broader co-researcher discussions on their substance use patterns and reasons for use, coping strategies surrounding substance use, and perspectives on misuse. They then dive more deeply into the nuanced identities, roles, and relationships that influence the women's use, before exploring substance use as a specific occupation and activity that impacts other occupations. Finally, co-researcher's experiences regarding healthcare

services will be detailed, leading into a discussion of a proposed initial thematic framework and co-researcher recommendations for healthcare and support providers who serve SMW who use substances.

Themes

1. Conceptualizations of Personal Substance Use and Defining Misuse Lie on a Spectrum

Conversations regarding co-researchers' personal substance use often intersected with defining what substance misuse was to each co-researcher. Many of the women described recognizing (for themselves) what amount of substance use constituted a “just right” amount, and when they were misusing. In discussing their recognition that their personal use had become harmful Elizabeth shared:

> “You know you need therapy, and therapy is money. So you...you don't get to do things the way you want to do it. You can't just start your day up on it like, ‘I want it because it will work out.’ It won't work out.”

The co-researchers who engaged in the study had varying levels of current and historical levels of substance use. Some were using one or multiple substances and did not feel that their substance use constituted misuse or required intervention at the time of engaging in the study. Other women identified their current or past use as harmful. Around seven of the co-researchers articulated that they felt they had current or previous experience with substance misuse. Across the co-researchers, various forms of support for one’s substance use and misuse was described. Two co-researchers reported receiving support services from various healthcare professionals, one co-researcher had a sobriety “companion,” and one co-researcher described receiving mental health support that was non-specified for substance use. Three co-researchers

noted that they were managing their harmful use independently, with one having received substance use support professionally and feeling that it had not been effective. One woman described taking personal action regarding her use and seeking peer support via Youtube, while another co-researcher described accessing ongoing therapy support across numerous therapists in addressing both substance use experiences and non-related topics. Three of the co-researchers verbalized that they did not feel that help regarding their substance use was needed at the time of engaging in the study. Of the co-researchers, some of the women were in the more initial stages of determining that they felt their use was harmful, and were being provided with support from friends and family. Some, given their prior substance use experiences, had chosen to maintain sobriety, and were sober at the time the study was conducted.

When defining substance misuse, the co-researchers often included terms such as 'overdose,' taking substances in a way they are not 'meant' to be taken, or using beyond what the body can 'take.' Misuse was frequently described as use that occurs often:

> "...I feel like that applies to a lot of other things as well...like, a bunch of different types of substances, and also...the amount that you're consuming, how many times a week, like, if you're doing something every day, multiple times a day." - Caroline

Using to be able to cope was also described:

> "Substance misuse is definitely a lot more like using it to cope. Um, like some drugs you can definitely do like, recreationally...like drinking, um...marijuana...harder drugs are like...kinda like...a little...little much,

because it's like, how much like...why are you doing it kind of thing?" - Alexis

During the member check process, a co-researcher went on to further highlight their substance use as a coping strategy for managing situations they found embarrassing.

Numerous co-researchers highlighted that misuse can center on use for daily survival:

"...the best thing you can just use to make sure that you can survive or just hang in there...is substance because it...it feels like that's like...the easiest way...that's the only thing you need available, that's the only thing that you can just like....push you through to like, wake up in the morning...until it gets to the point it turns into an addiction..." - Joan

"But I know definitely misuse is the...definitely feels more like...like needing it rather than just wanting it. The difficult time it is to just like...let go or know that you can live outside of it...misuse is the mindset around stuff as well as like the cravings and things like that to like...having that feel of you can't relax without it, or you can't do things without it..." - Alexis

Across the Photovoice workshops and interviews, the term "control" was often used as the co-researchers verbalized their perceptions of their personal use. This discussion was particularly targeted in regarding substance use as something that they wanted to control, as Tessa stated:

"...I always want to be the...in control of it. I don't want it to be in control of me." Co-researchers noted that substance use could come to control a person, as Elizabeth described, "...it can't be stopped. It's something that

your everyday life is...it's being controlled. You get...you can't live your everyday life without taking it.“

Renee supported this in sharing her experiences with using:

> “ ...let me try to do this assignment now without taking any substances...without using anything...let me just try...some days I can just be like, ‘Okay, today, I won't take anything at all.’ Yeah, I've tried that; I've almost...I end up failing, I end up failing at it. And then I still go back.”

In discussing aspects of control, the co-researchers described a plethora of personal decision-making factors that impact their decision whether to use and their quantity of use, with Alexis sharing:

> “But again I don't...I don't do it by myself...I'm just cautious about my drug use, and like...anything where I would feel like...completely out of body, I would not be able to do for the most part, but otherwise I also feel fully comfortable to like...if I'm in a place where...it's like...typical of people...like, using drugs, I feel comfortable that I can say no, or I can partake...partake with like...I guess...more like...expectations of rules for myself that I impose.”

When detailing feeling out of control with their use, the co-researchers often described cycles of use and their desire to seek help and re-establish control, as Caroline noted, “But then, when I'm not using it, it makes me feel even worse, and then I just...would like to accept myself without using them rather than only accepting myself when I am...”

Elton also expanded on exploring her control over her substance use:

"I'd sat down one day when I was on my vacation, actually took myself on a vacation, and asked myself like...revoluted myself in terms of, 'who am I?' Like...I had just find that and redefine it. I had to establish what I like, what I don't like, what are the triggers, what are the stressing factors...and now come up with like solutions written down, and I saw that in this...alcohol...that I was thinking this was an escaping...way of escaping this problem, like, it wasn't an ultimate solution, so I definitely recognized I needed help."

Substance use that had become misuse, and the negative experiences that came with that misuse is not what individuals described having personally envisioned for themselves, including Joan:

"...because I would have never imagined that I would be into what I was at all at...from the age I started, because I always saw myself as a straight-up student...and suddenly your life just crashes down, and you don't know how, and it kind of looks like the best way for you to get up is drugs, alcohol, because they look like the best substitute to get over whatever you're facing at that moment..."

Many co-researchers who reported experiencing harmful use described the negative impacts of use on their physical functioning (e.g., headaches, drowsiness, loss of appetite, impacts on blood pressure) and mental health, along with their desire to decrease their use:

"...and I'm trying so, so hard to ensure, that I...I stop, or I try to at least reduce the intake of my substance use so that I can live long on earth and also live a healthier life without migraines, without the pain, without feeling so tired and exhausted." - Taylor

Co-researcher's personal use and definitions of misuse were guided by a spectrum of unique person-specific ideas regarding control and use behaviors, with overlapping conceptualizations as well.

2. Purposeful Substance Use and Coping Strategies for Misuse are Recognized

The co-researchers often described the various purposeful reasons they chose to use a substance or substances. Half of the co-researchers who engaged in the study illustrated using substances for stress reduction and relaxation. The use of substances to not have to 'feel anything' and to assist with putting aside other concerns were also frequently voiced by co-researchers, including Joan: "I would....I would take that to calm my nerves, and at times like, just be high, so I'm not gonna feel anything..." and Rose, who stated, "I just want to rest and forget my problems, the situations I'm going through..."

For some, substances promoted the ability to sleep, creativity, and addressing loneliness. Multiple co-researchers described using substances when experiencing sadness, and wishing to be alone, including Rose:

"...when it comes to my daily activities...I don't just feel like going anywhere, I just want to be alone...I just want to be alone, left alone, I just want to take more alcohol so that I can just sleep all day and it makes

me...those tasks I'm supposed to all achieve, I can't achieve my tasks anymore."

The purpose for using substances for the co-researchers also included a desire to be more social as well, with half of the women describing the choice to use centering on whether they knew they would be socially engaging with others. Some of the women detailed their enhanced feelings of social confidence with using, including Alexis, "But for the most part, like, daily life like...I don't...I don't drink at all, except like in social kind of situations...".

For co-researchers who were in the process of or who had previously addressed personal harmful use, intentionally seeking supports and alternatives to substance use as a coping strategy for managing emotions and more was of importance. Numerous co-researchers described the various tools they had sought, including those within the queer community, and other peer support. Joan noted, "I went straight to that LGBTQ support group, and I found people who became not just friends with family to me...they helped me...". Elton noted that peers sharing their experiences with substance misuse on Youtube also served as a support.

In addition to coping strategies such as mindfulness practices and reading, music was often listed as an important outlet:

> "...I'll say, like the most helpful has been the music. Whenever I feel so down, I sometimes...like lack of sleep, or I feel like taking any substance, I listen to music. It calms my nerves down, it makes me happy, makes me forget about my...my troubles or my problems." - Taylor

Internal motivation to obtain an education was also detailed as a promoter for discontinuing use, along with taking care of oneself and engaging in other important activities.

3. Identity, Safety, Support, and Belonging in the Queer Community are Interconnected with Substance Use

Co-researchers' identities within the queer community were a common focal point. The women described the journey within emerging adulthood of navigating the nuances of their developing sexual identity:

> "…But then having to understand that after, like, more of your…'gay awakening' happens, it's like…you kinda start from square one, which no one tells you. It's like second puberty where you…like in high school I'd be like, 'oh, well, like I like that guy from over there. But, like, you know, I don't want to hold hands, I don't want to kiss him, I don't want to…anything like that.' And then having those same feelings about women…and just coming into terms with like…where attraction lies, and how it can be like, more of a case-by-case thing, which like, man…being like…super outspoken of like 'Hey guys, I'm pan, everything's great.'…*Alexis laughs*"- Alexis
>
> "…we get to plan who we are. You get to…you know what you want to do, you know who you want to be with, you know if you want to get married, you know if you want to stay single and just adopt kids. So, it's like that…you get to plan your life." - Elizabeth

In being a part of the queer community and navigating one's identity, the co-researchers often described a freedom in being true to oneself and a communal acceptance in engaging in

one’s desired activities. A supportive community spirit was echoed across the co-researchers, with multiple women sharing their experiences of creating “found” and “chosen” families (Jackson Levin et al., 2020). This included Caroline, who shared “...it's never one sided like, if something happens to one person, it's always like everybody has their back, which I think is really great. And just, women in general *Caroline laughs*, I feel like are just so supportive...”.

Joan also had experiences related to building a community surrounding her sexual identity:

> “...So my friends would always...we would always have this meet up after...after class. We would study together...even talk about my experience, they're like ‘Joan, do you want to talk to someone? If you want to talk to someone, just call me.’ So I would. I would mention a friend of mine...she was...she was...so often she would always show up at my dorm. She would bring food for me...they've been my...my support group ever since.”

Despite co-researcher's predominantly positive views of the queer community and their position within it, Alexis illustrated internal challenges regarding how one’s visual, gendered presentation can impact perceived acceptance within the community:

> “...I think on how I present myself like...varied, more like...’gender ambiguous’ and looking more butch and stuff and I know, part of it is like, preference, and then the other part sometimes is the fact that I feel like I have to like...perform a little bit more, just so that people know I'm not straight, which is like...not anything that it’s wrong to be straight, but I

want to be in those conversations about sexual minority women, and it's difficult if people see, ‘oh, your partner's a man,’ though, and it's like...but I'm also polyamorous and like...I like...tend to be more attracted to feminine stuff, anyway. *Alexis sighs* So then, it's like this ’Catch-22’ of...do I be like...more upfront about it and then people think that my partner's just a ‘beard’ or am I comfortable, just like...being ambiguous and people, either, like...having these assumptions that come with...you know...I'm a woman with short hair and its blue, and piercings, tattoos and stuff, and they're like, well, ‘queer coded’.”

This was explored in Alexis’ two Photovoice pieces, including ‘Nuances in Queerness’ (Figure 6.3):

Figure 6.3

Nuances in Queerness

1. *What do you SEE here*
   Queer woman feeling comfortable with a selfie to show off a new haircut

2. *What is really HAPPENING here*
   Coping with a pandemic with a haircut, feeling more comfortable with a shorter haircut than the norm/pixie cut

3. *How does this relate to OUR lives*
   Women primarily are still seen as aligning more queer when their hair is cut shorter. While this can be seen as a way to express comfortability in sexuality and just enjoying the style, you have to be a certain level of out to embrace it or be ready to be suspected of your romantic and sexual preferences when maintaining a cut like this. Since I've gone for shorter cuts for years now, I am reminded that people will assume I'm a lesbian/wlw focus or that I identify as a trans man. While the first part is true and the second part false, it says a lot about how the length and style of haircuts plays a role in people assuming the lives of one another.

4. *WHY does this problem or strength exist*
   Gender norms continue to play a role in that women are still viewed to have longer hair cuts. While I am an openly queer woman that loves to have short hair with butch presentation, some people might want to cut their hair this short and are not ready for the onslaught of questions or guesses towards sexual and romantic preferences even if the person identifies as cisgender and straight.

5. *How could this image EDUCATE the community or policy makers?*
   Hair should be viewed much more as a thing for people to be comfortable about without the marking of preferences besides image. In my personal experiences, I notice that having your hair a certain way shouldn't dictate how you feel inside whether that's gender or preferences.

6. *What can we DO about it?*
   Enjoy a haircut and use it as a tool to engage in knowing about others, not use it as a marker for a person's lifestyle prematurely.

Alexis also further explored these experiences within her piece, 'Uncomfortable Performance' (Figure 6.4):

Figure 6.4

Uncomfortable Performance

1. *What do you SEE here*
   Blurry picture of queer woman dressed in punk rock fashion for LGBTQ+ graduation
2. *What is really HAPPENING here*
   I didn't know what to wear that could be seen as "queer enough" while being somewhat business casual. While there was no dress code, I felt like punk rock fashion with a tie, suit vest, and short blue hair would speak volumes. I remember feeling embarrassed during the picture because I felt that the outfit wasn't as flattering, I had confirmed later on so my name was announced after every other name, and I still hadn't completed my thesis project. I felt unprepared overall.
3. *How does this relate to OUR lives*
   A lot of queer spaces delve into this concept of "performance" that coincides with gatekeeping. The thoughts of "Am I queer enough? Do I need to present more or less? What feels most comfortable at the moment?" go through my head primarily when entering queer spaces. As a woman who is on the fence of many labels to decidedly want to be known as "queer", it gets trickier to navigate public spaces. While I feel more comfortable in spaces I can be out, what can be worn easier because of the space might not always be comfortable. It is usually difficult for me to appear flattering due to my weight and being a fat queer person has other obstacles for fitting into a type of demographic.
4. *WHY does this problem or strength exist*
   The pressure to be seen as queer by your community is difficult to manage when you're fat and always on the fence for feeling like you're "queer enough".
5. *How could this image EDUCATE the community or policy makers?*
   The LGBTQ+ community should understand that being out in spaces doesn't need to be a performance, even if it is a self-imposed one because we need to push for comfortability and acceptance.
6. *What can we DO about it?*
   Challenge our takes on what people need to look like and do to be in LGBTQ+ spaces to be accepting and equitable throughout.

Co-researchers illustrated that substance use and engagement in the queer community go hand-in-hand, with Alexis sharing: "Yeah, so LGBTQ...drugs are just everywhere; it just makes sense for us. Pride is usually involved with like...lots of drinking and whatnot, but I feel like it's just a drinking culture, drug culture at times."

Substance use within queer social spaces was described as a source of connection, and a way to develop a sense of comfort, confidence, and community:

> "...we have no problems with substance use, it's very welcomed, it's very welcomed...you hardly have someone from the community who doesn't take

substances...it's a major connecting part, it connects us...Cause, how would we...how would we say we don't want people discriminating against us, and then we start to have our hatred for a person that takes substances and all of that..." - Renee

Caroline stated, "...but I feel like it's very common for substance use in those situations. So like you said, it's kind of like a way of fitting in when I am in those situations, too." For Alexis, substance use was a natural part of the queer community, as she noted:

> "I think it's just kind of like a given in the spaces with like LGBTQ... because, like...it's the being able to relax before you're able to like, be yourself kind of mentality." Alexis went on to additionally share that, "It was like a lot of it seemed like it started with like...me wanting to navigate queer spaces and not feeling...confident enough in them, or feeling like...just overthinking in general, that I'm not in that space correctly..."

In addition to being used for connection and confidence, substance use as a communal way for queer people to cope with discrimination was also outlined. Co-researchers described using with queer friends to feel safety and comfort amongst one another, including Elizabeth, who shared, "That's just their way of comforting you. If there were any better way of comforting you, they would have actually done that..."

Caroline described shared struggles within the community:

> "...but with the queer community, it's something that we all have in common, and we all know the struggles of being part of that community, so

> we kind of accept it just because we know that some people, just…they need it to get through whatever they're going through or whatever they have gone through."

Caroline further explored substance use and its intersection with self-perception and acceptance of one's sexual identity in her Photovoice piece entitled 'Photovoice 1' (Figure 6.5):

Figure 6.5

Photovoice 1

This photo was originally taken as a perspective piece for a photography class. The warped perspective of myself from others' eyes when they find out my sexual orientation, or when they see me holding hands with or kissing my girlfriend. The warped perspective of me that I would only see when I was sober. When I was under the influence of drugs and alcohol, I didn't care what others thought of me, and I simply saw myself as me – a regular girl doing normal things. It was only when I was sober that I would start to doubt who I am and view myself the way that society views me; as something that needs to be fixed to fit the "norm". I would rather drown myself in substances than ever feel like that. Now I am able to see behind the glass even when I'm sober; I'm able to see my beauty and importance despite the warped, surface-level view that others may have of me.

Within the member checking process, one of the co-researchers emphasized the importance of recognizing the role that substance use plays for queer women across these factors and its impact on belonging, identity, coping; they urged for the need to create

welcoming, nurturing spaces that address mental health, while decreasing SMW's need to use substances for creating social connections and coping with various experiences.

4. Familial Experiences Influence Personal Substance Use and Perceptions of Queer Standpoints

Co-researchers' relationships and experiences with their families were of importance when it came to defining their sexual identity and substance use. Numerous co-researchers described experiencing challenging childhood stressors, including a lack of parental involvement in their lives, and traumatic familial events that influenced co-researchers' self-identified harmful substance use, with Joan sharing about her substance use:

> "...I never thought that I would ever be that way, because I had a pictured life for myself, and I had my dad in it, and I never saw him out of the picture, though it's like things you never saw coming in or coming into your life, and things you never saw going out are just going out. And you just...you can't do anything about it. But I'm glad that I'm here today, and I can talk about it, and I can express how I feel without feeling judged or like written off by a lot of people..."

For some co-researchers, introduction to substances had occurred through a parent, with additional perceptions that parents themselves may have been using substances as a personal coping strategy for various factors, including their sexual identity. These parental experiences impacted co-researchers' personal use, as multiple women describe, including Alexis, who stated pertaining to her use:

> "Cautious, I guess. So, the only things I really do is alcohol and marijuana. Alcohol, I'm really cautious with it, because I know of like...my mom...So like...I'll go long periods without drinking, just because I want to remain like...a lightweight."

Co-researcher's relationships with their parents were also affected by their substance use behaviors, with conflict with parents (related to sexual identity or otherwise) sometimes leading to personal use:

> "When my parents kind of found out that oh, I started taking substances, I was taking marijuana, that day, they were very angry, they were very much angry. Of course, it's not something that from [country] where we come from, it's not something that's morally acceptable...it's not something that they take lightly...it's almost like I'm a bad child and all of that...But it really is...it's affected our relationships cuz it felt like they didn't know me...so when I go home, I don't actually...take it...so yeah, yeah, that's affected my relationship with my family." - Renee

The desire to discontinue or moderate personal substance use to improve relationships within family was viewed as a motivator for some co-researchers. Family members also served as sources of support and guidance regarding substance use, sexual identity, and beyond, with Caroline describing the guidance she received from her parents:

> "My parents have always, like told me, 'Never drink when you feel like you need to drink. You only do it when it's just like...you're feeling okay, you've had a good day, you're doing all right.' That's...otherwise when you feel like

you need to do it to cope with something, or because you've had a really bad day, that's never the answer." - Caroline

In shifting to discussions of sexual identity in specific, numerous co-researchers described familial relationship strain due to their sexual identity, both in being and not being "out" with their loved ones. The decision whether to be out with one's identity was a process influenced by co-researcher's anticipated familial reactions given sociopolitical leanings, as Caroline illustrates:

"...my immediate family is very accepting, but my extended family is very conservative. So, because I...I came out a little late, I think I was 17 or 18, because that is still so new... and I get very angry...not...I don't directly say anything to them, but when I hear them say things I get very, very upset, and that's kind of led me to just not showing them who I am, as much as I accept myself..."

Familial rejection of co-researchers' sexual identities was also tied by multiple women to religious underpinnings, including Elizabeth:

"...so I come from a Christian home, the Catholic Church. I was born in the Catholic Church, and so my parents are leaders in the church, but growing up, I discovered my love for the opposite sex was zero, and I really loved my same sex...so, I didn't know to handle it, so I talked to my mom. And she...she actually told my dad...they said I was possessed...I actually thought I was possessed; I actually thought something was wrong with me."

Numerous co-researchers described strained relationships and estrangement from their families due to their sexual identity and often returned to discussions on how important creating a "chosen" family (Levin et al., 2020) within the queer community was for them.

5. Discrimination and Stigma Regularly Impact Sexual Minority Women

In describing their daily lived experiences surrounding their sexual identity, the co-researchers, including Joan, detailed blatant (and at times aggressive) discriminatory and stigma-based interactions, from religious protests outside of Pride events, personal questions from others about their lifestyle, and learning of violence directed at other sexual minority individuals:

> "First of all, you have the biggest trial of your life...coming out, you, being queer in the first place...or like, owning up to your sexuality, which a lot of people do not accept no matter how they portray or are trying to make it look like we're being accepted, even like...here in college there's different cases of discrimination. Someone was assaulted right here in college. So I would say that everyone hasn't fully embraced it, and you come in from different backgrounds...people will always be people."

Elizabeth explored the impacts of discrimination and lack of acceptance in her Photovoice piece, entitled, 'Societal Attitudes Towards Homosexuality' (Figure 6.6):

Figure 6.6

Societal Attitudes Towards Homosexuality

Being a lesbian has not been easy I was disown by my religious father when I was a teen and that lead me to get myself involved in drugs and alcohol, I know it's wrong but sometimes I just want to leave this insane world and be in a world 🌎 where I only, exist. Don't even get me started on those who are gay, lesbian, bi, or trans and still practice a religion! Some people can't restrain from harassing those who are LGBT and religious.
People who fall into the LGBT spectrum are humans just like straight or cis people, and this fact should come long before we look at sexuality or gender.

Some would argue that LGBT+ have higher rates of suicide, self-harm and depression, and therefore LGBT should be considered a mental disorder. They wouldn't be wrong about one of those things;

More than two in five trans young people have attempted to take their own life. as have one in five lesbian, gay and bi students who aren't trans.

More than four in five trans young people have self-harmed, as have three in five lesbian, gay and bi young people who aren't trans.

Nearly half (48 per cent) of trans people under 26 said they had attempted suicide, and 30 per cent said they had done so in the past year, while 59 per cent said they had at least considered doing so.

However, we only need to look at the way these individuals are treated to see why this may be.

26% lesbian, gay and bi staff say they have personally experienced bullying or poor treatment from colleagues in the last five years as a result of their sexual orientation.

One in five LGBT people have experienced a hate crime or incident because of their sexual orientation and/or gender identity in the last 12 months. This figure has risen by 78% since 2013.

Two in five trans people have experienced a hate crime or incident because of their gender identity in the last 12 months.

Nearly half (45 per cent) of LGBT pupils - including 64 per cent of trans pupils - are bullied for being LGBT in Britain's schools. This is down from 55 per cent of lesbian, gay and bi pupils who experienced bullying because of their sexual orientation in 2012 and 65 per cent in 2007.

72 countries criminalise same-sex relationships.

A quarter of the world's population believes that being LGBT should be a crime.

Between 2008 and 2014, there were 1,612 trans people were murdered across 62 countries - equivalent to a killing every two days.

In more than half the world, LGBT people may not be protected from discrimination by workplace law.

Most governments deny trans people the right to legally change their name and gender from those that were assigned to them at birth.

I apologise for bombarding you with such depressing statistics, though I feel that awareness is necessary. In short, there is nothing wrong with LGBT whatsoever, but the fact that many people think there is can cause a huge stigma.
I could go on and on, but I don't want to be too negative.
What can we do?
Talk about it.
Discuss it.
Show it.
Educate people about it.

That's the only way we'll move forward

Co-researchers also noted that discrimination could also be more nuanced and non-verbal. This discrimination and strain included tokenization, fetishization, and pressure-filled interactions:

> "...I would before, hide the fact that I...I was a lesbian to anyone who was like, 'So who are you seeing? Which guy you seeing?' I'm like, 'Oh, I'm seeing this guy in...in [neighborhood], or so...' I was just...why? Because I...I was like...I was like, 'Oh, my God, if they find out I'm a lesbian, they're gonna go away." - Joan

These encounters were tied to experiencing uncertainty in social spaces and feeling the need to advocate for oneself to ensure safety and acceptance. Current legal proceedings also served as a non-direct source of stress for one of the co-researchers:

> "...me and my girlfriend, when the whole Roe versus Wade thing was happening, and they were discussing like, gay marriage and things like that, we were honestly contemplating just getting married...Yeah, we didn't, thank God, because...not ready for that. But the fact that we even had to like...sit down and have a conversation about it was difficult, and then, of course, like, the Roe v. Wade affected me as a woman..." - Caroline

Engagement in religious spaces that emphasize heteronormativity across gender and sexual identities and the intersection of these tenets with family member beliefs also impacted co-researchers regarding substance use and sexual identity:

> "So right now I come to church...that's also a sin there, it's not welcomed at all, and we also...we talk about how it's...it may be in the Bible...it's not

specified in the Bible, it's not specified or specifically 'ok smoking, or taking substance is the same', but, but it's seen as being wrong; you're seen as unvirtuous, you're seen as a sinner, in the church, you're seen as you're not a child of God." - Renee

In speaking about her experiences in recognizing her sexual identity and deciding whether to remain with her family given their religious beliefs, Elizabeth shared, "If I had met someone straight...I might actually have to hide it for the rest of my life. I might actually not be...I might actually just be scared of who I am."

Another prominent intersecting identity that impacted substance use and sexual identities was race. This was highlighted by co-researchers, particularly regarding racial stigma and societal stereotypes surrounding substance use. Joan described her experience as a Black woman:

"Drugs have been seen as something to connect to the Black community....It's something that we're known for...everywhere you go...even you get arrested by the police...the first thing you're going to be checked for is drugs...guns...so it's not like I...I came from a race who gave me a free privilege, but a race where I had to be questioned everywhere I go, and me proving to everyone once again that 'Oh, you know what? I'm Black, I'm a lesbian, and guess what? I'm a junkie!'"

While the focus of the co-researchers' experiences and discussions on identity did not often center on their student role, numerous women did describe experiencing discrimination regarding their personal substance use from peers. This discussion included detailing the

negative impact that student-held stigma surrounding substance use had on their school experience. Joan described, "I thought this was college, where nobody cared, where everyone would mind their business and everyone was just poking into my business, and it was so upsetting that I...I wanted to withdraw..."

Within the school setting, the co-researchers felt that differing types of substances were viewed uniquely, with some seen as more acceptable for use than others by peers, including alcohol, as Renee illustrates:

> "If it's alcohol, it's mildly accepted here. Alcohol is mildly accepted, so long as you are not an alcoholic or a drunk, you understand, but when it comes to marijuana, when it comes to tobacco, when it comes to...and the rest of them that's when the problems starts."

Co-researchers didn't stop at discussions of discrimination, however. Discourse included moving past the perceptions of others and working towards self-acceptance in the face of discrimination. Joan shared about the support she received from her girlfriend:

> " ...you can't shun me, you can't make me feel like I'm so little and crushable, and stuff like that, no...I'm proud of who I am, and I cannot ever change who I am.'...And that's something I've learned from my girlfriend, who always tells me like, 'You know what, if you keep wondering what people think, you're gonna get knocked up in the head. But if you just like, live your life and enjoy every minute of it...that's gonna be the memories they're gonna stick in for life and not what people are thinking.'"

6. Substance Use Can Be An Occupation and an Influencer of Other Occupations

Co-researcher perceptions of substance use had a very mutative nature. At times, use was described as an occupation unto itself, with women detailing the need to plan their substance use around what they wanted and needed to do each day. Substance use served as a specific task that co-researchers sought to engage in. The women also described the planning process surrounding using and the influence of substance use on other occupations:

> "I never do it when I'm working, because I know that I need to be like...full capacity of myself, and I never do it if I know that I have places to go to...Sometimes I...like...it, it becomes more like that extra sensory stuff, which is why I'll usually like....take like...a two milligram, or something...like a small amount at like...a music show or a concert..." - Alexis

> "...when I wake up, I would want to go for exercise, I want to go to the gym and exercise, but I just find myself getting high, that's in the morning, that's mostly the first thing I do...and it's really disturbing cause it's something I love doing before." - Noralynn

Co-researchers' treatment of substance use as an individual occupation was further emphasized by descriptions of use taking precedence over other occupations, including meal preparation. Some of the women also described the need to set aside personal finances for substances.

While substance use was described as an occupation, so too did the co-researchers illuminate the intersecting effect of substance use on other occupations. This included both

positive and negative aspects of influence. Numerous women highlighted how substance use effected their role as students, including Rose, who noted, "...in my daily activities, I find it so difficult to do what I'm supposed to do, to achieve my tasks, and also to study." Joan also supported this in noting the following:

> "I would say that at the time when I was a "junkie," cuz I...I slowly became a junkie. I...I never really had friends. I just had 'junkie' mates, because, you're like...'Oh, [Joan] we're... we're going to see a friend who's gonna hook us up. Do you want to come?' And I was like, 'Yeah, yeah...' I would ditch classes, and I would go...because a true friend wouldn't tell you to ditch classes to go get drugs."

One co-researcher shared that she felt that her use affected her ability to adequately communicate with her peers, while another, Caroline, described the challenges that substance use posed on her motivation for attending school:

> "I think it really impacted it. I started some types of substance uses in high school, and I've always been a good student my entire life, and I stayed a good student, but I never went to school. I never had the motivation to go. If I did go, I would leave halfway through the day, and I just had no motivation for that. I do think that that also had to do with some other like, mental stuff I was going through at the time, but I just would have rather been smoking weed than be at school and, I've never been like that...I would do things for others, but I would never like...indulge in the hobbies that I

used to be interested in, or the schoolwork that I knew I needed to do and I just felt very...like I didn't really care about anything else..."

For some women, substance use positively contributed to their school participation surrounding confidence and creativity. This trend of positive impacts of substance use on various occupations was also continued in discussing its facilitation of community and social bonding, which Caroline explored in detail:

"I feel like it helped my friendships with my friends, too, for similar reasons...and it kind of just gave us something to do, I guess. Cause a lot of my friends were also using...it wasn't just like I was the only one in the group...but with my friends, in hindsight I feel like again...now that I've stopped using, it's been kind of hard-to-find familiarity between us... "

One co-researcher also shared that substance use enhanced sexual intimacy with their partner, highlighting the broad span of occupations that substance use affects.

7. Healthcare and Other Support Providers' Actions and Responses Matter

Finally, when describing their healthcare access stories both for and outside of substance use needs, the co-researchers provided an expanse of experiences. The co-researchers emphasized the importance of how healthcare and other support providers' actions and responses matter when it comes to SMW's current and future healthcare-based decision-making. Some women described overt encounters with healthcare providers where disrespect or discrimination for one's choices had occurred, as Joan stated:

"...I got a nurse, actually started recommending her nephew for me...and I felt insulted because I'm like...'I told you my sexual orientation. I feel you

> should respect that and not...and I have a girlfriend,'...So cases like that do happen, and it's something I feel like nurses, nurses, are more of the...more of the major reasons why I kind of avoid hospitals, but doctors...I don't think doctors really care about that."

Some of the co-researchers also felt that their sexual identities and personal healthcare needs were not respected given their age, or that their experiences were not seen as valid by the support professionals they engaged with. Women illustrated that the manner in which someone is treated regarding their sexual identity and personal substance use has consequences, particularly as to whether they will seek out assistance when they feel they need it:

> "...But the way you're being treated...it's what determines if you're going to come back there, or you're like, 'Oh, my God! I'd rather stay sick than go there. Their services are horrible because everyone treats me bad.' But if it's a case where you have been treated equally with respect, nothing is being served to you any less, you're definitely going to rush to the hospital once you have any issues..." - Joan

These experiences and their impact on help-seeking can extend to observing the treatment of others, as Caroline described:

> "...I was in a mental health clinic, an inpatient mental health clinic, and there was someone with me there that was like going through a lot of like...gender dysphoria and things like that, and she or, they were not treated well at all, and it kind of...that was before I came out, and it was

> just really hard to see the nurses and everybody there treating them so poorly. And then it kind of just made me feel "less-than" as well, because I hadn't come out; it made me not want to come out..."

Many of the co-researchers who engaged in the study were receiving or had received support services for substance use, ranging from peer support groups to formal clinical intervention. Women who had obtained services described positive, affirmative experiences as well as finding supportive, non-judgmental or discriminatory practitioners. Alexis described her experience receiving support services here:

> "I have...I have two therapists. I have one that's like a little more on the 'Oh, I don't know...drinking...' And it's like, 'Okay, well, you're a little older, that's why.' And then I have another one who I actually talk to about like my LGBTQ stuff and they're super great. And when I talking about drinking and things like...when I...when I talk about drinking or substance use, it isn't like a, 'Oh! Don't...don't ever!', but it's more of a like, 'Okay, you know, do you feel like you're being safe in those instances when you are using it?'"

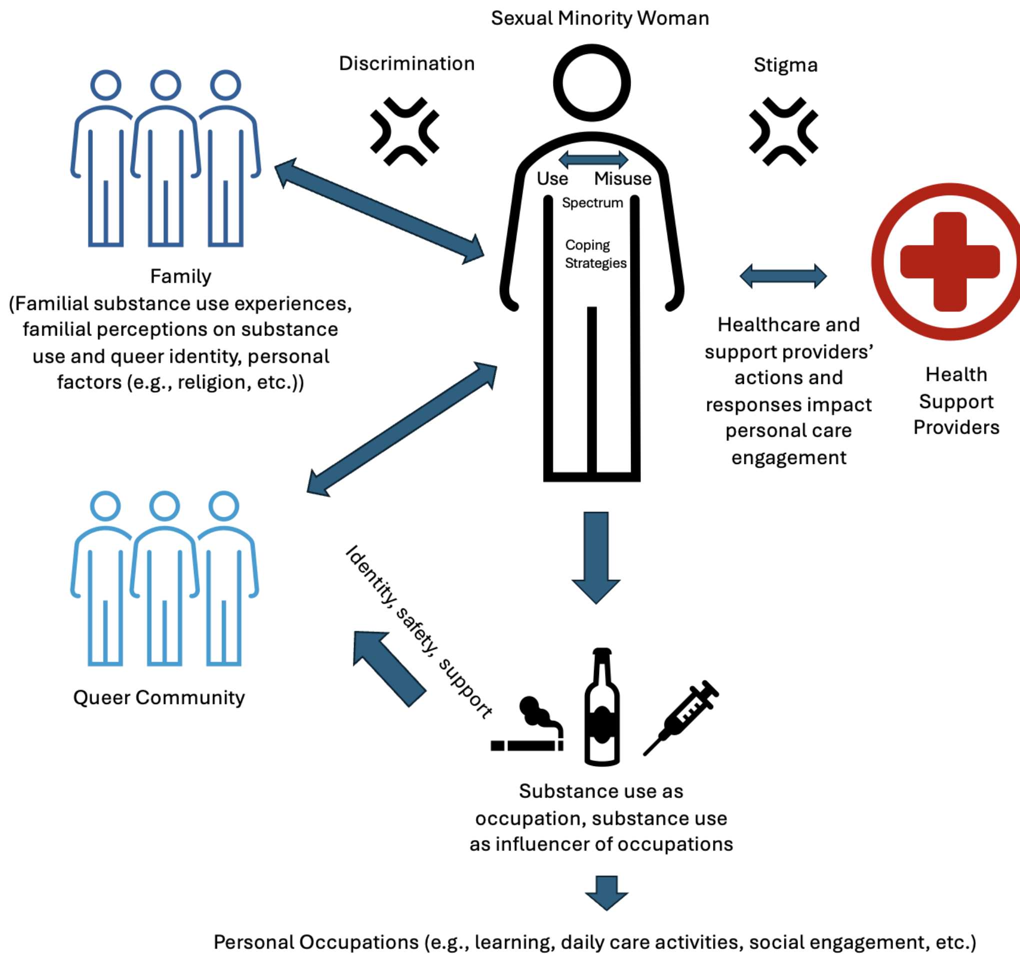
These experiences from the co-researchers highlighted the importance of intentional, non-biased, respectful provider encounters and service, which was very evident in co-researcher recommendations, explored later.

Thematic Framework

Prior to detailing co-researcher recommendations, it may be helpful to examine interactions between the themes as they apply at the personal level, as shown in the thematic framework in Figure 6.7.

Figure 6.7

Thematic Framework



Note. Microsoft Suite icons were used in generating this thematic framework graphic.

In Figure 6.7 we see a SMW, being identified by the study co-researchers as engaging with and being affected by numerous factors pertaining to personal substance use. At the internal cognitive appraisal level, there is a spectrum of substance use, with the person determining if they perceive their substance use to be within the bounds of what is acceptable to them as normal use, versus use that has become what they would consider to be misuse. Personal definitions of what constitutes misuse vary for each individual. Within the person also

lie various coping strategies for managing outside stressors, which can include the use of substances, as well as other strategies for managing challenges, such as music, social connections, etc. For the person, substance use may serve as its own occupation, requiring planning around use, time set aside to use, the desire to be alone, and more. Substance use can also serve as an influencer of other occupations, including in enhancing sexual intimacy, fostering creativity, and easing one's ability to feel socially connected within the queer community.

As the SMW engages within queer community spaces, she may find that substance use is an embedded part of the community and its social gatherings through her social engagement in places such as queer bars, Pride events, and more. The queer community has been described as generally accepting members, and supportive of their independence. Despite this description from co-researchers, being a part of this community can come with social expectations or assumptions regarding how people express their gender and sexual identities, which may influence the woman's substance use patterns and personal perceptions of her belonging and acceptance within the community. This community has experienced stigmatized views, discriminatory practices, and a lack of feeling safe, that in turn may lead to substance use as a communally supported coping strategy.

In addition to the queer community, family members may interact with and exert influence with the SMW. Familial experiences with substance misuse may temper the SMW's personal use behaviors and may negatively impact her as she grows and matures. Family members may provide support regarding one's sexual identity and substance use or hold personal beliefs regarding these factors, leading to strain between the SMW and themselves.

The SMW may choose not to disclose her sexual identity to some family members given the family member's personally shared beliefs. The SMW's desire to decrease her substance use may be influenced by her motivation to improve relationships with family members.

Societal discrimination and personally held stigmas can be experienced by the SMW even when she is not directly engaging in queer spaces. Engagement in and adjudication from religious entities was highlighted as a potential source of this stigma and discrimination. Racial bias and discrimination as it intersects with one's sexual identity and personal substance use patterns may also impact how others engage with the SMW. Discriminatory practices and stigmatized views can be blatant, such as via aggressive words and actions, or more nuanced, through probing questions regarding one's identity, and assumptive behaviors.

As the SMW engages in occupations within the systems and social groups she is a part of, she may make decisions regarding whether she will access healthcare services both related and unrelated to her substance use. Past encounters with healthcare professions impact this decision-making process, particularly in determining whether she will share her sexual identity status or substance use behaviors. The SMW may have past negative experiences, with healthcare providers dismissing her sexual identity or holding stigmatized views regarding her substance use and sexuality. She may have also had positive interactions, with her providers creating safe, supportive spaces through overt signage and empathetic care. Observing how others are treated by practitioners may also influence the woman's decision to obtain care, with experiencing others receipt of discriminatory practices from healthcare providers potentially dissuading her from seeking supportive care.

This framework begins to explore the interplay between SMW and the systems, spaces,

and interactions they engage with as they internally navigate their substance use. It is important to note that this framework was not reviewed through the member check process by the co-researchers and warrants further exploration with community members in determining its acceptability for SMW and usability within occupational science (OS) and occupational therapy (OT) practice. Co-researcher recommendations are detailed next.

Recommendations

The co-researchers provided recommendations for healthcare providers within the interview portion of the study which have been summarized here; some include quotes to support and enhance understanding of the recommendations. The implications of these recommendations for OS and OT practitioners are explored in Chapter 7, with actionable steps outlined.

1. Create a safe space for sexual minority women to discuss substance use and sexual identity through overt and non-overt measures.

Caroline shared about her experiences with healthcare providers who demonstrated overt and non-overt ways of creating safe, welcoming healthcare spaces for herself and others:

> "...I know my primary doctor right now; I love her so much, she is my favorite doctor I've ever had. The first time I went to go see her, she had the normal conversation about birth control and stuff like that, and I don't know exactly what she did to make me feel safe to just like...let her know...any decisions that might have been bad on my part, she was never judgmental about those. So when I did open up and say, 'No, that's not

needed, I have a relationship with the same sex partner…' She was just not judgmental at all. And now, every time I go see her for my yearly visit, she asks me how my girlfriend is doing, and she's one of the doctors that actually reads the chart before asking you all the same questions…

…I know when I worked at a pharmacy too, the pharmacy manager had a trans son, and he…his wife bought a bunch of pins with like the Pride flag on it, and he let us wear them all at work…but that was really nice, too, because just from the get-go like I walked in, I had never met the pharmacy manager, and I saw that pin, and I felt safe."

Caroline's Photovoice piece (entitled 'Photovoice 2') provides an illustration of what overt signage might look like both on campus and in healthcare settings, seen in Figure 6.8:

Figure 6.8

Photovoice 2

For so long, I was in environments that did not accept me for who I am; I would have to actively seek out communities that would. Most of the time, those communities would be in bars or clubs, filled with substances that I knew were not good for me. Now, simply walking around school, I can find love and support in an environment that is safe and healthy for me. Simple things, just like this sign, make me feel like I am not an outcast. I should not have to seek out communities; communities should welcome me with open arms, just as they do for others. These environments, despite all the progress we have started to make, can still be difficult to find. But when I do find them, my anxiety vanishes, and I feel a weight lifted off my shoulders, which is something that only substance use was able to do for me in the past.

Within the member check process, one co-researcher further expanded on defining a safe healthcare space for herself, which included creating a place that emphasizes each person's unique needs. This co-researcher also noted numerous ways in which healthcare providers can better create safe spaces, including maintaining SMW's privacy. They recommended creating an environment that emphasizes non-judgmental care that is informed by personal lived experiences and providing education on perspectives and identities that differ from the practitioner's.

Another co-researcher, through the member check process, specifically focused on the importance of a practitioner's verbal tone and how they physically conduct themselves when engaging with an individual, particularly when discussing substance use. They also denoted the negative impact that practitioner's verbal chastisement can have on their motivations in addressing substance misuse behaviors. Practitioner's physical responses to disclosures about sexual identity and intimacy practices, for this co-researcher, could signify to the woman whether the environment was safe for disclosure. These recommendations warrant consideration and pre-meditation from healthcare practitioners in providing a safe space, open for personal disclosure.

2. Take time to establish a relationship with the person being served, and work to understand their experiences and use.

Renee provided details for this recommendation this in saying, "…first off, they should try to understand the point of view of these women…they should try to understand things from their point of view…" This was also further supported by

Caroline, who noted, "...just, trying to understand their situation, understand why they're using instead of just shaming them for doing it...".

3. Recognize as a practitioner that despite hypotheses regarding someone's substance use, we cannot every fully understand a person's lived experiences.

The importance of this recognition was further emphasized by a co-researcher during the member check process.

4. Prioritize healthcare services to focus on needs, rather than sensationalizing sexual identity.

5. Practice love in engaging with and serving others who are using substances.

Elizabeth noted:

> "...you can profess your love to them in your own way, and tell them to stop...but then you are just trying to do what's best for them, and don't be harsh with them...You just need to show them love..."

In elaborating on the idea of practitioners engaging with others in a loving way, during the member check process, a co-researcher emphasized the need for health professionals to approach those they serve as people, not just patients. To this co-researcher, a loving relationship with a practitioner means that the person providing services is actively engaged with the woman they are serving, and looks to comprehend the person's lived experiences, emotions, and needs. This work should go beyond providing hands-on medical services, and creating a respectful, caring environment is incredibly important. For the other co-researcher who engaged in the member check, a similar denotation of the need for practitioners to demonstrate concern and a willingness to learn more about the person they are serving was

described. Additionally, the call for practitioners to recognize that people differ from one other and apply differing approaches and perspectives was made.

6. Do not discriminate in one's service to sexual minority women; demonstrate consistent respect and ethical care.

> "...I would really like them to know that they shouldn't treat us any less as they would...So I would say, if, first of all, they...they have to be non-judgmental. That would be a huge step to help you, because the thing is...we want to get help, but we're not going to if the eyebrows are going to be raised at us..." - Joan

7. Practitioners should not attempt to tell sexual minority women that they can't use substances.

8. Patience, respect for, and upholding personal choices alongside the provision of practitioner-provided education is key.

> "Well...like this substance use of a thing is choice...and you can only advise people on it...you really can't convince them. So, I feel it should be benefits of doing it, and also the disadvantages...people should see it and make a choice through that." - Tessa

Joan described wishing that, "...that respect to your privacy and your choices would be given to you on those aspects of your life..."

Co-researchers detailed a desire for practitioners to avoid telling SMW to discontinue using substances. Renee elaborated, "...if you're working with them, you shouldn't try to like...do not try to take it away from them..."

One of the co-researchers called additional attention to the importance of this respect during the member check process.

9. Discuss that use does not have to become misuse, and how this can be done.

This was supported by Renee, who stated, "...what you should try to convince them about is the fact that they can use it in a reduced...they can use it...without abusing it." Caroline further supported this in sharing that practitioners need to be: "...following up with the proper resources, and options that they have to try to stop misusing their substances."

10. Individuals may need collaborative monitoring and exploration with their practitioner(s) into substance use behaviors and patterns.

11. Practitioners should have a thorough knowledge of beneficial, safe, personally sensitive rehabilitative programs and services that they can call upon and refer individuals to who may need services for harmful substance use.

This recommendation was an addition created by a co-researcher during the member check process.

12. Practitioners need a greater awareness of the potential early start (pre-teens and teens) of substance use.

Discussion

This chapter detailed the demographic, thematic, and recommendation-based findings from the study, which were driven through co-researcher shared lived experiences and perspectives. Co-researcher demographics, including sexual identity, race, socioeconomic status, substance use, and type all varied. The themes explored by the co-researchers included

exploration into personal perceptions of substance use and misuse, the use of substance as a coping strategy along with the identification of alternate strategies, and the familial influence on substance use. Additional themes explored the queer community’s relationship with substance use, the role of substance use as an influencer of occupations and an occupation itself, the negative effect of discrimination on self-perception, and the impact that healthcare provider responses can have on SMW's supportive care access.

Co-researcher recommendations highlighted the importance of healthcare providers practicing without discrimination, using love in their practice, providing education without forcing use cessation, respecting personal choice, being patient and collaborative in the treatment process, and creating safe spaces for SMW, amongst other recommendations. These findings portray the wide expanse of experiences SMW in emerging adulthood have regarding their personal substance use and healthcare access. The implications of these findings will be further detailed in Chapter 7.

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Chapter 7: Reflection and Discussion

Abstract

In this chapter, I explore my reflections across the research process and detail how the study findings will be applied within my practice, occupational science (OS), and occupational therapy (OT). This examination includes details on the perceived strengths and challenges across the study methods; it highlights unanticipated changes surrounding determining co-researcher participation legitimacy, and the benefits of incorporating reflexive practices into the study methods. Next, discussion of the appropriateness of my chosen underpinning study philosophical and theoretical approaches are discussed. Comparison of the study findings to other current literature is detailed, which support consistencies in sexual minority women's (SMW) experiences surrounding factors like discrimination, queer spaces intersecting with substance use, religious stigma, and more. Recommendations for occupational scientists and therapy practitioners are outlined. Finally, future directions for this line of research and recommendations for applying the study findings to our practice are described.

Introduction

Co-researchers who participated in the study described a gamut of personal perspectives on substance use patterns, misuse, coping strategies, and the factors affecting their use. These experiences included influences from family, religious entities, the queer community, and their social relationships. Substance use as an occupation and influencer of others was also explored, along with co-researcher's experiences in healthcare settings. These themes and subsequent recommendations for healthcare providers offer invaluable recommendations for occupational scientists and therapy practitioners, as well as other healthcare practitioners; they have immediate implications for our understanding of substance

use in expanding our occupational imagination (e.g., Laliberte Rudman, 2014, 2019) and practice in serving SMW. Exploration into my reflections on the study process will be detailed next.

Reflections on the Study Methods and Personal Positionality

I wanted to devote a portion of this conclusive chapter to reflecting on my personal perspectives and experiences across the dissertation, as they inherently impacted decisions made within the study methods, analyses, and my future research. While the focus of this dissertation work was not on myself, I, (and hopefully my other co-researchers), was impacted emotionally and professionally by this work, just as who I am influenced the study process (England, 1994; Farias & Laliberte Rudman, 2016; Haraway, 2004; Harding, 1991; hooks, 1989; Laliberte Rudman, 2014, 2019; G. Rose, 1997). I also wish to include reflection to detail the impact of this work on my own practice and explore the dynamics between myself and the co-researchers to contextualize the study results (G. Rose, 1997). These reflections are subjective; they are limited to myself, and come with my personal biases, privileges, and lived experiences (Haraway, 2004; hooks, 1989). It is being mindful of this (Haraway, 2004; hooks, 1989) in these reflections that I take accountability for my engagement in the study, shed light on lessons learned for those who wish to engage in similar research, and demonstrate the power that qualitative research has in changing not only the lives of those who participate, but ours as researchers and practitioners as well.

Study Methods

I began this dissertation journey with the goal of reaching as many women as I could through my research. With the guidance of my fantastic dissertation committee, I came to understand that I could accomplish this aim while ensuring that I was able to thoroughly explore the lived experiences of those I would be engaging as co-researchers within the study. In narrowing my research population to student SMW in emerging adulthood, I found that the study became even more personal to me and led to internal reflection, shared experience-building with the co-researchers, and reckoning with myself in ways that have been invaluable.

When structuring the study activities to provide as much flexibility for participation as possible, my intentions were to promote co-researcher's willingness to engage, and demonstrate autonomy and respect for women's personal preferences, in keeping with participatory action research approaches (e.g., McIntyre, 2008). This structured flexibility in the methods created both benefits and challenges; similar to previous virtual research using Photovoice (Hughto et al., 2021); I felt that offering the methods virtually allowed for greater openness for women from across the community to participate given that they did not have to be on-site for the study activities (and therefore potentially by physically "out" with their sexual identity). The co-researchers were able to participate in whatever ways felt most comfortable, whether that included having their camera on or off. Challenges

with this flexibility began when ascertaining the legitimacy of the co-researchers' engagement. This issue arose around recruitment, co-researcher personal communication with me, and camera use during the study.

These concerns over legitimacy are similar to those documented in previous virtual studies (Pellicano et al., 2023; Ridge et al., 2023; Roehl & Harland, 2022), and include the following occurrences:

- Co-researchers had to self-identify with the inclusion criteria to be able to participate and were not required to demonstrate "proof" of their legitimacy in meeting the inclusion criteria (e.g., providing school-based emails, etc. (Roehl & Harland, 2022)).
- Numerous potential co-researchers responded very rapidly to study recruitment materials when posted (sometimes within minutes of me posting recruitment materials to various social media sites).
    - Initial email correspondence regarding the study often contained single lines of text noting the person's interest in participating in the study.
    - Email correspondence language was often highly similar between potential co-researchers or difficult to understand.
    - Emails from many of the co-researchers originated from the same email domain and had very similar address arrangements.
- Some co-researchers were suspected of attempting to participate in the study numerous times or sharing a common study "script" regarding lived experiences

with other co-researchers. This concern arose given how closely the co-researcher's shared experiences and demographics aligned.

- Some co-researchers had similarities in voice, signature style, and methods of participation in the study (e.g., ways of completing the consent form).
- Numerous co-researchers chose to complete the interview with their camera off.
- Some interviews were very brief, with co-researchers providing non-specific answers to questions.
- Some co-researchers discontinued participation in the Photovoice workshop sessions upon reaching the session in which they needed to take and upload pictures.
- Many of the co-researchers wanted to complete only the interview and were unable to verbalize their reasoning for not completing the Photovoice workshops.
- Some co-researchers demonstrated consistent and prioritized concerns regarding the compensation associated with the study, including timing and methods of compensation, despite consistent verbal confirmation from myself across the study surrounding the compensation process.
- Some co-researchers seemed confused or unclear of the purpose of the study and some focused on describing the substance use of others across the interview process. Some co-researchers did not talk about their student and queer identities despite directed questions and explanations regarding the study focus.

- During interview and Photovoice sessions, some co-researchers had what sounded like numerous other people talking in the same room, including the sound of other Zoom meetings occurring. Multiple co-researchers were heard talking to others intermittently.
- A potential interested co-researcher who had not completed the study screening process uploaded a consent form from another co-researcher who was previously screened.

After initiating the study, engaging with initial co-researchers in the recruitment and research activities, and experiencing the aforementioned factors, I began to feel a sense of unease surrounding the future of the study and the legitimacy of the data. Like Roehl & Harland's (2022) steps in addressing recruitment and participation concerns, I discussed my experiences with my faculty advisor (and subsequently, my institution's Institutional Review Board (IRB)). These discussions resulted in creating amendments to the study methods to address some of these potential concerns. As this challenge was occurring, I often found myself expressing apprehension in my study journaling and apprehension that I was making assumptions about potential and current co-researchers, particularly for those who had cultural backgrounds that expanded beyond the United States. Given that I had control over what data and experiences were considered "legitimate," per an implemented amendment legitimacy

screening checklist, I was wielding power that the co-researchers, in not being the facilitators of the study, did not possess.

Through the amendments targeting legitimacy of co-researcher participation, I implemented a requirement for potential co-researcher camera-use during the initial screening meeting, and created the aforementioned screening checklist that included a requirement of meeting multiple categories of concern before withdrawal from the study. Through these measures, I hoped to prevent unintended discrimination, yet like most of the current recommendations for virtual research screening available (e.g., Buhrmester et al., 2011; Pellicano et al., 2023; Ridge et al., 2023; Roehl & Harland, 2022), there was no steadfast way to guarantee this, nor the legitimacy of co-researchers' experiences, especially given the added flexibility in study participation.

Screening practices and checklists such as these bring up questions regarding the limitations of mine and other researchers' personal lived experiences, and how these might influence "legitimacy" screening checklist processes. Ultimately, we hold power as the facilitators of virtual research given our roles in academic and research institutions and our ability to make decisions about what data is considered "legitimate" in research. These roles and their associated power returns to the critical discussion of who constructs "knowledge" surrounding a research topic, including this study's (Haraway, 2004; Harding, 1983; Harding, 1991; Harding, 2004a; Harding, 2004b; Harding, 2004c; Jaggar, 2004; Sholock, 2012). Within

the study findings, I made efforts to represent as much of the data (which through the checklist, has been determined to be "legitimate") as possible in promoting the co-researchers as the constructors of the study's generative "knowledge" (Haraway, 2004; Harding, 1983; Harding, 1991; Harding, 2004a; Harding, 2004b; Harding, 2004c; Jaggar, 2004; Sholock, 2012). Across the study process, in demonstrating trust with the co-researchers, no co-researcher who engaged in the study and whose data is represented in the findings was withdrawn from the study. While some met multiple "areas of concern" regarding participation in the study via the screening checklist, none met the threshold for withdrawal from the study. Despite this, the findings must be viewed through the lens of healthy scrutiny. Similar to Roehl and Harland's (2022) "Unusual Circumstances" contextual call within their dissertation work, we must bear in mind these potential challenges to data legitimacy in analyzing and drawing conclusions from this study.

While it felt affirming that other researchers have also had similar struggles related to virtual research (e.g., Pellicano et al., 2023; Ridge et al., 2023; Roehl & Harland, 2022), this is a challenge that could have potential negative consequences for recruitment and community member engagement. These challenges could include non-inclusion of potential co-researchers across studies who may not have a private space to engage in virtual research, those who choose to share the study with others in their community with similar backgrounds, who speak English as a second language, or who need assistance from others in participating in virtual research. I feel that continued research and discussion regarding the needs for checks and balances within studies that are respectful of potential unique co-researcher requirements and

identities is strongly needed in preventing discrimination across potential co-researcher screenings and in ensuring the rigorousness of study data.

The Importance of Research Supports

Across the original study methods and particularly when navigating the amendments, a critical collaboration in ensuring co-researchers' safety, legitimacy, and their ability to engage in the study included my working relationship with our IRB and legal team. Given the challenges that arose with conducting the study virtually, providing the co-researchers with flexible engagement options, and navigating reportable co-researcher disclosures, it was imperative to have an open flow of communication with both these supports. Through these channels, I could discuss study protocol questions, troubleshoot maintaining the legitimacy of the data, and discuss mandatory reporting protocols. This was invaluable in ensuring that the study methods were adequately protecting co-researchers while upholding rigorous processes. I feel that having a good personal working relationship with these research entities and viewing them as resources rather than hinderances to the research process is critical in future research with similar levels of needed confidentiality, safety, and reporting protocols.

Study Activities

In reflecting on the use of Photovoice and phenomenological interviews, I found both served as incredibly rich qualitative methods for engaging with the co-researchers; using open ended questions within both

activities allowed for myself and the co-researchers to engage in conversations that were driven by what co-researchers chose to share. Through these questions, we could build from the initial discussions and skip queries that did not pertain to the co-researchers. Given the flexibility of the methods, we moved at the pace preferred by the women who engaged in the study. The study handouts were also useful resources for highlighting the steps needed to engage within the work.

The Photovoice workshop materials and sessions were informed by previous personal research (Selingo & Stoffel, 2021), other current approaches (e.g., Dobson, 2017; Dobson et al., 2022; Tomar, 2013; Tomar & Stoffel, 2014) and historical Photovoice studies (e.g., Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000). It is my hope that in building off of previous virtual Photovoice methods within this study using similar methodological approaches (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000) informed by co-researcher preferences, that the feasibility and acceptability of virtual Photovoice as a qualitative participatory action-research approach is strengthened (Catalani & Minkler, 2019; Sanon et al., 2014).

Photovoice workshop session materials emphasized education on privacy factors and included verbal and written encouragement for co-researchers to avoid taking and using photos that included identifiable information. This inclusion was implemented due to the increased confidentiality and safety needs for the co-researchers given the study topic and my plans to disseminate the study findings across broad academic and non-academic spaces. Concerns

regarding co-researcher safety and confidentiality in engaging in the Photovoice process surrounding substance use has been previously noted (e.g., Drainoni et al., 2019), with community members bringing up notable concerns regarding personal and peer-based safety within the photo-taking process. Discussions within Drainoni and colleagues' (2019) Photovoice work included focus on what and who could be included in co-researchers' photos, and the potential implications of inclusion. Within my study, despite similar conversations (Drainoni et al., 2019) related to co-researcher-driven photographic safety measures, every woman who engaged in the Photovoice process chose to include a picture or multiple photos that included their face and other identifying features. Most co-researchers also included focus on themselves and internal/external acceptance and appearance within their Photovoice piece narratives. I feel that this highlights how important it was to the co-researchers to be seen through lenses of their choosing, and the significance of how one views themselves regarding both their sexual identity and substance use. I found that having flexibility in upholding confidentiality *and* enabling inclusion of co-researchers' as Photovoice piece subjects was possible; I worked towards this flexibility through providing options such as blurring photos to promote co-researcher autonomy; I see this is a useful method in addressing sensitive topics such as sexual identity, substance use, etc.

While these Photovoice pieces included blurring to protect the confidentiality of the co-researchers, this decision was made on my part, prior to initiation of the study activities. My reasoning for this decision was given the anticipation of potential feedback that our IRB might have in

preventing the study from moving forward due to safety concerns; the co-researchers were not involved in this determination process. When replicating this study with larger populations, careful consideration and potential added flexibility to allow for a co-researcher to include Photovoice pieces with their face directly visible will be explored. Such a shift in study methods would likely require additional discussion with IRB and more frequent/intensified conversations surrounding consent and dissemination processes. Given the focus of the co-researchers on the “self” in their pieces, this additional assessment and potential inclusion of updated practices are warranted.

In briefly reflecting on the Photovoice gallery, I found that being very intentional and collaborative in planning the event with the co-researchers was important in demonstrating respect and sensitivity to confidentiality. The co-researchers were provided with options for autonomous decision-making across the process, including which community persons of interest would be invited, the outreach language that would be used with the identified persons and groups, and the overall flow of the workshop session. One co-researcher conducted independent outreach to identified persons of interest, though was told by those they connected with that there was not an interest in attending. Given the preferences and schedules of the other co-researchers, I completed the rest of the outreach after creating a script that all co- researchers could review and approve. I also provided the co-researchers with the option to require/not require attendees to RSVP in advance, though co-researchers did not respond regarding a preference. In creating the gallery session flow, I consistently

communicated with the co-researchers in determining preferences in order of presentation, and how the co-researchers wanted to engage in the gallery.

Within the gallery event, the co-researchers had the opportunity to come together and reflect on their experiences, with new perspectives being shared regarding the Photovoice pieces. This collaborative workshop event led to important, new reflections on sexual and gender identity, the role of substance use within the queer community, and factors leading to feelings of safety and acceptance of one's sexual identity. Given the feedback from the co-researchers, I felt that holding the gallery event after time had passed between co-researchers creating their Photovoice pieces and engaging in the gallery promoted reflections and subsequent discussions that may not have occurred had both women been a part of a "cohort" within the study (that in turn, included the gallery event after they had recently created their pieces). On the other hand, this gallery workshop and the reflections, experiential affirmations, and shared knowledge-building of the co-researchers highlighted the benefits of conducting the Photovoice process in a group format; I was grateful that multiple co-researchers were open to facilitating the gallery event. Interested community members' discursive engagement in the workshop also served to facilitate deeper conversations surrounding the Photovoice piece themes and promoted collective and personal reflection. This further serves as an example of the importance of providing such spaces for knowledge-building, that can lead to action across clinical and non-clinical settings. I found myself engaging in discourse during the gallery event in which I was able to share and process my experiences alongside the co-researchers in affirming ways. Overall, the gallery event was a critical part of this dissertation work in upholding a Photovoice-based participatory action

research approach (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998, Wang et al., 2000) and disseminating the findings in ways that can directly address challenges to SMW's healthcare experiences.

In shifting to address the interview portion of the study, my decision to approach the dissertation methods from a phenomenological perspective (Gallagher, 2012; Giorgi, 1997; VanManen, 1990), made the determination to use a phenomenological approach to the interviews a natural one. Much like my broad, phenomenological approach to the methods, I wanted the interviews to allow for a breadth of co-researcher driven discussions that could be elicited by thoughtful, open-ended questions. I did not want these questions to become too direct, preventing co-researchers from centering their discussions on topics that were of importance to them within their lived experiences. This desire is reflected in the generalized phenomenological references and content I applied to the interviews.

Using my goals for the interviews as a guidepost (Gallagher, 2012; Giorgi, 1997; VanManen, 1990), I drew from my chosen underpinning theories and models (Queer'ed Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway. 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Love, 2011; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) and the Person-Environment-Occupation (PEO) model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) to structure the

questions that the co-researchers would be asked. This process came with the recognition that through my chosen data analysis process (reflexive thematic analysis (Braun & Clarke, 2019, 2020; Braun et al., 2018; Byrne, 2022), informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014a,b) I would need to carefully articulate how these chosen theories and models were synthesized alongside co-researcher's shared experiences to inform the study findings. Using a broad phenomenological approach to the interviews ensured that I was able to obtain a wide range of experiences that were important to the co-researchers, promoting more co-researcher driven influence on the analysis process (Gallagher, 2012; Giorgi, 1997; VanManen, 1990).

While other recent studies have used a phenomenological interview approach to examine the experiences of various populations' substance use (e.g., McKenzie, 2018; Shafiq & Fatima, 2023; Touseef et al., 2023), emphasis across these studies has been placed on using a specific, singular phenomenological methodological approach (primarily Interpretive Phenomenological Analysis (IPA)) (Smith et al., 2009, as cited in McKenzie, 2018 and Shafiq & Fatima, 2023). The IPA approach applies specific perspectives on how knowledge is constructed, with an emphasis on creating knowledge through the connection between those who participate in the research process and the researcher (Smith et al., 2009, as cited in Shafiq & Fatima, 2023). Through IPA-based collaborative knowledge-building with co-researchers, the researcher is supposed to garner an enhanced comprehension of the phenomena being studied (Cresswell, 2013, Larkin & Thompson, 2012, Larkin et al., 2006, Pietkiewicz & Smith, 2014, Reiners, 2012, as cited in McKenzie, 2018).

Interpretive Phenomenological Analysis is influenced by numerous philosophical underpinnings (Cresswell, 2013, Larkin & Thompson, 2012, Pietkiewicz & Smith, 2014, as cited in McKenzie, 2018); it includes a specific method for analyzing data through strategic steps (Smith et al., 2009, as cited in McKenzie, 2018), making it a stand-alone method of data analysis in its own right. While IPA includes attention to researcher reflexivity within the research process (Creswell, 2013, Larkin et al., 2006, Pietkiewicz & Smith, 2014, Reiners, 2012, as cited in McKenzie, 2018) and analysis steps that result in themes (McKenzie, 2018; Shafiq & Fatima, 2023; Smith et al., 2009, as cited in McKenzie, 2018; Touseef et al., 2023), the method centers on an inductive approach to data analysis (Smith & Osborn, 2015). Given this focus (Smith & Osborn, 2015) I feel would the application of a method such as IPA within the study would not have allowed for the comprehensive synthesis and application of my chosen guiding theories and models within the interview question creation and analysis processes, or the thorough interweaving of my own reflexive practices across the methods and study findings dissemination.

By maintaining a separate, broad approach to the interview process that did not include an embedded, pre-set data analysis approach (Gallagher, 2012; Girogi, 1997; VanManen, 1990), I perceived that I was able to more clearly delineate within the analysis process where co-researchers' shared lived experiences resulted in new "language" building surrounding phenomena versus where my application of my chosen theories and models was used to give linguistic structure to the phenomena being described by the co-researchers (Braun & Clarke, 2020; Schwandt, 1998; Widdicombe & Wooffitt, 1995); this flexibility was heavily promoted through my use of reflexive thematic analysis, which emphasizes flexibility in the theme generation process regarding deductive versus inductive analysis, experiential versus

phenomenological analysis approaches, etc. (Braun & Clarke, 2019, 2020; Braun et al., 2018; Byrne, 2022; Clarke & Braun, 2014a). This brief discussion of why a more specified phenomenological interview approach (and subsequent data analysis approach) was not applied is included to illustrate the intentional decision-making that went into the intersection of study methods tenets and the analysis processes relating to the broader guiding philosophical and theoretical tenets of the study. My choice in methodological and analysis tools has additional implications going forward as well, in looking to continue to build our professional knowledgebase surrounding women's substance use needs in a way that is as community-member informed as possible.

When getting to the heart of my goals for the phenomenological interviews with co-researchers (Gallagher, 2012; Giorgi, 1997; VanManen, 1990), I am incredibly grateful for the feedback from committee members and mentors regarding the need to broaden the questions to create an inclusive environment for open co-researcher discussions. This feedback ensured that I was not leading the co-researchers when sharing their experiences with substance use and their sexual identity; it also confirmed that the co-researchers were able to define substance misuse and their lived experiences on their own terms. I am hopeful that the phenomenological interview structure and questions helped to shift the power dynamic between me and the co-researchers to one of collective knowledge-building. For me, the strategic outline of the interviews made rapport building feel more natural through collaborative discussion. I perceived that the interview

questions helped to more deeply probe into the experiences that the women who engaged in the Photovoice sessions had briefly discussed. I also felt that this structure promoted that the co-researchers had more control over the overall flow and tone of the interview (and thus, data-collection) process in determining what experiences and factors were most important for them to disclose.

Regarding communication between me and the co-researchers across the study, multiple, thorough forms of email outreach were needed in addition to my initial verbal descriptions and email scripts. This additional outreach often included detailed reminders on the required methods for submitting materials, as some co-researchers would upload incomplete copies of the materials, incorrectly completed forms, etc. Given the difficulties with some co-researchers in submitting materials to Qualtrics and considering that the co-researchers might have preferred to submit materials via their prior-established email connection with me, I would consider using email as the primary form of submission in future research.

Another notable factor that arose during the study was mandatory reporting, as a co-researcher disclosed an experience that required consideration of the need to report to higher authorities (ultimately, reporting was needed). The process of learning what constituted a reportable disclosure and carrying out the reporting was challenging for numerous reasons. In receiving updated, more detailed

mandatory reporting training during the study through my clinical capacity as an occupational therapist, I returned to the questionable co-researcher disclosure that I had made an initial judgement call on in earlier months. During this retroactive reflection, I consulted with numerous experts, including committee members and IRB staff. It was in escalating questions upwards to our legal team that additional clarification and details on what disclosures could be considered reportable was made clear. In reporting, a lack of details regarding the personal information for those who were potentially considered at risk, along with my intense feelings of guilt made this an emotionally low point for me in the study.

With time having lapsed since engaging in the study activities with the co-researcher, having built rapport and trust with this individual, and having not had direct contact with the potential impacted peoples discussed within the reportable disclosure, I had significant concerns about violating personal confidentiality and the relationship I had built with this woman. While it was made clear throughout the study to the co-researchers that I am a mandatory reporter through my role as a school employee and practitioner, as a researcher and person, I looked to create a safe space to engage with others in sharing their experiences. Given this, my role as a reporter in the context of my employment and my clinical position led to feelings of dis-ease and confusion. I was also concerned about re-traumatizing the co-researcher, and placing an additional burden on others who may have

already received care support and legal intervention. I also struggled with my fear that I was reinforcing a history of researcher interference that disincentivizes study participation and erodes at community member relationships (Lytle et al., 2021); I am not the first researcher to voice such concerns regarding the morals of, ethics of, and challenges to autonomy pertaining to mandatory reporting (Geiderman & Marco, 2020; Lytle et al., 2021; Sieber, 1994). Mine (and others') concerns center on that in reporting disclosures where it is not highly evident that others are experiencing immediate harm, we are sending the message to those we serve that we are there to police and preference the needs of the "state" over the those of the person (Geiderman & Marco, 2020). In the future, I plan on seeking certificates of confidentiality to try to address this barrier and prevent further negative participation outcomes for future co-researchers (Sieber, 1994).

While my initial study protocol included verbal guidance to co-researchers during each meeting regarding my responsibilities as a mandatory reporter, when working with co-researchers who require increased levels of confidentiality, I came to feel that having a detailed protocol in place for addressing reportable factors should ideally be established at the start of the study, rather than as a proposed amendment (as was the case in my study). In creating these materials for an amendment (which ultimately were not used due to finishing data collection), I reflected on how often trauma can play a role in our substance use, and how widespread this trauma may be within our interpersonal

networks. We need to establish awareness and sensitivity prior to conducting research, including a clear determination of how much our roles and associated responsibilities as researcher, practitioner, and employee intersect. In general, I, along with other researchers (Lytle et al., 2021) strongly call for greater emphasis on mandatory reporting trainings for researchers that provide numerous and detailed scenarios covering types of potentially reportable disclosures; additional discussion across the academic and research communities regarding where the roles of practitioner and university employee end within research are needed as well. I place increased time and attention to this conversation within the scope of this dissertation work to encourage other researchers and practitioners to do the same as they carry out their various roles in serving others.

Finally, it is important to focus some discussion on the potential impact that the order of co-researchers' study activity engagement had on the women's experiences and knowledge building. When asked by myself, one of the three co-researchers who completed both the Photovoice *and* interview portions of the study did not indicate they felt that the order in which they engaged in the study impacted their perspectives shared within either activity. Despite this, the other two co-researchers who completed both tasks shared their perceptions that completing the Photovoice workshops first shaped the way they viewed the phenomenological interview going forward.

For one co-researcher, completing the Photovoice workshop sessions first allowed them to later "attach meaning" to their Photovoice pieces through personal reflection across the

interview process. For the other co-researcher, the Photovoice process allowed them to gather some of their experiences in a visual format in creating meaning that they were then able to articulate and explore through the interview process. While both co-researchers viewed these experiences in slightly different ways, I would argue that their perspectives on the order of engagement in the study signal that the initial emphasis on knowledge-building through visual methods for the co-researchers created differing forms of “knowledge” when compared to the interview data. This form of “knowledge” was reciprocally defined by the “language” created and used by the co-researchers through the interview questions. Findings from these co-researchers indicate that visually expressing one’s lived experiences may assist in the conceptualization process of putting one’s lived experiences into words and provide enhanced meanings to the discursive knowledge created by co-researchers.

Had the co-researchers completed the interview prior to the Photovoice workshop sessions, one has to wonder if the Photovoice pieces would have included greater emphasis on the specific topics that the women were encouraged to discuss through the interview questions as opposed to the factors that the co-researchers chose to cover within their pieces (e.g., gender and sexual identity representation, societal discrimination, self-acceptance, and the importance of safe space signage). Of note, the Photovoice piece factors explored were not specific topics covered within the interview questions. In wondering aloud, I might guess that co-researchers had a potential greater degree of perceived freedom in what topics they chose to address in their Photovoice pieces, having not engaged in the interview questions (which were chosen by me and therefore assigned importance by myself as the facilitator of the study). In future iterations of the study, I plan to return to this discussion in determining

whether it is more beneficial to facilitate co-researcher choice in study activity engagement order, or to consistently structure study methods to hold the Photovoice workshop sessions first. I look forward to hearing my colleagues' reflections on these potential options.

Data Analysis and Member Checking

The use of Braun and Clarke's reflexive thematic analysis (2019, 2020; Braun et al., 2018; Byrne, 2022) (informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014, a,b)) promoted dynamic examination of the transcripts in a way that ensured data manageability; it also fostered critique of the chosen underpinnings for the study against co-researcher data, and enabled me address my own assumptions, experiences, and biases as the facilitating researcher. When engaging as a researcher in reflexive thematic analysis (TA) Braun and Clarke (2019, p. 592) note that:

> "...it *required* the researcher to articulate the assumptions that informed their approach and how exactly they enacted TA. It offered an approach that required reflexivity, theoretical knowingness and transparency."

Using this method of analysis, "stories of shared meaning" as opposed to "domain summaries" are derived through the created themes, with flexibility in the theoretical underpinnings that researchers can use within the analysis process (Braun & Clarke, 2019, 2020; Braun et al., 2018; Byrne, 2022; Clarke & Braun, 2014, a,b). The thematic (and reflexive thematic) analysis process emphasizes that themes can and should be iteratively reexamined and further honed across the analysis to ensure that each theme is distinctive (Braun & Clarke, 2012, 2019, 2020; Braun et al., 2018; Byrne, 2022; Clarke & Braun, 2014a,b). I found that the development of a strong philosophical and theoretical foundation used in conjunction with positionality practices within the study allowed me to

identify and ground my internal personal hypotheses regarding potential study findings across the methods and subsequent data analysis; this enabled my ability to naturally critique these hypotheses through the voices of the co-researchers (Braun & Clarke, 2012, 2019, 2020; Braun et al., 2018; Byrne, 2022; Clarke & Braun 2014a,b).

Using a synthesis of virtual and physical workshop session transcript and field note coding allowed for numerous layers of comparison that I feel might have been missed had I used qualitative coding software. In analyzing the data myself and presenting the findings to the study co-researchers for member checking, I perceived the importance of continuity for the co-researchers; the person who had engaged with them in the study methods was the person analyzing the data and returning it to them for final thoughts, additions, amendments, and more.

The member check process served as a valuable aspect of the study, despite the small number of co-researchers who engaged. After sending out multiple rounds of outreach to request feedback from the co-researchers, multiple women responded to the outreach to ask whether there was compensation associated with the check. Across these correspondences, with guidance from Dr. Stoffel, I began to include language to the co-researchers that highlighted the intentional lack of compensation in preventing co-researchers from feeling pressure to provide only positive, affirmative feedback regarding the study themes and recommendations (Birt et al., 2016).

After notifying the co-researchers that the member check was optional and that there was no compensation associated with involvement, I did not hear back from those who reached out to ascertain whether they would be receiving a gift card for their participation. This occurrence brings up the important query of whether compensation might be incorporated into the member checking portion of future iterations of this work, and the ethical quandaries this poses, similar to other ethical considerations about researcher facilitation of the member check process (e.g., Birt et al., 2016).

In engaging with the two co-researchers who chose to complete the member checking process, providing numerous platforms (emailing and meeting virtually) for co-researchers to engage appeared to be helpful, as both co-researchers used varying approaches when engaging in the process. Both women also provided detailed feedback in affirming the study findings and brought additional perspectives and ideas to the study themes and recommendations. Given these experiences, the member check served as a critical activity within the study in ensuring that the findings that readers of this work engage with are indicative of the experiences of the women who engaged in this study. In future work, I plan to continue to offer co-researchers multiple ways to engage in this process and look to include in-person and group meeting offerings to enhance co-researcher's experiences with member-checking (Birt et al., 2016).

Personal Journaling and Positionality

The assessment process across the dissertation in identifying each 'voice' was a reflective practice in and of itself (Morris, 2012; Perryman-Fox, 2020). While biased in being my own personal estimate, identifying what type of "voice" and whose "voice" was "speaking" within each dissertation chapter has proven to be a critical experience for me in recognizing the mutable nature of "knowledge" building, across my personal construction and those of the co-researchers' (Harding, 2004a; Harding, 2004b; Harding, 2004c); this experience was affirming in identifying the influence of the many standpoints of women explored within the study, including the impact of other scholar's voices that contributed to the dissertation work (Harding, 2004a). In more deeply reflecting on my own standpoints and "voice" within the study, I found the process of journaling to be a wonderful outlet for not only reflecting co-researchers' disclosures, and the implications for our practice, but my own emotional responses. This activity included a helpful, iterative process of examining and critiquing the impacts of my lived experiences, biases, and approaches to engaging with the co-researchers and co-creating "situated" knowledge with them (Haraway, 2004; Harding, 2004b, p. 133). In reviewing my entries, I found myself asking questions that arose from co-researcher's experiences pertaining to my own positionality and practice, along with the tenants of the OT profession. For example:

> "During the interview today, I found myself thinking about those micro-level things we do in the clinic that could send a message to the

people we work with that we might not be a “safe” or understanding person to disclose to. When I use medical-based terms like “substance misuse” and “opioid use disorder,” in talking with people on the unit about their experiences, and I helping, or making them feel like a diagnosis? When our profession neglects to address substance use and sexuality in practice or assigns a negative connotation to these factors in our literature or personal verbalized philosophy, are we quietly (or loudly) sending the message that we are not a “safe” profession to come to?”

Similar to my colleague Michelle Perryman-Fox's reflections within her dissertation process (Perryman-Fox, 2020), in writing reflexively through the positionality framework prompts (Andersen, 1983; Carastathis, 2014; Crew, 2021; Finlay & Gough, 2003; Harding, 1983; Harding, 1991; Heldke, 1998; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008) outlined in Chapter 2, and recognizing my own standpoints as woman, student, and member of the queer community, I began to consider my answers to the interview and Photovoice-session questions I was asking the co-researchers. I found through this reflection that some of my answers surprised me. In thinking about others in my life who use substances, I considered the spectrum of use and non-use I see, including people who have chosen to maintain sobriety, others who are struggling to control their use, and those who are experiencing harmful use but have not addressed this; I have loved ones and people I serve within my practice who

fit in to many of these categories, all of whom perceive their substance use or non-use in unique ways.

While I do not use other substances aside from alcohol, I tend to hold a great deal of hesitancy around them, such as marijuana, cocaine, LSD, etc. Much of this is due to observing the experiences of those I care about when it comes to these substances, while some of it pertains to the realization that if I were to use these substances, I could potentially lose my livelihood and all I have worked for. Despite this potential, I have the privilege of being in a racial group, socioeconomic tier, profession, and set of social groups who I observe have the ability to (and often do) enjoy the use of alcohol and other substances with little in the way of negative repercussions to their social, professional, and familial standing, *even when use has become detrimental*.

While I have had personal involvement with others close to me struggling with harmful substance use, these experiences have always been through the lens of multiple privileged identities. Substances are also a commonplace staple around me; in providing a few examples, they're embedded in much of my personal and professional events, with substances like alcohol serving as a networking tool in conference happy hours and most social gatherings I attend, and the recreational use of cannabinoids by others in some of my social groups is often commonplace.

I have not, nor do I personally know of someone close to me who has personally experienced harmful substance use that is not protected by one or more of these factors, outside of my practice as a practitioner in behavioral health. Despite my education and practice experience surrounding substance use and sexual identity, in engaging with the co-researchers and reflecting on my personal and professional views and experiences on substance use, I am inherently biased in how I perceive the spectrum of use given my identities. In listening to the experiences of the co-researchers, particularly with regards to race and socioeconomic status as they relate to substance use, the disparities in the consequences of use (including casual use) for those who are not white or in the middle to upper socioeconomic classes, are stark. The fallout from substance use/misuse and sexual identity described by the co-researchers, including discrimination, stress, and at times, fear, are not a universally shared experience by all substance users: substance use is inherently political, and I am certainly not the first researcher to note this (Dollar, 2019; Matsumoto et al., 2021).

These study findings, particularly the co-researcher recommendations, are targeted at a profession whose providers are predominantly white (82.5%) (Banks, 2022), and who make an average salary of $92,800 and $66,280 a year across occupational therapists and therapy assistants, respectively (U.S. Bureau of Labor Statistics, 2023a; U.S. Bureau of Labor Statistics, 2023b). I cite these factors to highlight that in addition to the research supporting our gaps in education and provider knowledge surrounding substance use (Egan & Cahill, 2017; Mattila &

Provident, 2017; Mattila et al., 2022; Thompson, 2007) and sexual identity (e.g., Bolding et al., 2022; Nowaskie et al., 2020; N. Rose & Hughes, 2018; Willey et al., 2023; Young et al., 2020), our workforce possesses inherent privileges, standpoints, and statuses impacting our understanding of substance use and other personal factors that are at odds with the realities of many of the people we serve; I interpret this professional homogeneity (Banks, 2022; U.S. Bureau of Labor Statistics, 2023a; U.S. Bureau of Labor Statistics, 2023b) and subsequent lack of lived experience as pointing towards a larger need to diversify and better educate our profession to thoroughly meet populations' needs. I personally feel that an important place (for me) to start in the systemic process in better addressing substance use and sexual identity was in reflecting inward, towards my personal and professional views, patterns, roles, and behaviors surrounding substance use. Given my positive experiences with this reflexive process, I would encourage others to consider this as a preliminary step as well. This reflexive process can involve asking ourselves difficult questions, including: "Am I asking this person to make changes to their substance use patterns that I would not make/have not made? Am I passing judgement on this person's sexual identity and attributing it to the challenges they have experienced with substance use? Are we as practitioners enacting what we preach regarding our own substance-use within professional settings such as conferences?"

The positionality framework and the reflective questions addressed through my introspection and journaling across the study led to personal

considerations that had implications for my interactions with co-researchers, *and* my practice. In engaging in the reflexive process during the study and data analysis, and highlighting this call for collective and individual reflection across our roles as practitioners, researchers, advocates, educators, and community members, I hope to encourage fostering a deeper connection to ourselves and the people we serve. A potential starting point could be addressed through applying the structured reflexive framework I have proposed in this work internally.

Final Thoughts

A common topic of discussion amongst Standpoint theorists includes whether someone who is "outside" of the community being targeted through research should facilitate the generation of knowledge that is from and for people in that community (Collins, 1986; hooks, 1989). As a part of the queer community, I found myself identifying with many of the experiences disclosed and could speak to them in building a shared knowledgebase and place of understanding with the co-researchers. During the dissertation process, when listening to the lived experiences and bravery of the women who engaged in the study, I felt empowered to come out to my own family, an experience which for me will always be tied to this work and period of my life. In coming out to my family, these women's stories, and their commitment to bettering the lived experiences of those within the queer community served as sources of significant strength for me. I feel indebted to the co-researchers who graciously served within this study,

not only for the knowledge they have contributed towards SMW’s experiences with substance use, but in their modeling of self-love, acceptance, and confidence.

Despite these shared perspectives and standpoints, as I engaged in the study process and reflected through my journaling, I found myself recognizing experiences described by the co-researchers that differed greatly from mine, particularly when it came to the intersection of socioeconomic status, race, religion, and substance use. As someone who is white, middle class, and non-religious, these differences, as well as the co-researcher's recommendations that addressed these factors, made me recognize the limited lenses through which we as practitioners (even across our own unique identities) may be coming to our work with in meeting the needs of the wide, unique span of individuals we serve. I think this is particularly of concern if we are not seeking out continuous opportunities for reflection and challenging our current body of knowledge.

This recognition and the reflection process across study reminded me of the importance of the continued learning and work we need to do to better understand the experiences, strengths, and challenges of those we serve whose intersecting identities impact their substance use and healthcare experiences. There were times during co-researcher sharing where I experienced discomfort; I felt upset for the co-researchers, and at a loss for words given their experiences. I felt challenged with what to say in

the face of the blatant discrimination and threats to safety and security that so many of the co-researchers described. Listening and verbally affirming the co-researchers served as powerful tools in these moments, as well as reflecting on why I felt discomfort. Growing from these contemplations, I worked to consistently address how I might better support co-researchers in future conversations. While I keenly felt these gaps in my knowledge and personal experiences, I felt deeply appreciative of the experiences, standpoints, kinship, and humor we shared, and grateful for the opportunity to feel and confront my discomfort.

I share these experiences to highlight that often, we as OT practitioners and other healthcare providers have times where we are disconcerted, when we are confronted with experiences, challenges, and discrimination that we have never and will never navigate because of who we are. I feel that when these conversations occur with regards to substance use, and really any context, we need to probe our feelings of discomfort, rather than run from them; we need to focus on our ability to listen without trying to solve, or mend. I feel that this could potentially be as important to those we serve as the clinical and psychosocial interventions and research we implement. We must commit to expanding our own personal understanding and reflexive skills before we can truly serve others whose experiences differ from ours regarding the way they wish to be served. So often, when asked why they wanted to engage in the study, the co-

researchers stated that they simply wished to be a voice for the queer community regarding substance use; that they wanted to speak out on something that is often difficult to discuss or is often dismissed.

As occupational science, therapy practitioners, and other healthcare providers, we can stand as witness to these voices; we can take active steps to ensure that we are not purveying the harmful healthcare experiences, discrimination, and stigma that can surround addressing substance use for SMW and beyond. I believe that an important step towards this comes with recognizing where and how power operates in our relationships with our colleagues, administrators, and the people we serve, and working towards collaborative empowerment that leads to the societal level changes emphasized by scholars in our field (e.g., Godoy-Vieira et al., 2018; Spiegel et al., 2015). I would argue that this starts with getting into the practice of engaging in active personal reflection (with excellent examples such as Perryman-Fox's 2020 work serving as a guide) as a consistent part of our practice, whether that is through journaling, creating spaces for professional discursive exploration, or simply meditating on our encounters and the care with provide to the people we serve.

The co-researcher's recommendations did not include what might be considered lofty goals (e.g., changing the social systems of inequity and discrimination surrounding substance use (which are indeed needed (Godoy-Vieira et al., 2018))). They ask for each of us as healthcare providers to consider the stigma and biases we come with in serving SMW who use substances on

the personal level, avoid promoting our vision of what substance use should or should not look like, and practice with unconditional love for our fellow human beings. These study findings and recommendations show us, including myself, that the start of improving our care surrounding substance use begins at the individual practitioner level, meaning we all must take responsibility for using these findings in reflecting on our own positionalities and practice.

Discussion

This study and co-researchers' shared lived experiences resulted in numerous themes and recommendations that can be directly applied within our occupational science and practice. To root the implications of the results with respect to other current findings that have explored this population's experiences, discussion on the applicability of the study's proposed philosophical and theoretical underpinnings will be detailed first.

Application of Guiding Philosophy and Theoretical Underpinnings: Assessing the Findings Through Occupational Science and Therapy Lenses

My choice to ground the study in the transformative paradigm (Mertens, 2009; Mills, 1959), through occupational imagination (Laliberte Rudman, 2014, 2019) feels appropriate given co-researchers' fluid descriptions of the individual occupations they engage in (including substance use), and substance use's mutable influence on many of the contexts of other occupations they take part in as "occupational beings" (Yerxa et al., 1990). In building our occupational imagination surrounding what influences substance use and how we might view and address use and misuse in the future (Laliberte Rudman, 2014, 2019), the co-researchers described a plethora of nuanced social factors, including the intersection of racial

discrimination and substance misuse, the multifaceted use of substances in the queer community, and the impact of historical family trauma, and interpersonal relationships and dynamics on personal substance use. These conversations also included exploration into the societal levels of acceptability surrounding substance use, and the mental effect of sexual-identity based discrimination. Across these described experiences, power operated in unique ways, with co-researchers describing inequitable encounters with healthcare providers, negative and (at times threatening) interactions with others who were not queer, and discrimination from individuals who maintain significant levels of personal power, including law enforcement and employers.

Co-researchers' description of personal and systems-levels strengths also contribute to our understanding of substance use, sexual identity, and addressing harmful substance use; they enhance our understanding of the importance of familial and queer community member support, personal coping strategies, self-love, and therapeutic-based interventions. These multi-level strengths, challenges, and power dynamics speak to our need as scientists and practitioners to deeply explore the shifting status of substance use as an occupation (Helbig & McKay, 2003; Hocking, 2020; Kiepek 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014) versus substance use as an impactor of other occupations (Helbig & McKay, 2003; Hocking, 2020; Kiepek 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2020a). They also call on us to more firmly commit to collaborating with community members to address the social-level issues identified by the co-researchers, that are contributing to harmful substance use, while strengthening

personal and community supports to transform the lives of the people we serve (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019). In more strongly identifying and taking on our role as collaborative community advocates, we can uphold a more emancipatory approach (Godoy-Vieira et al., 2018; Spiegel et al., 2015) to preventing harmful substance use and getting at the heart of the broader social systems that contribute to substance misuse through an OS (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019; Yerxa et al., 1990) and imaginative lens (Laliberte Rudman, 2014, 2019).

In shifting to exploring the applicability of Women's Standpoint Theory to the findings, the standpoints (e.g., sexual, racial, cultural, age-based, student, socioeconomic, etc.) of the women who engaged in the study stood apart from standpoints that often dominate the facilitation and focus of research and knowledge generation (Haraway, 2004; Harding, 2004a; Harding, 2004b, pp. 129-133; Sandoval, 2004; Sholock, 2012). Co-researchers represented numerous intersecting and non-intersecting sexual identities, socio-economic backgrounds, spiritual beliefs, and racial and ethnic identities, with women crafting collective knowledge in creating a more well-rounded picture of personal substance use and the systemic factors that influence use and misuse (Haraway, 2004; Harding, 2004a; Harding, 2004b; Harding, 2004b, pp. 129-133; Jaggar, 2004). The co-researchers also independently placed focus on critiquing systems of power they operate within and are negatively impacted by, including religious and healthcare institutions (Jaggar, 2004), truly creating knowledge that is "for" women (Harding, 2004a, p. 4; Harding, 2004c).

Across the co-researchers who engaged in the study, there were multiple "truths" that differed from one another (Haraway, 2004); for some co-researchers, there were no perceived

challenges in feeling a part of the queer community, while for others, perceiving that a person was welcomed was directly connected to one's physical representation of gender and sexual identity. Some co-researchers felt that the queer community did not have challenges regarding harmful substance use practices, while others felt that substances are used in coping with discrimination, and that use is inherently tied to the community. These unique perspectives and experiences are in line with Critical Realist's (Altheide & Johnson, 2011, p. 581; Redman-MacLaren & Mills, 2015) assertions that knowledge is constantly being built, and Standpoint Theorist's beliefs that our understanding of an issue is always incomplete given situated positionalities (Collins, 1986; Haraway, 2004; Harding, 2004a; Harding, 2004b; Harding, 2004b, pp. 129-133; Jaggar, 2004). This study and the co-researchers opened the door to future personal reflection and research that continues to incorporate other standpoints and positioning.

The intersecting application of Queer (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) with Women's Standpoint (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) theories was pertinent in not only structuring the study activities and demographic collection process to allow for self-identification, but in exploring those self-identities within the context of the findings (Butler, 1999; Love, 2011; Jakobsen, 1998; McCann & Mohaghan, 2020; Macuch, 2017). The co-researchers spoke of a spectrum of sexual and gender identities; they eschewed the "fixed" categorizations that political, academic, research, and clinical entities often apply (from my

personal experience) in self-identifying during the study demographics process and describing how they affirm their internal identities and positioning within the queer community (Love, 2011). Discussion with the co-researchers regarding the steps they took to feel more a part of the queer community through changing their physical appearance, and expressing and intimating their sexual identity in ways that did not meet “norms” outside of the queer community were grounded in Queer Theories’ recognition of the impact of societal norms and co-researchers' resistance to those norms (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020).

Further identification of the impact from social norms (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) within the study process was critical in critiquing the power dynamics surrounding co-researchers’ intersecting standpoints including political, spiritual, racial, and sexual identities (Butler, 1999; Jakobsen, 1998; Macuch, 2017; McCann & Mohaghan, 2020). During conversations regarding the impact of engagement in religious institutions that reinforce gender and sexual identity heteronormativity, Queer Theories became particularly salient in examining expressions of power differentials ((McCann & Mohaghan, 2020). These included a span of experiences, from a lack of feeling safe with disclosing one’s substance use and sexual identity within Christian churches, to the fractionation of familial relationships due to religious beliefs regarding sexual identity (McCann & Mohaghan, 2020). Application of Queer theories within the study was highly important in contextualizing the shared and differing lived experiences of the co-researchers with respect to the larger systemic and social theatres they are directly impacted by (detailed later in the discussion section) (Butler, 1999; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020).

In engaging in reflexive thematic analysis and analyzing the applicability of my initial hypotheses and chosen philosophical and theoretical underpinnings through the co-researchers' shared lived experiences, I found that not all my initial assumptions were applicable (Braun & Clarke, 2019, 2020; Braun et al., 2018; Byrne, 2022) (as informed by thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2014, a,b). I initially hypothesized that the co-researchers would have varying perceptions of the impact of their environments, personal characteristics, and the occupation of substance use on use behaviors and patterns (similar to the scaffolding provided through the PEO model, which I chose to use in structuring the study activities (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011)). In engaging in the study activities and analysis process, I was not anticipating the particular emphasis that many of the co-researchers placed on wielding (and at times, lacking) control over their use, and how this control manifested in differing ways (e.g., limiting substance use to social engagement, discontinuing substance use, feeling as though substance use had taken control of the person, etc.). I also did not estimate that I would encounter the number of challenges in the application of the PEO model that I came to experience (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) in conceptualizing the numerous facets of the co-researchers' lived experiences.

In my initial dissertation proposal, I outlined my intent to continue with the application of the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011), and its intersection with the tenets of Queer'ed Women's

Standpoint Theory (Andersen, 1983; Butler, 1999; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Jakobsen, 1998; Love, 2011; Lugones & Spelman, 1983; Macuch, 2017; McCann & Mohaghan, 2020; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012) to provide structure in analyzing and subsequently disseminating the study data. This desire to use the PEO model was driven by multiple considerations: I perceived there was a clear connection between one's intersecting standpoints with one's personal, environmental, and occupational contexts when using substances (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011), and I wanted to implement a commonly applied and well-understood model within OT and OS to ground the exploration of these two nuanced concepts (sexual identity and substance use). In my dissertation proposal, I discussed that the decision to employ my proposed underlying theories and models across the study methods and analysis would ultimately depend on their fit with the co-researchers' shared experiences. The purpose of this was to ensure that my study process was in keeping with the core principles of participatory action research (PAR) (McIntyre, 2008) in de-constructing traditional, colonialist, researcher-driven approaches to knowledge building through emphasis on community-member decision-making (Rumsey et al., 2022).

Within this study, the co-researchers shared complex stories regarding their substance use that featured intersecting personal factors and identities shaped and affected by broader

systemic factors. Within the analysis process of shifting these stories to comprehensive themes (Braun & Clarke, 2012, 2019, 2020; Braun et al., 2018, Byrne, 2022; Clarke & Braun, 2014a,b) I found that attempting to encompass such multilevel experiences, factors, and identities within the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) felt narrowing and incomplete, particularly in exploring the intersection between personal contexts with historical and societal factors, and detailing where power operated across the co-researchers' identities and relationships (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019). For instance, in generating a theme surrounding personal control, the co-researchers described substance use behaviors and perceptions connected to their ability to engage in other occupations, differing social peer perceptions surrounding what constituted "misuse," internal bodily functioning influencing decision-making, perceptions surrounding race and sexual identity in relation to what was considered harmful use, and more. Attempting to trifurcate these personal experiences would not do justice to the multi-intersectional factors described by the co-researchers.

Recognition of this lack of perceived fit between co-researcher experiences and the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) came through consistent critique within my journaling and the iterative review of my initially applied philosophical and theoretical applications within the study; this process proved to be critical in ensuring that the co-researcher's shared experiences were accurately represented (Braun & Clark, 2012, 2019, 2020; Braun et al., 2018; Byrne, 2022). This recognition on my part is demonstrated in the lack of organizing co-researcher themes and subsequent quotes around the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011), and

leaving the data to flow more naturally, with intersecting standpoints explored across the themes and quotes. This (to me) allowed for stronger recognition of how co-researchers' 'lived experiences' were reflectively built through study method engagement as they explored numerous lenses and phenomenological interpretations of their realities (Burch, 1990, p. 134). The commitment to emphasizing co-researchers' experiences in structuring the study findings upholds the study's transformative approach (Mertens, 2009; Mills, 1959) in challenging myself and readers to broaden our conceptualizations of substance use and misuse (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019).

The implications of refuting the application of the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) within the study, in keeping with a transformative approach (Mertens, 2009; Mills, 1959) span beyond this research within the fields of OS and OT. Dickie and colleagues (2006) examined the individualistic focus of OS and called for a move away from a singular emphasis on occupation as related to the individual, noting that occupation is not "independent from a larger experiential whole" (p. 84). Dickie et al. (2006), argued that historically, OS has conceptualized the situating of the person and their personal "contexts" (e.g., American Occupational Therapy Association 2002, Christiansen, 1994, Clark et al., 1991, Nelson, 1988, Wilcock, 1993, Yerxa, 1993, as cited in Dickie et al., 2006) as center stage. While some recognition of culture and personal meaning (Mandel et al., 1998, p. 327, as cited in Dickie et al., 2006) exists and could be seen as potentially expanding our understanding of occupation, Dickie and colleagues (2006), argue that occupations have primarily been examined at a personal, individualized tier, rather than systems-level perspectives. This can lead to conceptualizing the person as singularly in control of their occupation(s), without recognizing the systems, contexts, and other individuals that exert influence (Dickie et al., 2006). In engaging

in the data analysis process and considering all that the co-researchers had shared regarding the nuanced systems, interpersonal relationships, cultural factors, and identities that shaped their engagement in substance use and other occupations, I came to worry that use of the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) in structuring the analysis and serving as a lens through which to analyze the findings would result in the loss of recognition of how these described factors influenced and were influenced by the co-researchers (Dickie et al., 2006). At worst, I was concerned that such application of the model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) would result in the ties between themes and data being lost due to rigid categorizing, leading readers to conclude that the co-researchers were the singular controllers, influencers, and affected persons regarding their substance use and sexual identity experiences (Dickie et al., 2006).

To avoid falling into such traps, Dickie et al. (2006) call for a more "transactionalist" approach (Dewey & Bentley, 1949, as cited in Dickie et al., 2006) to OS, with exploration into the responsive interactions one has with the systems around them (Garrison, 2001, as cited in Dickie et al., 2006). This call for expanded OS perspectives on occupation (Dickie et al., 2006) has concurrent themes with more recent requests for an emancipatory shift in how we address occupation with the people we serve, including recognizing the important systems that impact individuals, and dedicating ourselves to collaboratively work towards communal empowerment (Godoy-Vieira et al., 2018; Spiegel et al., 2015). Dickie and colleagues' note also fits in well with the growing recognition in OS that personal reflection as practitioners, academics, scientists, and advocates, that challenges our personal and professional conceptualizations of occupations through OS and imagination is needed in enhancing the field (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019). Through organizing the study findings using

words, phrases, and quotes that came directly from the co-researchers as opposed to structuring the themes around the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011), we can be more fully grounded in the lived experiences and realities of queer women, while ensuring that we are garnering a holistic perspective of the systems, identities, other individuals, etc., that impact the co-researchers (Dickie et al., 2006).

Analyzing underpinning philosophical and theoretical approaches in creating and applying the themes and recommendations within the study were important in contextualizing the study results with regards to other current literature and their implications for personal application. The influence of these applied (and non-applied) lenses should be considered by the reader as they engage with the application of the findings, which are explored next. This decision-making process within the study also has implications for our future research, practice, and advocacy efforts. Like other scholars in the field of OT (Duncan, 2011, pp. xi-xii; Turpin & Iwama, 2011) I recognize the value of our professional OS and OT professional theories, models, frameworks, and foundational texts in guiding our practice, demonstrating our professional body of expert knowledge, and providing the scaffolding for generating new knowledge. While holding this shared belief (Duncan, 2011, pp. xi-xii; Turpin & Iwama, 2011), I also want to use my experiences within this study in assessing the applicability of the PEO model to urge caution for practitioners, academics, and advocates in avoiding a steadfast focus on solely engaging with and utilizing OT profession-specific conceptualizations in our approach to knowledge-building, practice, research, and advocacy efforts.

Being personally and professionally humble and committed to continuous learning means setting aside our professional constructs when we reflexively determine with those we

serve that these conceptualizations do not adequately encapsulate the needs or interests of the person or community. Another important step includes reflecting on why we chose a specific construct in the first place. In the case of this study, given my professional practice experience in using PEO and familiarity with the study topic, I felt well-versed in applying the model's tenets and constructs (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011); additionally, I perceived that the PEO model helped to provide order and focus across the topics of discussion included in the Photovoice workshop session materials and interview questions. Within and outside of this dissertation work, as we continue to critique our approaches through critical dialogue across our scholarship, practice, and advocacy work, we are contributing to growing occupational science in "questioning the familiar and exploring the unfamiliar" (Laliberte Rudman, 2014, p. 380, 2019, p. 167) and challenging the "dominant modes of thought and structures" (Laliberte Rudman, 2014, p. 383; Gane & Back, 2012, as cited by Laliberte Rudman, 2014, p. 383; Laliberte Rudman, 2019, p. 167; Gerlach et al., 2018, Laliberte Rudman & Dennhardt, 2015, as cited in Laliberte Rudman, 2019, p. 167). In practice, I believe this can manifest in actively seeking and engaging with differing epistemological approaches, theories, models, and frameworks across professions and tactics (e.g., Queer Theories (Butler, 1999; Jakobsen, 1998; Love, 2011; Macuch, 2017; McCann & Mohaghan, 2020) and Women's Standpoint Theory (Andersen, 1983; Carastathis, 2014; Collins, 1986; Haraway, 2004; Harding, 1983; Harding, 1991; Harding 2004a; Harding 2004b; Harding, 2004c; Heldke, 1998; hooks, 1989; Jaggar, 2004; Lugones & Spelman, 1983; Reid & Frisby, 2008; Sandoval, 2004; Sholock, 2012)) to infuse our current ways of meaning-making and bodies of

knowledge with reflexive, refreshed lenses (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019).

Sometimes there may not be a clean or neat replacement theory, model, framework, etc. to apply in conceptualizing a health phenomenon or personal client experience, and that's where we can create wholly new constructs, or pull from multiple approaches to innovatively examine the phenomena of interest (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019). Within this study, challenging my assumptions and applications of the PEO model (Law et al., 1996; Strong et al., 1999; Strong & Rebeiro-Gruhl, 2011) allowed for a richer data analysis experience and findings that (it is my hope) better uphold the lived realities of the women who engaged in this dissertation work. Ensuring that we are exploring how individuals operate within and are shaped by the systems and people the engage with, including through how we structure our research findings, is critical to the expansion and application of occupational science in engaging with those we serve (Dickie et al., 2006).

Analysis of the Findings

When engaging with the study findings and putting them into action, we need to avoid applying the results to all SMW, given that this study was conducted within the United States, with women who do not represent all regions of the country (Kiepek et al., 2019). We must be cognizant that this study constitutes only one piece of the continued knowledge-building process surrounding SMW's lived experiences with substance use in emerging adulthood (Haraway, 2004). With that, we can now examine the study results as they compare to other current knowledge in this area of study.

Demographics Analysis

In assessing the co-researchers' demographic makeup, there are numerous factors to probe more deeply. While the study included more women co-researchers who identified as Black than those with other racial identities, white study populations can often be a primary focus of such substance use research as it intersects with race, gender, and sexual identity, making this a critical study in uplifting Black women's voices (Mereish & Bradford, 2014). Within the study, co-researchers also identified themselves across a broad spectrum of ethnicities. The co-researchers' socioeconomic brackets were fairly split, with seven women placing within the middle-income bracket of the U.S. middle class socioeconomic tier, and five placing below the lower middle-class income bracket, according to the U.S. Bureau of Labor Statistics (2023c). For some, discussions of financial challenges related to balancing substance use and other needs were tied to their reported socioeconomic bracket. When examining education, more than half of the women who disclosed their highest degree completed had finished an undergraduate degree, meaning that most co-researchers were completing a secondary degree at the time of the study. This increased representation within secondary degree seekers is a departure from other current research exploring the substance use experiences of SMW in higher education, which often focus primarily on undergraduate-level individuals (e.g., Griffin et al., 2022; Kollath-Cattano, 2020; C. Lee et al., 2016).

This study did not compare the differences in lived experiences between sexual minority and heterosexual women regarding substance use, meaning we cannot juxtapose use types and rates reported within this study to previous comparisons. In keeping with prior research on SMW's substance use patterns (Karriker-Jaffe et al., 2022; Rosner et al., 2021), most of the co-researchers described using alcohol as a preferred substance, quickly followed by marijuana.

Fewer co-researchers reported using substances like cocaine and heroin. The frequency of co-researcher's weekly and monthly use was also fairly evenly distributed across both spans of time. While it may be tempting to categorize reported rate of substance use through clinical definitions such as binging, harmful use, etc., I urge us all to return to the shared experiences of the women in the study in honoring their definitions of substance misuse and the personal effects of their substance use, including the good and bad.

Deeper Thematic Reflections. For the co-researchers, delineating personal substance use and defining substance misuse often included varying descriptions of exerting personal control over one's use. This recognition of substance misuse and the perception that use can (and at times can't) be controlled is supported in previous literature (Decorte, 2001; Nhunzvi et al., 2019). As early as 2001, researchers recognized the juxtaposition between oft-applied clinical classifications of substance misuse ("any use of an illicit drug"), and actual social perceptions of patterns surrounding substance use (Decorte, 2001). Similar to Decorte's (2001) and Nhunzvi and colleagues (2019) findings, co-researchers described various factors that led to their feelings of control (or lack of control) over their use that were non-dependent on clinical definitions of overuse.

In keeping with prior research (Ioannides, 2021; Nhunzvi et al., 2019), for co-researchers who felt that their substance use was currently out of their control, those who chose to exert specific control over their use, and those who had chosen to decrease their use recently, decisions to exert or re-exert control were connected to numerous drivers. These included a desire for increased well-being, wishing to prevent or move away from one's dependency on a substance or substances as a coping strategy, and recognizing parent's or

friend’s harmful substance use. The recognition of the significant impact of perceived personal control of use and social use norms on planned patterns of substance use has been corroborated in previous research (Nhunzvi et al., 2019; Orbell et al., 2001) and warrants more consideration in how we as researchers, academics, and practitioners apply the terms ‘harmful use’ and ‘substance misuse’ to others’ use, particularly when the people we serve may be using personal perspectives of control and social norms to serve as benchmarks in evaluating their use (Decorte, 2001; Ioannides, 2021; Nhunzvi et al., 2019; Orbell et al., 2001).

In addition, we should be careful in assuming that one’s perceived current lack of control over their substance use can be singularly tied to “deficient” self-regulatory skills and center this as our primary focus in therapeutic services, as called for in previous research (Bakhshan & Hossienbor, 2013). Co-researchers within the study described a spectrum of substance use and personal coping strategies, with periods of non-harmful and harmful use, and strategies for managing emotions and stressors that did and did not include substance use. Co-researchers were also well versed in the negative effects of substance use and could identify how these effects impacted their daily functioning, similar to prior studies (e.g., Decorte, 2001). This indicates that while some may require education on the effect of substance use and collaborative building and enhancing of self-regulatory skills, these areas should not be the sole focus of support services, including occupational therapy.

Exploration with individuals regarding perceptions of control and lack of control over substance use should be handled with thoughtfulness. Conversations where one’s personal perceptions of their substance use may be at odds with what practitioner-recognized behaviors (e.g., misuse, abuse, dependency), may benefit from practitioner-incorporated motivational

interviewing (MI) techniques that include discussing and affirming an individuals' control of their substance use (Miller, 2005, as cited in Moyers & Martin, 2006; Moyers & Martin, 2006). Using MI, the practitioner and person being served can collaboratively explore whether the individual might desire to change their substance use behaviors, and if so, where they might be within that change spectrum (Moyers & Martin, 2006). Personal control of substance use receives explicit focus within the discursive process (Moyers & Martin, 2006). When serving someone who may not have extensive knowledge of the relationship between substance use and their personal health, MI techniques demonstrate promise as an intervention approach (Dülger, 2023).

Co-researcher perspectives on the role of substance use within the queer community at both a communal and personal level corroborated and enhanced previous literature denoting the common connections between queer social and community spaces centering on substance use consumption (Faderman, 1991; Felner et al., 2020). This included focus on those in the emerging adulthood period of life (Demant et al., 2018). Events such as Pride were described as inherently linked to substance use by the co-researchers, which is unsurprising, given the targeted marketing and sponsorship of substances such as tobacco and alcohol at Pride events (Spivey et al., 2018) and the previously described link LGBTQIA+ celebratory events and substance use (Felner et al., 2020).

The co-researchers described multiple purposes for their substance use within queer spaces, including using to feel increased comfort and acceptance within the community, using as a coping strategy for managing sexual identity discrimination, and using to build social relationships, amongst other factors. Aside from specific discussions related to substance use in

queer spaces, when exploring the relationship between substance use and socialization, previous populations have described a similar spectrum related to substance use in serving a dual role as a tool for social connection *and* isolation (Wasmuth et al., 2014). Again, these reasons for use are in keeping with other recent literature exploring SM and SMW-specific experiences surrounding substance use in queer spaces and point to the multifaceted role substance use plays within the community (Chow et al., 2013; Demant et al., 2018; Gruskin et al., 2007), including specifically in emerging adulthood (Felner et al., 2020).

A specific topic related to one's perceptions of "passing" within the LGBTQIA+ community included gender and sexual identity expression. For one co-researcher in particular, concerns over attaining the acceptance of other peers in the queer community (and subsequently feeling welcomed within queer spaces) were related to their partner's gender identity as it intersected with the co-researcher's sexual identity. Additionally, this conversation included focus on the co-researcher's gender identity expression as it intersected with her sexual identity and feeling acceptance. While often, conversations regarding "passing" relate to how one expresses physical and behavioral attributes that are socially contrived surrounding gender binaries (man and woman) (Pfeffer, 2014), within this study, concerns about the co-researcher's physical gender and sexual identity expression in "passing" were more closely related to acceptance from others in the queer community.

Concerns of being "(mis)-recognized" as "heteronormative" by individuals with varying sexual and gender identities, including those in partnerships with another person with differing identities, have been voiced before in navigating one's place in the queer community (Pfeffer, 2014) and the desire to avoid becoming an "invisible" member (N. Brown, 2009). For this co-

researcher, making changes to their physical appearance strengthened their feelings of belonging to the queer community and goal to prevent social questions regarding their sexual identity and belonging within queer spaces. In understanding the importance of "passing" in gaining acceptance from others within the queer community, it is critical to return to our appreciation that negative social reactions to how one expresses their gender identity can affect SMW and how they experience stress (Herek, 1995), with these stressors being linked to potentially harmful substance use (Lehavot & Simoni, 2011).

Minority Stress Theory. In addition to potential challenges to one's acceptance within the queer community (N. Brown, 2009; Pfeffer, 2014; Herek, 1995; Lehavot & Simoni, 2011) described by one co-researcher, minority stress theory (Brooks, 1981; Meyer, 2003) can be applied in making sense of other stressors, stigma, and discrimination explored by the women in the study. Co-researchers detailed numerous stressor sources as negatively influencing their substance use decision-making, including instances of broader social discrimination from peers and unfamiliar persons that led to feeling unsafe. Additional stressors included feeling responsible for educating others on and defending one's sexual identity, and an overall lack of experienced social respect. Such discrimination (including discrimination within interpersonal relationships) has been described as leading to increased substance use across sexual minority groups, including women with varying sexual identities (Krueger et al., 2020).

Specific attention was paid by the co-researchers to the intense internal challenges that came from clashes between their sexual identities and substance use, with the beliefs of their religious affiliations, and subsequently their family members. For some co-researchers, religion, specifically Christian religious sects, played an important role in their self-identity and

relationship with family members (with focus often placed by the co-researchers on parents). A lack of religious acceptance of sexual identity, and in turn, parental acceptance, was tied to feeling a dearth of support, hiding one's substance use, and strife and estrangement from family. While personal religiosity has been found to be a protective factor regarding substance use for emerging adults (Palamar et al., 2013), it is important to note that this mediating relationship has been found with heterosexual women, as opposed to SMW (Drabble et al., 2016). Religiosity and spirituality have also been linked to potentially increasing the risk of harmful substance use for SMW (Drabble et al., 2022). This negative interaction between religiosity and substance use for SMW may be attributed to many of the experiences that the co-researchers described, including religious-based discrimination, feelings of separation from others in one's religious group, and strife within interpersonal relationships due to religion (Wilkinson & Johnson, 2020) (including familial relationships (Cerezo et al., 2020)). This is not to say that personal religious practices have not been found to be helpful in coping with discrimination derived from being a sexual minority (Brewster et al., 2016); the co-researchers simply did not focus their discussions on such experiences.

In addition to familial relationship challenges and personal harmful substance use related to religious discrimination, the co-researchers detailed numerous other aspects of familial relationships in impacting their substance use and perspectives on sexual identity. Similar to previous findings, co-researchers described a lack of parental and extended family support related to their sexual identity that resulted in stress and feelings of guilt (Puckett et al., 2015) leading to the use of substances as a coping mechanism (Felner et al., 2020; Rosario et al., 2014). Parental experiences surrounding substance use and mental health challenges were

noted as well. This included discussions of some co-researcher's introduction to substance use by a parent, observing a parent using with harmful results, and observing a parent's struggle with mental health.

For some, parental introduction to substances as an adolescent resulted in continued use of said substance(s) in emerging adulthood, while for others, these experiences resulted in increased intentional control of substance use as an adult. Current literature suggests that adolescents' personal perspectives on and use of substances are influenced through observing the substance use patterns of their parents, particularly misuse (McLaughlin et al., 2016). There have also been ties between maternal substance misuse and increased risk for alcohol misuse in young adulthood (Yule et al., 2018), with a decreased risk of using "hard drugs" over time for adolescents with strong maternal relationships (Branstetter et al., 2011). While outside the scope of this work, a deeper exploration into the impact and mediating relationships between SMW's substance use, parental and familial substance use behaviors, and adverse childhood experiences (ACEs) would be worthwhile, in considering the link between experiences with multiple ACEs and developing harmful substance use patterns in emerging adulthood (Shin et al., 2018).

Additional stressors pertaining to healthcare access experiences were described across the co-researchers, specifically regarding sexual identity and substance use behaviors. Co-researchers' descriptions of healthcare provider stigma regarding sexual identity and personal substance use are in line with previous reports of healthcare provider discrimination and subsequent sexual minority stress that can result in further harmful substance use (Abrahão et al., 2022; Slater et al., 2017). The co-researcher's descriptions of their awareness of, personal

experience with , or witnessing of discrimination from providers based on sexual identity and substance use was tied to a decreased desire to access the spectrum of healthcare services, similar to previous reports from sexual minority individuals (Whitehead et al., 2016). Additionally, a lack of feeling comfortable in being “out” with one’s healthcare provider has negative implications for disclosing substance use (Klitzman & Greenberg, 2002).

Finally, co-researchers did not place an explicit, consistent focus on how their sexual identity and substance use intersected with their student roles (or age) across the interviews or Photovoice workshop sessions, which may be due to a multitude of personal factors. Given this lack of co-researcher focus, less emphasis is placed on detailing the implications of the student role within the dissertation. Despite this, the co-researchers did describe the varied social acceptability across substances according to their collegiate peers. This spectrum of social acceptability amongst college-aged students regarding differing substances (Kollath-Cattano et al., 2020) and perceived levels of harm across substance types (Lipari & Jean-Francois, 2016) have been documented in prior work (Kollath-Cattano et al., 2020; Lipari & Jean-Francois, 2016); these findings indicate that collegiate students may consider some substances more harmful and socially used than others, and that this perception directly relates to one’s personal use choices. Additionally, of note, Mackert and colleagues’ (2014) study suggests that the more experience students have with substance misuse, the less likely they are to hold stigmatized perspectives regarding substance use. The co-researcher's descriptions of student-based discrimination and these findings point towards a potential need for increased education in the emerging adulthood period regarding substance use and misuse in preventing discrimination-based stressors for those experiencing harmful use (Mackert et al., 2014).

The unique challenges that sexual minority individuals navigate in emerging adulthood (Felner et al., 2019) and the general social discrimination related to sexual identity described by the co-researchers can serve as additional stressors that SMW must navigate, and can influence substance use behaviors negatively (McCabe et al., 2010; Rosenthal et al., 2023). Given that many of the experiences described by the co-researchers align with the lens of Minority Stress Theory (Brooks, 1981; Meyer, 2003), this theory may be helpful in conceptualizing the intersection between personal standpoints and larger social systems when looking to explore SMW's experiences with substance use and misuse more deeply.

The Role of Occupational Science and Therapy. Within the study activities, the co-researchers described the phenomenon of substance use as both an occupation itself (Helbig & McKay, 2003; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014) and influencer of others (Helbig & McKay, 2003; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2020a); in keeping with the works just noted. This nuanced perspective on substance use is one that we as occupational scientists and practitioners are uniquely situated in addressing (Stoffel & Moyers, 2004) given our understanding of the person as an "occupational being" (Yerxa et al., 1990), and our emerging recognition of the complex systems that effect substance use (Godoy-Vieira et al., 2018; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014). In concurrence with previous findings, co-researchers described substance use as an embedded part of their daily routines (Hocking, 2020; Guyonnet et al.,

2023; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2020a; Wasmuth et al., 2014), with intentional planning surrounding how and when they used. As with previous disclosures regarding personal substance use, substance use during the day could be purposeful as a coping strategy and could result in social isolation (Nhunzvi et al., 2019; Vegeris & Brooks, 2022; Wasmuth et al., 2014).

Some co-researchers explained that engaging in substance use had replaced other important identified occupations, while others felt that their use of substances was needed to make it through the day, a sentiment that has been voiced by others (Guyonnet et al., 2023; Nelson, 2023). As previously noted, substance use was also strongly connected by the co-researchers (and in prior work (Chow et al., 2013; Demant et al., 2018; Gruskin et al., 2007; Macuch, 2017)) as an inherent part of the queer community (with both positive and negative aspects described within the connection), warranting further exploration as to the influence of substance use as an occupation and influencer of others on the collective and individual identities of sexual minority individuals within the queer community (Hocking, 2020; Twinley, 2020b, p. 7). These descriptors of substance use within daily contexts point towards its role as a stand-alone occupation at times, warranting support services that acknowledge the role that use can play within one's daily routine and identity and explore what use looks like to each person (Helbig & McKay, 2003; Hocking, 2020; Kiepek 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b, p. 7; Wasmuth et al., 2014).

Co-researchers aligned with previous research study populations across research in detailing their choice to use various substances to affect other occupations: co-researchers'

relationships between substance use and other occupations included using to enhance or facilitating sexual intimacy (Kiepek, 2016, p. 12; Kiepek et al., 2019; Rosner et al., 2021), to be more social with peers (Borsari & Carey, 2001), and to facilitate increased perceived creativity across needed tasks (M. D. Newcomb et al., 1988). Co-researchers also identified how their substance use negatively impacted their ability to engage in other occupations in ways denoted in previous research, including challenges with exercising (Stamates et al., 2022), and academic motivation (Phillips et al., 2015) amongst others. These findings enhance our profession's current understanding of substance use as both an occupation (Helbig & McKay, 2003; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b; Wasmuth et al., 2014) and influencer of others (Helbig & McKay, 2003; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2020a), particularly through the lens of SMW who are positioned in the queer community.

As scientists and therapists, not only must we recognize the fluid nature of substance use (Helbig & McKay, 2003; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Twinley, 2020a), but the larger social and personal systems at play that influence personal use (Godoy-Vieira et al., 2018). Shaping and broadening our imagination of the multifaceted nature of substance use helps us to push back against traditionally held perspectives on use and misuse within the profession while personally and professionally growing (Farias & Rudman, 2016; Godoy-Vieira et al., 2018; Laliberte Rudman, 2014, 2019). Given co-researchers' shared perspectives and their

intersection with previous findings, we as practitioners need to be entering every study, educational offering, service encounter, interprofessional interaction, and advocacy opportunity with an awareness and addressment of these personal and systemic factors.

Current evidence-informed research that addresses occupational therapy's scope of services are available (e.g., Amorelli, 2016; Doğu & Özkan, 2023; Ryan & Boland, 2021), including support services focused on women (Leppard et al., 2018). These resources offer valuable tools for approaching and addressing misuse, though they place focus on individual substance use factors rather than collective, societal systemic factors that impact personal use (Doğu & Özkan, 2023; Leppard et al., 2018; Ryan & Boland, 2021). In reflecting on the scope and state of the OT profession's current addressment of substance use, a challenge outlined in the literature includes OT students (OTS) receiving notably varied levels and types of education regarding mental health (and subsequently substance use) (Egan & Cahill, 2017), with OTSs also reporting a lack of desire to work with individuals with substance use disorders (Mattila & Provident, 2017).

Given these factors (Egan & Cahill, 2017; Mattila & Provident, 2017), it is natural that issues in addressing substance use and misuse translates from education to practice, as evidenced by work such as Mattila and colleagues' (2022) recent research. Mattila and colleagues' (2022) research points towards the significant gap in knowledge that OT practitioners have surrounding substance use-directed care. Similarly, Thompson's early 2007 study also demonstrated the notable dearth of OT providers' knowledge and assessment of substance use across settings, and a study as recent as 2019 by Hildebrand and Boerding on commonly used substance use assessment tools concluded with a call to expand our substance use assessment outside of behavioral health settings, given the prominence of substance misuse. Another recent study

implementing a scoping review of OT interventions highlighted the need for increased research on the efficacy of OT interventions for substance misuse (Ryan & Boland, 2021). These findings (Egan & Cahill, 2017; Hildebrand & Boerding, 2019; Mattila & Provident, 2017; Mattila et al., 2022; Ryan & Boland, 2021; Thompson, 2007) demonstrate that across the OT profession spectrum, from student to practitioner, and from assessment to treatment, we are not meeting the needs of those who use substances.

I think that it is telling that while multiple women in this study reported receiving occupational therapy services across differing settings, the co-researchers demonstrated difficulty articulating the specific role of OT within their care experiences and the focus of OT services. Similar to our ability to address the span of substance use across care settings (e.g., Amorelli, 2016; Davies, 2006; Doğu & Özkan, 2023; Kiepek, 2016; Stoffel & Moyers, 2004), so too are we able to facilitate critical discussions on sexuality and sexual intimacy as they intersect with daily functioning *when we choose* to provide platforms for these discussions with the people we serve (N. Rose & Hughes, 2018). In addition to general barriers in discussing substance use and misuse across clinical settings (e.g., (Egan & Cahill, 2017; Hildebrand & Boerding, 2019; Mattila & Provident, 2017; Mattila et al., 2022; Ryan & Boland, 2021; Thompson, 2007), current research points to multiple impeding factors in adequately addressing the sexual identity needs of SMW and other SM populations (Bolding, et al., 2022; Nowaskie et al., 2020; Willey et al., 2023; Young et al., 2020). Recent findings include the tie between practitioner religiosity and decreased adeptness and awareness of SM needs, a dearth of practitioners outside of behavioral health settings who feel comfortable addressing these factors in entering the profession (Bolding et al., 2022), and general reports of lacking knowledge surrounding sexual health of the queer community (Young et al., 2020). These findings are

unsurprising, as OTSs are reporting that they do not feel clinically prepared to incorporate discussions on sexual identity in to care (Nowaskie et al., 2020), and there is a paucity of critical research examining OT program curriculum surrounding sexual and gender identity services (Willey et al., 2023).

The care (or lack of) we provide SMW and other populations surrounding substance use and sexual identity, are also further impeded by the stigma pertaining to substance misuse (Earnshaw, 2020; van Boekel et al., 2013) and serving sexual minority individuals (Ayhan et al., 2020; Cochran et al., 2007). There can be numerous reasons for healthcare provider discriminatory practices, including influences from one's religious and personal belief systems, and lacking experience addressing factors such as sexual identity (Ayhan et al., 2020). In tackling gaps in OT practitioner and other healthcare provider knowledge *and* internalized stigma surrounding substance use and sexual identity, increased education on these topics and opportunities for working with individuals with differing identities is key (Ayhan et al., 2020; Howard et al., 2010).

There are numerous tools and approaches we as a profession can use in increasing our education surrounding substance use and sexual identity, addressing our personal stigmatized views, and improving the care we are providing. From an educational perspective, increasing opportunities for learning about effective addressment of substance use and sexual identity while incorporating materials such as motivational interviewing regarding substance use patterns (Shannon, 2015; Stoffel & Moyers, 2004), screening, brief intervention, and referral to treatment (SBIRT) (J. Brown et al., 2024; Mattila & Provident, 2017; Scudder et al., 2021), and incorporating directed sexual-identity-based curriculum (Larson & Stutz, 2014) into OT program curriculum are imperative. The potential for translating specialized substance use (Mattila et al.,

2022) and sexual identity-based trainings (Young et al., 2020) in greater detail into continuing education forums also warrants discussion. Opportunities for specialized fellowships (Johns Hopkins Medicine, n.d.; U.S. Department of Veterans Affairs, 2023), shadowing and fieldwork opportunities (e.g., Precin, 2007), mentorship from expert practitioners (Johns Hopkins Medicine, n.d.; U.S. Department of Veterans Affairs, 2023), and training on implementing SBIRT (J. Brown et al., 2024; Mattila & Provident, 2017; Scudder et al., 2021) in one's system or setting could also serve as valuable strategies for practitioners to grow their skillsets in supported environments that promote hands-on learning experiences. To accomplish this, greater priority for supportive funding, programming, and inter-collaboration across our profession and professional organizations is needed. Grounding the approaches just mentioned in broader, emancipatory discussions that include focus on the systemic factors that impact substance use and sexual identity and empower individuals as change-makers (Godoy-Vieira et al., 2018; Spiegel et al., 2015), and providing opportunities for students', practitioners', policy makers', and advocates' personal reflection and identification of gaps in knowledge, personal standpoints (Harding, 2004a), and internalized biases and stigma also serve as needed measures.

When looking to address substance use more broadly within the societal and clinical spheres, OT practitioners can benefit from using a strengths-based approach (Sargent & Valdes, 2021). Based on the findings from this work, application of this approach (Sargent & Valdes, 2021) could include harnessing supports that SMW may possess as described by the women in this work, including incorporating "found" and "chosen" family (Hull & Ortyl, 2019) into plans for addressing harmful substance use, building on women's knowledge of their substance use patterns and positive and negative outcomes from use, recognizing the importance of substance use in creating a space for oneself within the queer community, and utilizing coping

strategies that women have be identified as helpful in addressing stressors and difficult emotions. Active recognition of the impacts of social systems issues on substance use such as poverty (Walker & Druss, 2017), ableism (Robb, 2015), racism (Farahmand et al., 2020), sexism (Scheer et al., 2022) and colonization (Laenui & Williams, 2022) must be incorporated into addressing substance use as well.

Finally, in coming to our education, service, and advocacy regarding SMW who use substances (and others), we must uphold the co-researcher recommendations to practice with love. While the concept of enacting love in our work can be difficult to define or quantify, recognizing and addressing when we might feel "irritation" (Mattila et al., 2022) in working with individuals who are experiencing harmful substance use is critical. In gathering resources related to practicing with love, I feel that Höppner et al. (2019) and Sena (2022)'s works are also potentially important sources to engage with in evaluating and addressing the role of love in our practice. Consideration as to how love might operate and manifest itself within the modes of engaging with others through our commonly applied concept of "therapeutic use of self" (Taylor, 2020), or across personal "love languages" (Folkens & Roberts, 2019) may also serve as fruitful endeavors for better defining and applying love within our practice (though additional research regarding these hypotheses is needed). As illustrated, the resources, spaces for reflection, and opportunities for enacting these needed changes within the profession are present; we as a profession, at the individual and group levels, need to decide that substance use and sexual identity are two inherently critical pieces of the puzzle in coming to know the people we serve in a truly holistic way.

Recommendations

I have noted potential actionable next steps that those across the OS and OT professions can consider and implement in applying the study findings to our work, in ways that build from co-researcher recommendations. Going forward, I argue that there is a need for:

- Continuing to personally reflect on and engage in research and scholarship that expands and challenges our current professional conceptualizations of substance use and misuse, thus expanding our occupational science (Farias & Laliberte Rudman, 2016), and imagination regarding substance use and misuse (Laliberte-Rudman, 2014, 2019) and improving the care we provide to those we serve. This could be addressed through:
    - Expansion of this dissertation work with SMW and other populations of women (e.g., older women, adolescents, etc.) and addressing the future trajectories of research (which will be explored next).
    - Continuing to support and build from the work of scholars in our field who call for new ways of perceiving and addressing substance use (e.g., Helbig & McKay, 2003; Hocking, 2020; Kiepek, 2016; Kiepek et al., 2019; Kiepek et al., 2022; Nhunzvi et al., 2019; Nhunzvi & Galvaan, 2020; Stoffel & Moyers, 2004; Twinley, 2013, 2020a,b;Wasmuth et al., 2014).
    - Evaluation of the validity and community member acceptability of profession-based tools such as the occupational profile (American Occupational Therapy Association, 2020) and targeted screening and

assessment instruments (e.g., The Role Checklist (Scott et al., 2017) SBIRT (J. Brown et al., 2024; Mattila & Provident, 2017; Scudder et al., 2021) in addressing substance use across OT settings (Rojo-Mota et al., 2017). This need extends to further detailing our role as OT practitioners in addressing substance use (Doğu & Özkan, 2023) and the effectiveness of interventions targeted at addressing substance use and misuse (Ryan & Bolland, 2021).

- Increased emphasis in OT program education (and Accreditation Council for Occupational Therapy Education (ACOTE) standards (ACOTE, 2024)) should be placed on ensuring that the standards promote the incorporation of evidence-informed approaches to addressing substance use such as SBIRT (J. Brown et al., 2024; Mattila & Provident, 2017; Mattila et al., 2022; Scudder et al., 2021), and motivational interviewing (Moyers & Martin, 2006; Shannon, 2015; Stoffel & Moyers), etc.) across settings, with additional emphasis on examining the personal and societal-level influences of substance use; this call extends to addressing sexual identity (Criniti et al., 2016; Duran & Valdes, 2021; Eglseder et al., 2018).
    - This process entails assessing and potentially amending our current ACOTE standards (ACOTE, 2024) (or engaging in deeper assessment and addressment regarding how the standards are consistently enacted across OT program curricula (as noted by Egan & Cahill, 2017 in addressing mental health)) to better encapsulate holistic practice that recognizes the impact of substance use and sexual identity on everyday functioning.

- Additional steps should also include targeted curriculum surrounding substance use and sexual identity across OT preparatory courses given gaps and challenges in provider knowledge and addressment of substance use (Egan & Cahill, 2017; Hildebrand & Boerding, 2019; Mattila & Provident, 2017; Mattila et al., 2022; Ryan & Boland, 2021; Thompson, 2007):
    - Such educational materials and class activities should be generated and carried out in collaboration with individuals who have experience with harmful substance use, and those who are a part of the queer community, in acknowledging the "nothing-for-us-without-us" approach, applied by Wang and colleagues (1996) (Bandauko & Arku, 2023).
    - Consideration should be placed in incorporating broader "emancipatory" education in OT programs on social, systemic factors in conceptualizing health factors including substance use and identities (Godoy-Vieira et al., 2018; Restall & Egan, 2019; Spiegel et al., 2015).
    - Course activities and assignments surrounding personal reflexivity processes in practice should be carried out with students in promoting the continuation of these practices as students become practitioners, advocates, academics, etc. (Di Tommaso, 2020, pp. 169-170).

        - Provision of advanced, hands-on educational opportunities for practitioners to continue to hone clinical skillsets surrounding substance use and sexual identity should continue to be made available, including through current fellowship and mentoring opportunities (e.g., Johns Hopkins Medicine, n.d.; U.S. Department of Veterans Affairs, 2023), SBIRT trainings as potential offerings (e.g., J. Brown et al., 2024; Mattila & Provident, 2017; Mattila et al., 2022; Scudder et al., 2021) and opportunities within fieldwork (e.g., Precin, 2007).

- Incorporation of safe space signage and inclusive language should be consistently applied in service environments and OT educational programs per co-researcher identified benefits. Please see Caroline's Photovoice piece in Chapter 6 (Figure 6.8) and Lee and Kanji's (2017) "Queering the Health Care System: Experiences of the Lesbian, Gay, Bisexual, and Transgender Community" article for potential ideas for signage.
- Active examination and addressment by OT practitioners across the various domains of practice, teaching, advocacy, and administration surrounding personal and professional views and practices in addressing substance use and sexual identity (Farias & Laliberte Rudman, 2016; Laliberte Rudman, 2014, 2019):
    - This includes assessment of personal and system-based policies and approaches for creating safe spaces for those experiencing harmful substance use, individuals who are racial minorities, members of the queer

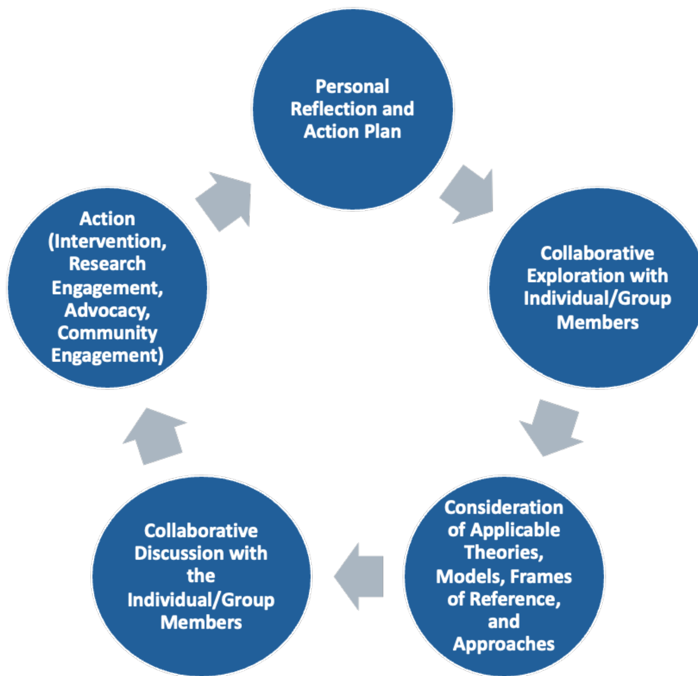
community, individuals with disabilities, etc. (Leclair et al., 2019; Restall & Egan, 2021).

- Application and incorporation of philosophical, theoretical, and framework approaches to our research, practice, education, and advocacy that promote reflexive practices and firmly recognize and explore the differing and intersecting standpoints, experiences, and perspectives we share (Kinsella & Whiteford, 2009; Perryman-Fox, 2020).
- Openness to recognizing when our chosen underpinning OT practice theoretical and framework constructs do not comprehensively meet the needs or experiences of the people we serve, including a commitment to exploring new avenues of shared knowledge building (Maclean et al., 2012).

In providing a potential resource for addressing the final three recommendations just noted, I propose the following cycle (shown in Figure 7.1), which can be used across programs, systems, and roles within OS and OT. While I will use substance use and sexual identity as topics to guide an example of how this cycle might be carried out, this approach can potentially be applicable to other health factors and is informed by the participatory action research process (McIntyre, 2008).

Figure 7.1

A Reflective, Imaginative, Transformation Process in Occupational Science and Therapy



Personal Reflection and Action Plan: We start our cycle at the personal reflection and action plan stage. In imagining that we are a practitioner who is looking to conduct research into the community needs of SMW who attend their program and use substances, the practitioner may begin by considering the queries and inter-relationships explored in Figure 2.2 in Chapter 2. This could take place via internal reflection, journaling, discussion with colleagues, etc. After identifying the impact of potential biases and one's lived experience on the research process and interactions with others, the practitioner could create a brief written (or internal) action plan for how they intend to consistently address these factors.

Collaborative Exploration with Individual/Group Members: Next, the practitioner meets with women in the community who access the program to gain a greater sense of their experiences, needs, and perspectives on the research process. Discussions of community member

engagement in the process as collaborative experts (McIntyre, 2008) take place, including the outlining of roles, program/community member expectations, privacy measures, etc.

Consideration of Applicable Theories, Models, Frames of Reference, and Approaches: From there, both personally and collaboratively, the practitioner can explore potential applicable theories, models, frames of reference, and approaches to the research to find what is most acceptable to the women who will be engaging with the practitioner (Maclean et al., 2012). The practitioner can call upon OS and OT-based sources, as well as models, approaches, etc., from outside the profession depending on what women feel is most important. Ultimately, new models, theories, and approaches can be created or combined based on women's ideas and needs. There is the potential for collaboration with other professions (e.g., social work, public health, physical therapy, etc.) based on community-member identified perspectives and needs.

Collaborative Discussion with the Individual/Group Members: Next, the practitioner will establish with the women (and any other persons of interest identified across the previous steps) the formal research process and how the chosen guiding underpinnings will be applied. This step can be revisited after the next step if needed. In this case, potential community members determine what they would like to explore, what community spaces and supports are available to SMW regarding substance use, and what they would like to examine regarding how this specific OT program (and facility) is connecting women to these resources.

Action (Intervention, Research Engagement, Advocacy, Community Engagement): The research is carried out as determined by all parties. Assessment of and updates to the research protocol are made by the practitioner and community members as needed. Within this example, community members and the practitioner may create a formal process for reviewing whether an organization, space, group, etc., constitutes a queer-friendly/queer-directed substance

use support for women, and work towards creating a database. Examination of current program practices surrounding referrals and compiling notes and program resources can also be conducted. Analysis of the findings could be carried out in numerous ways, with dissemination methods determined by the women who are participating (McIntyre, 2008). Across this process, emphasis should be placed on considering how the study, intervention, advocacy work, etc., can be applied or enacted across the larger community or systems in working towards a transformative approach (Godoy-Vieira et al., 2018; Mertens, 2009; Mills, 1959; Spiegel et al., 2015).

Personal Reflection and Action Plan: In returning to this step, the practitioner could review Figure 2.2 to examine whether their perspectives, biases, and experiences were changed given engagement in the research process (Laliberte Rudman, 2014, 2019). Review of the research process and outcomes could include formal measurements and processes, or internal or written reflection. Creating an action plan regarding next steps, including study expansion, additional dissemination efforts, changes to one's practice, etc., could also take place.

Dissemination of Findings

The findings from this study have been and will be disseminated across varying spaces. The co-researchers who completed the Photovoice workshop portion of the study had the ability during the workshop sessions to determine what community parties they wished to share their Photovoice pieces with and did so through a virtual Photovoice gallery, which served as an initial dissemination of the Photovoice pieces within the study.

In addition to the co-researcher Photovoice gallery and publication of this dissertation work, specific publications that focus on the applied reflexivity study practices, the guiding framework applied to the research, the study methods, and the research findings will be

disseminated. Emphasis will be placed on sharing these results through OS and OT-based journals to reach practitioners and OT administrative personnel, including the American Journal of Occupational Therapy, Canadian, British, and Australian Journals of Occupational Therapy, Occupational Therapy in Mental Health Journal, Occupational Therapy in Health Care Journal, Journal of Occupational Science, etc. Qualitative journals such as the Qualitative Research Journal, and Qualitative Research in Health journal will be considered for dissemination regarding the study methods as well. I will also apply to professional conferences to further enhance the dissemination of findings, such as the American Occupational Therapy Association (AOTA) Inspire annual conference, World Federation of Occupational Therapists (WFOT) Congress, AOTA's annual Mental Health Specialty conference, and qualitative research conferences.

Within my own practice and research, I commit to implementing the findings across my roles as a research, educator, practitioner, and advocate. Within my teaching within OT programs, I look forward to collaborating with students to identify strategies and interventions for addressing substance use and sexual identity regardless of their practice setting. Within these discussions, I will include reinforcement for students that they can serve as advocates within their own career trajectories as well. Within both my educational and practice workspaces, I will lead conversations regarding the creation of and application of safe-space and inclusive signage within office, practice, and commonly trafficked spaces. I will continue across my roles to engage in reflective journaling in assessing and addressing how my experiences, gaps in knowledge, biases, impact my roles within the OT profession. Through my engagement within organizational spaces (e.g., AOTA and WFOT) and advocacy endeavors, I will continue to raise awareness of the importance of addressing substance use and sexual identity

across the span of occupational science and therapy, including our responsibility in directing efforts to breaking down the systemic challenges that influence personal substance use and internal identities. In disseminating the study findings at the public and personal level, the limitations of the study must be considered.

Limitations

This study has limitations that are worth both exploring and addressing in future research inquiries. In total, twelve women engaged in this study (not including those who were withdrawn). These women represented varying regions of the United States, and differing racial, ethnic, sexual, gender educational level, age, and socioeconomic status identities. This represents a small number of the overall population of SMW, warranting expansion of this study to a larger sample who is representative of each United States region. While no co-researcher data across the twelve women was identified through the legitimacy screening checklist as requiring removal from the study, there is a chance that non-legitimate data may have been included in the dataset due to the subjective nature of numerous checklist aspects and the timing of the implementation of the checklist.

Additionally, while conducting the study in a virtual format provided flexibility for women across the country who were interested in participating, in having all of the research take place online (due to co-researcher location and preference), potential co-researchers who did not have access to tools like laptops and Zoom are not included within the study findings (Carter et al., 2021). This format, as well as the timing of recruitment, also led to needed modifications to the Photovoice methods which prevented co-researchers from being able to *consistently* engage with one another and develop collective perspectives on their lived experiences (though some co-researchers were able to meet through the community presentation-based optional fifth

Photovoice workshop). As Photovoice methods traditionally include collective engagement (Dobson, 2017; Dobson et al., 2022; Selingo & Stoffel, 2021; Tomar, 2013; Tomar & Stoffel, 2014; Wang, 1999; Wang & Burris, 1997; Wang et al., 1998; Wang et al., 2000), this modification serves as limitation within the study, in some respects.

In determining the target study population for the study, care was placed in the recruitment language to ensure that all women, including trans individuals, could participate in the study. While this was the case, trans women may have felt that the study was not primarily targeting them and subsequently chosen to withhold from participating. Women who are trans have critical and unique experiences that warrant application of these study methods solely with them (M. E. Newcomb et al., 2020; Nuttbrock et al., 2014). Similarly, most of the women who participated in this work self-identified as being lesbian. While this is by no means a shortcoming of the study, current literature indicates that women who identify as bisexual consistently demonstrate higher levels of substance use compared to heterosexual or lesbian women (Rosner et al., 2021; Schuler & Collins, 2020), which may (according to Schuler & Collins, 2020) be related to bisexual women having to navigate stigmatized perspectives on their sexuality (Zivony & Saguy, 2018), and increased rates of personal violence (Johns et al., 2018; Turell et al., 2018). Bisexual women's experiences related to substance use require deeper investigation in creating better directed care support, resulting in the need for this study work to be replicated with this population. Finally, some co-researchers noted that they had a live-in partner or child. While the focus of the study was on women's lived experiences, future expansion of the study to include deeper discussions of the influence of partners and children on substance use experiences could be beneficial in creating a more holistic perspective of SMW's realities.

In pivoting to the study methods, given that all the study co-researchers chose to engage in the workshop virtually, and there were lags in recruitment interest, the Photovoice workshop sessions were completed individually; this means that co-researchers did not have the opportunity to engage with one another and develop a collaborative knowledgebase beyond the virtual Photovoice gallery event. As researchers choose to use Photovoice in future work, consideration should be placed on balancing the benefits and flexibility of virtual methods with the those of in-person, group engagement in the Photovoice process.

The Photovoice pieces, interview results, and subsequent study conclusions and recommendations may demonstrate a bias, as the co-researchers had to choose to engage in the study, and therefore demonstrated an increased willingness to examine their substance use in a social context. Given this, co-researchers may have had differing perspectives compared to an individual who chose not to engage in the study, but who may have had unique experience regarding substance use. In addition to this, excluding individuals who were acutely intoxicated at the time of the consent process may have also eliminated women with unique perspectives on substance use which differ from those who participated in the study. In focusing on SMW, women who engaged in the study had to be comfortable with being "out" with their identity in a public space; this presents as a limitation, as the voices of SMW who do not feel comfortable or safe in being "out" with their sexual identity status were not included in the study. It is my hope that such women can review this work, now that it is complete, and find that they may not be alone in some of their experiences, and that supports are available. Finally, this study's scope is limited in that it does not include women under the age of 18 or over the age of 29. Despite this, the study serves as an important foundation for future research that could examine differing age groups and SMW populations.

Future Directions

As this dissertation study ends, I plan to grow the work to include larger groups of SMW, and other populations of women, with an emphasis on group based Photovoice workshop sessions and expanded phenomenological interviews that are informed by this study's findings. It is my intention to use the recommendations and identified healthcare challenges from the co-researchers to conduct a Delphi study with expert OT practitioners across education, practice, and advocacy settings (similar to Leclair et al.'s 2019 study). The purpose of this work will be to better understand how the profession is currently responding (and not responding) to SMW in emerging adulthood and other female populations' needs surrounding substance use and misuse. I would also like this line of research to generate strategies regarding how OS and OT can improve the services we are providing those we serve. Additionally, I plan to conduct continued participatory action research approaches with SMW in exploring the initial proposed thematic framework from this study to evaluate its acceptability and applicability to the women in this population. The goal with formalizing this framework would be to have it serve as a potential tool for practitioners, scientists, and advocates to explore for collaborative community-based application.

Finally, it is my long-term goal to take the findings from these studies and use them to develop educational modules that address substance use and can be implemented across OT educational programs. I plan to apply for supportive grant funding for this study through outlets such as the American Occupational Therapy Foundation's (AOTF) Health Research Grant (AOTF, n.d.) and the Patient Centered Outcomes Research Institute (PCORI) (PCORI, n.d.). Continued research examining the impacts of virtual methods on co-researcher and data

trustworthiness is also recommended in creating consistently applicable, non-discriminatory screening practices in virtual research.

Final Comments

It is my sincerest hope that readers of this work take the opportunity to reflect on this material and consider how they might apply it to their understanding of themselves and their service to SMW through the occupational science and the occupational therapy professions. In upholding the voices of the women who engaged in this study, I encourage you to go forward in your practice with an increased awareness of the intersection between substance use and sexual identity, an appreciation of how who we are impacts the service we provide others, and consistent enactment of love in all that you do. Thank you for engaging with this work; I am so excited regarding the new ideas and actions we may go forward with in better serving sexual minority women in the future of the occupational science, the occupational therapy profession, and beyond.

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Appendix A: Final Study Consent Form

UNIVERSITY OF WISCONSIN – MILWAUKEE
CONSENT TO PARTICIPATE IN RESEARCH
INDIVIDUAL PARTICIPATION CONSENT
[THIS CONSENT FORM HAS BEEN APPROVED BY THE IRB (23.154) FOR 1 YEAR PERIOD WITH THE MOST RECENT AMENDMENT APPROVED ON 08/16/23]

Study Title: Qualitative Exploration into the Lived Experiences of Sexual Minority Women in Emerging Adulthood Who Use Substances
Person in Charge of Study (Student Principal Investigator (SPI)):
My name is Lauren Selingo. I am a PhD candidate in the Department of Rehabilitation Sciences and Technology at UWM and an Occupational Therapist.

Overview of Study

Purpose: To better understand the lived experiences of sexual minority women who use substances and their healthcare experiences related to substance use.

Procedures: Participants will engage in in-person or virtual sessions exploring Photovoice methodologies, creating a Photovoice piece describing their lived experiences as sexual minority women who use substances, and sharing their pieces and perspectives with their peers and potentially community members. Participants will also complete one-on-one interview and demographic information collection with the student principal investigator that explores their perceptions and experiences regarding substance use.

Time Commitment: Total time commitment for this study will be ~8 hours (or less) across 4-5 weeks, though this may be shorter depending on participants' needs and schedules.

Primary risks: Minimal psychological discomfort due to nature of discussion of substance use and the risk of having one's personal information disclosed to others.

Benefits: Increased personal awareness of one's lived experience surrounding substance use, and potential increased healthcare and community awareness regarding sexual minority women's experiences with substance use. Potential increased awareness of community mental health and substance use resources.

Compensation: Participants will receive compensation for engaging in the study up to a total of $50.

Inclusion Criteria:

- Must be between 18 and 29 years of age
- Must identify as a woman
- Must be living in the U.S. at the time of the study and across the 4-5 weeks needed to complete the study tasks.

- Must be an active student in higher education (college, technical college, university, etc.)
- Must identify as a sexual minority (lesbian, bisexual, pansexual, asexual, queer, questioning, etc.)
- Have experiences using a substance or substances (alcohol, marijuana, tobacco, opioids, illegal substances, etc.)
- Have access to reliable transportation if engaging in the study methods in-person (e.g., a car, bus transportation, walking, etc.)
- Have consistent internet and email access
- Must be comfortable with the potential for other participants to know one's sexual identity

Exclusion Criteria:

- If you are an active student in high school
- If you do not fluently speak and read English
- If you have a cognitive disability (e.g., intellectual disability, dementia, traumatic brain injury)
- If you are experiencing acute medical needs (due to substance use or otherwise), (e.g., demonstrating symptoms of illness due to recent substance use, illness, etc. (e.g., shortness of breath, severe cough, difficulty maintaining attention, vomiting, etc.) that requires medical assistance)

You are being asked to participate in a research project. Your participation is completely voluntary. You do not have to participate if you do not want to and you may withdraw from the study at any point in time without penalty.

Study description:
Sexual minority women (SMW) who are students, have unique relationships and experiences with substance use (including alcohol, marijuana, opioids, tobacco, and other legal and illegal substances). SMW also have healthcare encounters that are impacted by their sexual identity, interpersonal relationships, roles, potential trauma experiences, engagement in community spaces, stressors, discrimination, and stigma. These factors can influence SMW's substance use. Substance use has an impact on long-term personal and health outcomes, though may not be included in discussions with healthcare providers. Occupational therapists (OTs), as part of the healthcare team, can serve SMW, and provide a safe, open environment for discussions of substance use. Occupational therapists and the healthcare community, however, have current gaps in knowledge, stigma, and little research in providing SMW with community informed care, requiring the need for research created by SMW that highlights their experiences and needs.

Participants in this study will engage in an active role that provides an outlet for self-expression, introspection, and exploration using photography and written narratives, and one-on-one interviews with the student principal investigator (SPI) (Lauren Selingo). These methods will provide a wealth of qualitative data in better understanding SMW's experiences, needs, barriers and facilitators in discussing substance use with providers. This project's intent is to provide insight into student SMW's experiences with substance use with the goal of giving this

population a platform to voice their needs to individuals in the community who can enact change (whether this is in the local community and/or healthcare spheres).

Approximately 25-30 SMW will participate in the project. Your participation in the project will take approximately ~6-8 hours total.

What will I be asked to do if I participate in the study?
First Steps
If you agree to participate, you will be assigned a participant number to promote anonymity and will be able to choose to complete the one-one-one lived experience interview with the SPI or the 4-5 virtual or in person Photovoice workshop sessions first. The order is up to you.

Photovoice Workshop Sessions
You will be asked to join other participants of the project in four to five 1-2 hour sessions that involve taking photographs, writing narratives to accompany the photographs, discussing the ethics of photography, how to take photographs, and developing themes within photographs. The third workshop session will happen outside of a formal meeting at a time of your choosing and will include taking the photos that will be used in your Photovoice piece(s). Depending on the group's preferences, an optional fifth session may occur, in which you may present your photo and narrative to community members. It is highly encouraged that you attend all workshop sessions, as each session builds off one another in terms of content. You may complete the Photovoice workshops individually with the SPI, or participate in the workshop sessions without creating a Photovoice piece.

One-on-one Interview
You will also be asked to engage in a one-on-one interview with the SPI across one to one-and-a-half-hours, during which you will discuss various factors surrounding substance use (e.g., community perceptions around substance use, personal roles, family experiences related to substance use, etc.) and demographic factors (e.g., age, type of substance(s) used, number of children, etc.). While it is encouraged that you complete both the 1:1 interview and Photovoice workshops sessions, you are welcome to complete only the interview or only the Photovoice workshop sessions as you are willing and able.

Important Recording Information
With your permission, the SPI will record you (both audio and video) during the group sessions and the interview via the Zoom session recording function should you participate in the study virtually or in-person. The recording will be done to make sure that the SPI accurately records and interprets your views. If you do not wish to be recorded and are participating in a virtual workshop, please keep your video and audio off throughout the sessions and feel free to add feedback/participate in the session discussions via the chat function or through observing. If you do not wish to be recorded if participating in in-person sessions, the SPI will have you sit outside of the camera scope.
Next Steps
After participating in the Photovoice workshop sessions and individual interview, the SPI will engage in the data analysis process, after which she will reach out to you to engage in the member check process. During this process, which should take no more than half an hour, you will have

the opportunity to look at the results of the data analysis and provide feedback. This process will take place using your preferred method (in-person or virtual meeting, or via email).

What risks will I face by participating in this study?
The potential risks for participating in this project are moderate. Psychological risks are no greater than you would experience from engaging in conversations regarding your substance use with a peer. While there are numerous safeguards in place to protect participants' confidentiality and anonymity, given that use of electronic methods and study topic, there is no way to ensure that participants in the group will not learn of other participants' specific sexual identity or share information about what is discussed in the group outside of the Photovoice workshops sessions, or that a data breach may occur.

While I will ask that all participants keep information that is shared confidential at the beginning and end of each session, there is no guarantee that information that you share with the group during any session will remain confidential. Please only share what you are comfortable with others knowing.

What is being done to minimize the potential risks?
Psychological: There is a small chance that you may feel uncomfortable talking about aspects of your substance use and personal experiences. **You do not have to answer any questions that may make you uncomfortable or share experiences that you wish to keep private.** You can also leave the study activities at any time. You will be provided with a list of mental health resources should you be aware of any issues related to your psychological well-being.

Please see the "Confidentiality" section (#7) for additional steps being taken to minimize the risks noted above and support participant confidentiality.

Participation in this study and any study materials you contribute to or create will have no bearing on your status as a student, including coursework and grades. This study information is being collected for the sole purpose of the SPI's research and for the purposes of improving healthcare service for marginalized sexual minority women.

If you're harmed from being in this study, let the SPI know as soon as possible. If it's an emergency, get help from 911 or your doctor right away and tell the SPI afterward. The SPI can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.
Will I receive any benefit from my participation in this study?
You may find the following activities to be beneficial, such as developing an awareness of how one's lived experience, community, supports, and barriers effect your substance use.

You may also learn about community mental health and substance use resources, while potentially generating actionable results for improving community supports and healthcare services provided to sexual minority women.

Your participation will help enhance the body of literature on sexual minority women's experiences surrounding substance use and healthcare related to substance use and potentially

lead to actionable steps healthcare professionals can take in improving services for sexual minority women.

The benefits of participating in the program outweigh the potential risks.

Who is funding the study and are subjects paid or given anything for being in the study?

This study is being funded by the UWM Chancellor's Graduate Student Award (CGSA).

Participants will be provided with a $50 total in Amazon gift cards across the study, should they complete all aspects of the study (the one-on-one interview and Photovoice workshop sessions). Ten dollars will be sent out via gift card after completion of the second Photovoice workshop session, with $15 dollars sent out via gift card after the final Photovoice workshop session to thank participants for their time and shared experiences. Participants will receive a $25 gift card after completing the 1:1 interview. Light refreshments will be provided at in-person workshops to demonstrate appreciation for participants' engagement in the study and their time.

Will I be charged anything for participating in this study?

You will not be charged for any costs associated with taking part in this study.

General Information

- All information collected about you throughout the course of this study will be kept confidential to the extent permitted by law.

Who will have access to my data?

- The SPI will be the only one who has access to identifiable information (names, email, phone number, video recordings). The SPI will oversee and manage all study data.
- The SPI's faculty mentor (Dr. Virginia Stoffel, PI, UWM) and a student research assistant from UWM will have access to anonymous data (no names, email, phone number, etc.). Only your participant number will be connected to this data.
- The graduate research assistant will have access to audio recordings.
- The Institutional Review Board at UWM or appropriate federal agencies like the Office for Human Research Protections may review the study materials and your records.

How is the data being stored?

- Virtual data (e.g., uploaded Photovoice pieces, interview transcripts) will be stored:
    - On the SPI's password protected and a password protected and encrypted iPad
        - Storage and data analysis will be conducted via a password-protected and encrypted survey site and drive (Qualtrics and OneDrive, maintained by the UWM).
- Physical data (e.g., Photovoice pieces created and presented in person, study forms, transcript print-outs) will be kept in a locked lock box in the home of the SPI that is only accessible to the SPI.

Physical consent forms and Photovoice pieces completed in-person will be scanned and uploaded to OneDrive by the SPI when complete.

Where Will My Name Appear in the Data?

- You will choose the Photovoice images and narratives displayed for a Photovoice exhibition, and how to identify yourself (using your name, a pseudonym, or remaining anonymous) if the group determines that they would like to present to other community members.
- Your name will not appear in the demographics information you provide. You will have the ability to decide whether you would like to answer questions that could potentially be used to identify you (e.g., age, sexual identity, etc.).
- Your name and identification information will not be shared with your school or community program.
- The SPI will present research findings to the occupational therapy and healthcare research communities, to UWM and Marquette LGBTQ Center staff and will publish results in scientific journals or present them at scientific conferences.
    - The dissemination materials will be completely de-identified. If direct quotes are used, the SPI will use participant's documented preferences in using "anonymous" or a pseudonym.

Data Breach: There are inherent risks any time you share information online, including having data hacked or intercepted. This can lead to a breach of confidentiality, or the chance that your data could be seen by someone who should not have access to it. To minimize this risk, the SPI is implementing the following practices:

- Remove all identifiers from dataset after collection.
- Identifying information will be kept separate from your research data, but the SPI will be able to link it to you via your participant number. This link will be destroyed after the SPI finishes analyzing the data and defending her dissertation (anticipated May, 2024).
- Your photo and interview quote consent forms will be destroyed 2 years after completion of the study (estimated to be completed in May 2024).

Further Steps to Protect You and Your Information

Identifiable data will be maintained by the SPI after the end of the study for a period of 2 years after the end of the study (estimated to be May 2026) before being destroyed. The de-identified dataset will be kept for future research. While you will not be directly informed of future studies, you are encouraged to keep in contact with the SPI regarding continued research.

Are there alternatives to participating in the study?
No.
What happens if I decide not to be in this study?

Your participation in this project is <u>entirely voluntary</u>. You may choose not to complete the study, or withdraw from the study at any time. You are free to not answer any questions or complete

portions of the study. Your decision will not change any present or future relationships with the University of Wisconsin Milwaukee or Marquette University.

If you decide to withdraw or if you are withdrawn from the project before it ends, the SPI will use the information collected up to that point. To withdraw from the study:

- Email the SPI, Lauren Selingo (contact information listed below)
- Include your name and the date you would like to withdraw from the study.

If you wish during or after the study to withdraw the use of your study materials (photographs, narratives, direct interview quotes) from exhibits, reports, and publications, prior to them being published:

- Email the SPI with your name, decision to withdraw materials, and date you would like materials withdrawn. You will receive written email confirmation of your withdrawal from the study or withdrawal of study materials.

In certain situations, the SPI may determine that it is necessary to remove a participant or potential participant from the study. This decision will be based on the following circumstances:

- Violation of Study Protocol: If you fail to adhere to the study's protocols, guidelines, or instructions provided by the SPI.
- Noncompliance with Informed Consent: If it is discovered that you provided false information during the informed consent process or violated the terms outlined in the consent form.
- Safety and Well-being Concerns: if the SPI determines that your continued participation in the study poses risks to your safety, well-being, or violates ethical guidelines.
- Study Amendment or Termination: In the event of significant changes to the study protocol, study termination, or external factors beyond the control of the SPI.

Should such removal occur, the participant will receive written notification from the SPI with an explanation for the decision and will be compensated according to how many of the research tasks they have completed immediately up to their removal from the study. You will have the opportunity to discuss the decision, ask questions, and seek clarification from the SPI. All data associated with the study will not be included in the study data analysis and dissemination. Any collected personal data (consent form, correspondence, etc.) will be maintained until the end of the study and will be deleted upon the completion of the study.

If a participant were to be removed from the study, they will be unable to complete additional activities (e.g., the interview) associated with the study that they have not yet engaged in, along with receiving compensation for those activities.

Are there any accommodations you might need throughout the study or during specific study activities such as the Photovoice workshops, interview, or member check process (e.g., an ASL interpreter, closed captioning, electronic copies of study materials, etc.) ?

If yes, SPI or Participant may list here: ____

Who do I contact for questions about this study?

For more information about the project or the project procedures or treatments, or to withdraw from the project, contact the student primary investigator:

Lauren Selingo, MS, OTR/L
Department of Occupational Science and Technology
University of Wisconsin – Milwaukee
lselingo@uwm.edu

To speak with the Primary Investigator of the study and the student primary investigator's faculty advisor, please contact:

Virginia Stoffel, Ph.D., OT, FAOTA
Department of Occupational Science and Technology
University of Wisconsin – Milwaukee
P.O. Box 413
Milwaukee, WI 53201
stoffelv@uwm.edu

Who do I contact for questions about my rights or complaints towards my treatment as a research subject?

The Institutional Review Board may request your name, but all complaints are kept in confidence.

Institutional Review Board
Human Research Protection Program
Department of University Safety and Assurances
University of Wisconsin – Milwaukee
P.O. Box 413
Milwaukee, WI 53201
(414) 662-3544
irbinfo@uwm.edu

Research Subject's Consent to Participate in Research:

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read or had read to you this entire consent form, including the risks and benefits, and have had all of your questions answered, and that you are 18 years of age or older.

____

____

Printed Name of Subject/ Legally Authorized Representative

____

Signature of Subject/Legally Authorized Representative Date

Research Subject's Consent to Audio/Video/Photo Recording:

It is okay to video me and use my video-taped data in the research.

Please initial: ____Yes ____No

It is okay to audio-tape me and use my audio-taped data in the research.

Please initial: ____Yes ____No

Principal Investigator (or Designee)
I have given this research subject information on the study that is accurate and sufficient for the subject to fully understand the nature, risks and benefits of the study.

____ ____________________

Printed Name of Person Obtaining Consent Study Role

____ _____________________

Signature of Person Obtaining Consent Date

Appendix B: Screening Script

Screening Script:
Thank you so much for your interest in the study and for meeting with me today! I am excited to be able to talk with you a bit more about what the study involves in terms of time and activities. In starting, I wanted to note that you are required to turn on your camera for some or all of the screening meeting today. This is to ascertain your active participation in the screening process. (If participant has not turned on camera, SPI will request they do so at this time).

Today what we will do is briefly review the study, and then talk through the inclusion and exclusion criteria of the study, or the requirements to be able to participate in the study. After that, if we determine you meet the inclusion criteria, we will move on go through the informed consent form, during which you will be able to decide whether you would like to participate in the study or not. The entire process, should you meet the inclusion criteria, will take around a half hour. Do you have any questions before we start?

To provide a brief overview, the purpose of the study is to better understand the lived experiences of sexual minority women who use substances and their healthcare experiences related to substance use.
If you meet the criteria and decide to participate, you will engage in in-person or virtual sessions in which we explore Photovoice methodologies, create a Photovoice piece describing your lived experiences as a sexual minority woman who use substances, and share your pieces and perspectives with peers and potentially community members. You will also engage in a one-on-one interview and demographic information collection with me that explores your perceptions and experiences regarding substance use.

The total estimated time commitment for this study will be ~8 hours (or less) across 4-5 weeks, though this may be shorter depending on participants' needs and schedules.

Some of the risks of the study include minimal psychological discomfort due to nature of discussion of substance use, and the risk of having one's personal information shared with others. I will share more with you about what I am doing to mitigate these risks as we discuss the informed consent form.

Some of the benefits of the study may include developing an Increased personal awareness of one's lived experience surrounding substance use, and potential increased healthcare and community awareness regarding sexual minority women's experiences with substance use. You may also experience an increased awareness of community mental health and substance use resources. You will be compensated for your time and expertise, and will receive up to $50 through Amazon gift cards in participating in all of the study activities.

Next, we will talk about the inclusion and exclusion criteria. I will ask you a series of questions to determine whether you meet the criteria for participating in the study. Please let me know at any time if you have questions or need clarification. First, I will discuss the inclusion criteria:

Inclusion Criteria:

- Are you between 18 and 29 years of age?
- Do you identify as a woman?
- Are you currently living in the U.S., and will you be living in the U.S. over the next 4-5 weeks?
- Are you an active student in higher education (college, technical college, university, etc.)?
- Do you identify as a sexual minority (lesbian, bisexual, pansexual, asexual, queer, questioning, etc.)?
- Do you have experiences using a substance or substances (alcohol, marijuana, tobacco, opioids, illegal substances, etc.)?
- Do you have access to reliable transportation if engaging in the study methods in-person (e.g., a car, bus transportation, walking, etc.)?
- Do you have consistent internet and email access?
- Are you comfortable with the potential for other participants to know your sexual identity?
    - Can explain here that various privacy measures are in place to prevent others from knowing one's sexual identity if they do not wish, however, there is no way to confirm for certain that others will not share what is discussed during the group portions of the study outside of the group.

Exclusion Criteria:

- Given what has been shared, do you wish to participate in the study? (If participant says no, discontinue screening process and thank them for their time).
- Are you an active student in high school?
- Do you speak and read English fluently?
- Do you have a cognitive disability (e.g., intellectual disability, dementia, traumatic brain injury)?
- Are experiencing acute medical needs (due to substance use or otherwise) (e.g., needing medical assistance due to recent substance use, potential overdose, illness, etc.)?

If participant meets criteria for engaging in the study: Thank you very much for completing the initial screening process with me. Given your answers, you meet the criteria to be a study participant. Next, I will go over the informed consent form with you, which will provide you with a deeper overview of the study, what to expect when participating, and the option to choose whether or not you would like to participate in the study.

If participant does not meet the criteria for engaging in the study: Thank you so much for completing the screening process with me. Given (one, some) of your responses to the inclusion and exclusion criteria requirements, you do not meet the requirements to be able to participate in the study. I very much appreciate your time, and look forward to potentially working with you in the future.

Appendix C: Screening Checklist

Study "Red Flags" (must have three or more to be considered ineligible for participation in the study, and have their data removed from inclusion in the study data analysis and findings at any point across the study process):

- Potential participant does not attend their scheduled screening meeting and does not follow up independently with researcher (more than x2 times no-show would automatically count in disqualification)
- Consistent researcher difficulty in understanding potential or current participant email messages
- Potential participant or current participant setting on camera during screening or study session meeting does not match with US time zones (e.g., appears to be nighttime when all US time zones would be experiencing daylight)
- Potential participant inconsistency in answering screening prompts (e.g., saying they are both a college and high school student)
- Participant providing inconsistent information with what they shared during the initial interest outreach to SPI, screening process, and/or study sessions (e.g., name, student status, personal experiences, etc.)
- Potential or current participant sending identical or highly similar study information/materials or using identical or highly similar language from multiple email accounts/"persons"

- Suspicious outreach/activity related to compensation (e.g., stating that participant has not received compensation when there is proof of card activation) on behalf of participant

- Participant submitting a Photovoice photo or photos that are stock photos and are not photos that they took themselves.

Appendix D: Communications/Meeting Preferences Form

Communication and Meeting Preferences Form IRB #__23.154________

You are being asked to complete this form to provide the study Student Principal Investigator (Lauren Selingo) with your contact information for study outreach, scheduling, and dissemination efforts. You are also being asked to provide your preferences for conducting the study meetings in-person or virtually. All efforts will be made to accommodate your preferences. All information provided in this form will be destroyed at the end of the dissertation defense (estimated May 2024). This information will be stored electronically on a password-protected device and will only be accessible to me (Lauren Selingo). You have the ability to change your preferences at any point during the study. Please email me at (lselingo@uwm.edu) with any requested changes and I will update the form. Thank you for completing the form, and **please let me know if you would like a copy of your completed portion of the form.**
Phone Number: _________________
Email: _______________________

Please place an X for your preferred method of contact:

- Phone
- Email
- Either

Please review the two potential schedules for completing the study steps and choose your preferred completion order below:
I would prefer to complete the Photovoice workshops:

- First
- Second

Please place an X for your preferred method of participation:

- In-Person
- Virtually (Using the Zoom platform)
- Either

I would prefer to complete the one-on-one interview:

- First
- Second

****If you are unable to attend a workshop, please contact the PI, Lauren at lselingo@uwm.edu and we can schedule a make-up time or meet early prior to the next Photovoice workshop.**

Please place an X for your preferred method of participation:

- In-Person
- Virtually (Using the Zoom platform)
- Either

Please place an X for your preferred method of participation in the member-check process (reviewing the final study themes, participant recommendations, and overall study findings):

- In-Person
- Virtually (Using the Zoom platform)

- Virtually (Using email)
- Either

Participant Study Number (for Primary Investigator to complete only):______________
Participant Pseudonym/Anonymous Preferences for Photovoice (for Primary Investigator to complete only): ____________________
Participant Pseudonym/Anonymous Preferences for Interview (for Primary Investigator to complete only): ____________________

(FOR PRIMARY INVESTIGATOR TO COMPLETE)

Payment 1 Issued:

Payment 2 Issued:

Payment 3 Issued:

Appendix E: Photovoice Workshop Session Facilitator's Manual

FACILITATOR'S MANUAL FOR FIVE-PART PHOTOVOICE WORKSHOP

PART I – (Introduction, Total ~30 minutes)

1. Verbal reminder regarding participant numbers, disclosure, etc. (will be included each session) 5 minutes
   Recording, Mandatory Reporter, Mental Health Resources, Can Leave/Break at Any Time
2. Informing Regarding Informed Consent
   a. Review Informed Consent Form 10 minutes
      a. Answer any questions that arose
2. Discuss Study Process 10 minutes
   a. Describe field note process
   b. What is my role as an occupational therapist, and what role do occupational therapy and occupational science play pertaining to substance use and healthcare?
   c. What do we mean by healthcare providers?
   d. What do we mean by substance use services and service care?
   e. Discuss Photovoice workshops and interview
   f. Discuss ability to participate without creating a Photovoice piece

   f. Walk-through tutorial on using Zoom
   g. Ask about the dates and times—do they work for everyone?

3. Closing of Session 1 5 minutes

PART II (Overview, Stages and Processes, Examples) – (Total ~2 Hours)

1. Photovoice: An Overview 10 minutes
   a. Read through the *"Photovoice: An Overview" Handout*
   b. Provide examples of when and who Photovoice has been used for
   2. Stages and Process 10 minutes
   a. Read through the *"Stages and Process of Photovoice" Handout*
   b. Explain what will be occurring throughout the Photovoice workshop
3. Examples of Photovoice 10 minutes
   a. Show examples of Photovoice from previous workshops
   4. Thinking About Ideas and Problems 20 minutes
   a. Read through the *"Thinking About Ideas and Problems" Handout*
      b. Request input from the participants
5. SHOWED 15 minutes
   a. Read through the "*SHOWED Example" Handout* and *"Questions to consider when writing SHOWED…" Handout*
   b. Pass out/show pictures as samples
   c. Discuss samples
7. Who Is Our Audience? 5 minutes
   a. Read through the *Handout*
   b. Ask what participants think (family members, university staff, public, legislators, etc.)

6. Ethics 15 minutes
   a. Read through the *"Becoming A Visual Researcher – Ethics of Taking Pictures" Handout*
   b. Describe ethics and discuss they are important in taking photographs
   c. Go over "*Review of Guidelines for Photo Mission" Handout*
   d. Roleplay to practice obtaining consent
7. Brainstorm Ideas for Photo Mission 15 minutes
   a. Write a list *"What Does It Look Like? Making Ideas Into Photos" Handout*
   b. Go over *"What Does It Look Like? Making Ideas Into Photos" Handout*
   c. Read through the *"Picture Taking Tips" Handout*
8. Closing of Synchronous Session 3 10 minutes
   a. Provide Participants with Photo Prompt
   b. Provide participants with verbal reminder regarding photos and *"SHOWED" example* and plan photo mission
   b. Verbally conclude session – first payment to be issued

PART III (Individual Work, Total 30 minutes)

1. Take Pictures – Photo Mission ~30 minutes
   a. Participants will individually take pictures using cell phones

PART IV (Photovoice Creation, Total ~2 hours)

1. Ask Participants How Taking Photos Went 5 minutes
2. Review Photos 10 minutes
   a. Questions with SHOWED
   b. Keep a log of who is taking what pictures
   c. Ask questions to stimulate more ideas
3. Select ~3 Photos to Write About 30 minutes
   a. Write first draft
   b. Read aloud to others
   c. Give and receive feedback
4. Edit and finish writing
   a. Writing and Feedback 15 minutes
   b. Edit
   c. Read aloud to others 15 minutes
5. Critical Discussions
   a. Discussion of Collective Photovoice Pieces
   b. Encourage a more critical group discussion
   c. Refer to *Handout*—Thinking About Ideas and Problems
   d. Discuss potential platforms for display
6. Break
   a. Break 10 minutes
   b. Finalize photos/narratives for sharing with others 5 minutes
   c. Complete paperwork with Photovoice permissions
8. Present Photovoice Pieces Completed Today 30 minutes

9. Verbal Closing
    a. Reflect on choice for engaging in Photovoice session second vs. first and vice versa.
    b. Discuss next steps (study timeline, presentation etc.) 5 minutes

Potential PART V (with Invited Guests, Total ~1 hour, 30 minutes) - determined by participants

a. Present Photovoice Pieces 20-30 minutes
b. Discuss reaction to Photovoice Pieces (participants and invited guests). 20-30 minutes
c. Generate participant recommendations for determined interested community parties 20-30 minutes

Appendix F: Photovoice Workshop Session Materials

Photovoice: An Overview

You are the expert—tell your story…

What is Photovoice?

- It is a process used to help people share their stories.
- It puts cameras into the hands of people that have a story to share.
- You take pictures that reflect your experiences.
- You discuss your pictures and share your stories.
- You write about your pictures.
- You find common joys and concerns with each other.
- When concerns are identified, programs and services can be changed to better meet the needs of the people sharing their stories.

Background

- Photovoice combines participation and action as a method of research
- It has been used for:
  - Women in China
  - Homeless individuals
  - Youth exposed to violence
  - Older adults experiencing pain
  - Black survivors of breast cancer
  - People living with mental health diagnoses
  - Black sexual minority women's experiences with substance use

Goals

1) It allows people to record and think about strengths and problems in the community.
2) It allows people to share their stories in a group.
3) It directs these stories at people in the community who have the power to make decisions.

Stages and Processes of Photovoice

1) Think about ideas/problems (e.g., balancing substance use with other occupations and roles, (e.g., being in an aromantic/romantic/asexual/sexual relationship, employment, socializing, child-rearing, being a spouse, sister, caretaker, etc.)

2) Think about an audience
a. Who needs to know my perspective?
b. Why is it important that they know?

3) Training
a. Learn how to be a visual researcher
b. Learn about taking photographs
c. Ethical issues

4) Think about ideas for taking pictures—what does it look like?

5) Taking the pictures—the Photo Mission

6) Group discussion
a. Select photographs
b. Reflect on your pictures and share your stories
c. Identify common joys and concerns
d. Write stories about the photographs

7) Think about people that you could teach about your experiences. Think about people that could make decisions to better meet your needs.

8) Evaluate
a. What did you learn?
b. What was helpful?

9) Share your project

Thinking About Ideas and Problems

1. What are your important stories about being a sexual minority woman who uses a substance or substances?

2. What are your important stories about being a sexual minority woman in emerging adulthood (18-29 years of age)?

3. What do you like about using a substance or substances? What are the good things?

4. What is hard about using substances? What are the not-so-good things?

5. What do you like about being a sexual minority woman in emerging adulthood (18-29 years of age)?

6. What are the not-so-good things about being a sexual minority person in emerging adulthood (18-29 years of age)?

7. What do you like about being a sexual minority woman in general? What are the good things?

8. What is hard about being a sexual minority woman in general? What are the not-so-good things?

9. What are some things you wish others knew about your substance use?

10. How could you take pictures showing the good things?

11. How could you take pictures showing the not-so-good things?

SHOWED Example

What do you **SEE** here?

What is really **HAPPENING** here?

How does this relate to **OUR** lives?

WHY does this problem or strength exist?

How could this image **EDUCATE** the community or policy makers?

What can we **DO** about it?

Thinking About My/Our Audience

Think about an audience for our project

- Who do you think needs to see or hear our work the most in order to better meet your substance use and healthcare needs?
- Write down one or two audiences
- Write the message you would send them so they can understand what it is like to be a sexual minority women (ages 18-29) who is a student and who uses substances:

1) Audience:

My/Our message would be…

2) Audience:

My/Our message would be…

Becoming a Visual Researcher

Ethics of Taking Pictures

1) What are *ethics*?

2) Why is it important to consider *ethics* when taking pictures?

3) What would you NOT want to be doing while photographed?

4) What are some risks of taking pictures?
   a. To you?
   b. To the subject of your photograph?

5) Imagine you want to take a picture of a stranger. How would you approach this individual? What would you say?

6) What are some rules we can agree to follow for our project?

7) What are some good things we can get from sharing our pictures with people in the community?

REMEMBER—A PICTURE IS NOT WORTH TAKING IF IT WILL CAUSE DANGER OR HARM TO YOU OR ANYBODY ELSE!

Review of Guidelines for Photo Mission

Do…

1) Always **ask permission** if you are taking a picture of a person or their things. It is nice to introduce yourself by your name and smile if you feel comfortable! Let the person know the purpose of taking the photo, including what the study is about.

2) If you are taking a picture of a child who is under 18, you need to obtain written consent of the parent/guardian and the assent of the child to take the picture, including separate written consent from the adult if they will also be in the picture. The parent/guardian should fill out the consent form.

3) Come up with an explanation of why you want to take the picture.

4) Remember that most people do not want a picture when they are doing something they may consider embarrassing:
   a. Crying
   b. Losing their temper
   c. Eating
   d. Kissing
   e. Using drugs (you cannot take photos of individuals using substances)

5) Feel free to set up shots before taking a picture to capture a scene/idea/emotion.

6) **PAY ATTENTION!** Don't put your safety at risk. Be aware of your surroundings.

7) Some places won't allow you to take pictures. If you can, ask permission. If someone tells you to stop taking a picture, do so **immediately.** We don't want to get anyone in trouble.

8) Remember to smile if you feel comfortable and say **"THANK YOU"** if someone lets you take their picture.

Don't…

1) Take a picture of a person or yourself with personal identifiers visible (e.g., tattoos, the person's face, the person's home, a birthmark, etc.).

2) Take a picture of a person or you using substances.

3) If you are taking a picture of items used for substance use, including illegal items (e.g., needles, a bong, etc.), do not include identifiers in the photo that could be used to identify you or someone else (e.g., your home, your car, a commonly accessed space that you use).

What Does It Look Like?
Making Ideas Into Photographs

- Look over the brainstorm list
- Think about ideas of what it is like a sexual minority woman in emerging adulthood who uses substances
- Pick a few of the ideas
- Think about how you can turn the ideas into a picture

Brainstorm Idea	Taking a Picture
For example: Idea Person Experience Place Emotion Activity	Think to yourself: What would it look like? How would I know when I see it? Where do I find or see it? Who does it? Who represents it? Where does it happen? What could represent this?

Appendix G: Phenomenological Individual Interview Script

Introduction: Thank you so much for being here today and for engaging in this interview and demographics collection with me. We are going to be spending the next hour and a half or so together talking about your experiences with substance use, which may bring up some difficult emotions and uncomfortable or triggering memories for you. Just to review, when referring to substances, this can mean alcohol, tobacco, marijuana, and any illegal or legal drugs or medications. Substance use services can mean community supports, healthcare services, and social supports.

Before we jump into the discussion, I have a few housekeeping pieces; first, I wanted to discuss a bit about where I am coming to this discussion from as an occupational therapist and through an occupational science lens. (Describe role and occupational science for those completing the interview prior to the Photovoice workshops). Secondly, I'll be jotting down brief keyword field notes as we go through the interview that help to summarize what you are discussing, reflect on emotional responses to what you are sharing, and help contextualize what we are discussing. I also want to remind you that you have a form that was handed out along with the study consent materials that has mental health resources and their contact information listed. Please use these resources at any time if you feel they would be beneficial for you. Also, I want to emphasize that you are free to end the discussion at any point in the session if you begin to feel uncomfortable and take breaks. You do not have to engage in the conversation or answer any questions you would not like to answer. Participation is completely voluntary, and you may leave the session at any time.

Just a reminder as well, given that I am an occupational therapist and state employee, so there are certain things I am required to disclose to state governing bodies and the police, including if a child, elderly individual, or personal with disabilities is being abused, and if you are in immediate danger or pose a danger to someone else. Please keep this in mind as we are talking, and know that outside of those factors, absolutely nothing your share here will be reported with your name attached to it. You will have the opportunity to determine whether any direct quotes are from your interview are shared in publicized findings, as well as whether they will be presented with a pseudonym or as "anonymous."

In addition to the mental health resource sheet, I am available over email outside of the session if you have any questions, concerns, or needs pertaining to any aspects of the study. My contact information is provided on the consent form you signed. Do you have any questions for me before we start? If not, please feel free to ask questions throughout the interview.

Before we begin, please note your participant number to assist with the analysis process.

Question 1: What made you want to do this interview (first or after the Photovoice workshop sessions based on participant choice)?
Question 2: Tell me about yourself and your upbringing.
Question 3: How would you define substance misuse? What does it mean to you?
* Create an agreed upon definition of substance use that will be used going forward throughout the interview.
Question 4: Do you have any family members or friends who have had experiences with harmful substance use?
Question 5: What is your relationship with substance use?

Question 6: How has substance use impacted your relationships with family and friends? Can you give some examples?
Question 7: What communities are you a part of and how do you think these communities view substance use?
Question 8: What effect, if any, does your substance use have on the tasks you need and/or want to do?
Question 9: Tell me about some positive outcomes that you've experienced from using a substance or substances.
Question 10: What is some of the main challenges of substance use in your life? Personally, and socially?
Question 11: What effect has your substance use had on your overall health and well-being?
Question 12: If you have experienced any negative outcomes associated with your substance use, what have you done to address your substance use on your own, or with the help of others?
Question 13: What are some of the reasons that you have decided for or against accessing services?
Question 14: What personal strengths or supports do you have to manage your substance use effectively?
Question 15: What are some recommendations you have for healthcare providers who are working with sexual minority women who use substances? What are some things you would like them to know?

Go through Demographic Form with participant next, followed by the Interview Form.

Appendix H: Interview Preferences Form

Interview Form

I took this interview as a participant in the study on women's lived experiences through the University of Wisconsin- Milwaukee to convey my perspective on the experiences of being a woman, which is part of a study being carried out by Lauren Selingo, MS, OTR/L. I understand that my direct quotes from the interview may be included in a research report (e.g., the dissertation defense to the dissertation committee (defending the study methods, analysis, and findings) and the published dissertation as a written research piece) and subsequent professional publications (e.g., publication of articles in professional/academic journals regarding the study methods, results, etc.), and other exhibits at local, state, national or international health, public or professional conferences to disseminate the findings from this study (e.g., conference posters and in-person or virtual presentations at conferences that involve the use of multimedia (Powerpoint, etc.)). I understand that I may choose to my direct quotes displayed anonymously or I may choose to have a pseudonym (a different name) used.

_______ Include my direct quotes in the research report and subsequent professional publications as "anonymous"
______ Include my direct quotes in the research report and subsequent professional publications with a pseudonym (a different name).

______ Include my direct quotes in any exhibit/presentation as "anonymous".
______ Include my direct quotes in any exhibit/presentation with a pseudonym (a different name).
______ I do not give permission for any of my direct quotes to be included in any research report and subsequent professional publications in any form.
______ I do not give permission for any of my direct quotes to be included in any exhibit/presentation in any form.

I understand at any time prior to the printing of the research report I may choose to withdraw my consent for my direct quotes to be included. I understand that I may also decide to change the way I am identified at any time prior to the printing of the report or subsequent professional publications. Once the report or subsequent professional publication is published, I may choose to withdraw my release of my direct quotes for possible future publications.

I understand I may withdraw my permission for my direct quotes to be included in a health, public or professional exhibit at any time prior to the opening of such exhibit. I understand I may decide to change the way I am identified at any time prior to the opening of such exhibit.

This consent form and any information on it will be kept confidentially a password protected document accessible only to Lauren Selingo. If I have any concerns or questions about this project, I can contact Lauren Selingo, MS, OTR/L, PhD Candidate, at lselingo@uwm.edu.

I understand that I am being given a copy of this consent form for my own records.

_______________________________ _________________________
Interviewee signature Date

Appendix I: Photo Preferences Form

Photo Form

Qualitative Exploration into the Lived Experiences of Women
I give permission for public dissemination of my photograph and narrative titled:
____
I took this photo and wrote this narrative as a participant in the Photovoice workshop through the University of Wisconsin-Milwaukee to convey my perspective on the experiences of being a woman, which is part of a study being carried out by Lauren Selingo, MS, OTR/L. I understand that the photo and narrative may be included in a research report (e.g., the dissertation defense to the dissertation committee (defending the study methods, analysis, and findings) and the published dissertation as a written research piece) and subsequent professional publications (e.g., publication of articles in professional/academic journals regarding the study methods, results, etc.), and other exhibits at local, state, national or international health, public or professional conferences to disseminate the findings from this study (e.g., conference posters and in-person or virtual presentations at conferences that involve the use of multimedia (Powerpoint, etc.)). I understand that I may choose to have the photo and narrative displayed anonymously or I may choose to have a pseudonym (a different name) used.

_______ Include this photo and narrative in the research report and subsequent professional publications as taken by an anonymous photographer/narrator.
______ Include this photo and narrative in the research report and subsequent professional publications as taken by a photographer/narrator with a pseudonym (a different name).

______ Include this photo and narrative in any exhibit/presentation as taken by an anonymous photographer/narrator.
______ Include this photo and narrative in any exhibit/presentation as taken by a photographer/narrator with a pseudonym (a different name).
______ I do not give permission for this photo and narrative to be included in any research report and subsequent professional publications in any form. .
______ I do not give permission for this photo and narrative to be included in any exhibit/presentation in any form.

I understand at any time prior to the printing of the research report I may choose to withdraw my consent for this photo and narrative to be included. I understand that I may also decide to change the way I am identified as the photographer/narrator at any time prior to the printing of the report or subsequent professional publications. Once the report or subsequent professional publication is published, I may choose to withdraw my release of this photo/narrative for possible future publications.

I understand I may withdraw my permission for this photo to be included in a health, public or professional exhibit, publication, or report at any time prior to the opening of such exhibit/publication. I understand I may decide to change the way I am identified as the photographer/narrator at any time prior to the opening of such exhibit/publication.

This consent form and any information on it will be kept confidentially a password protected document accessible only to Lauren Selingo. If I have any concerns or questions about this project, I can contact Lauren Selingo, MS, OTR/L, PhD Candidate, at lselingo@uwm.edu.

I understand that I am being given a copy of this consent form for my own records.

________________________________ _____________________________

Photographer/narrator signature Date

Appendix J: Photography Consent Form

PHOTOGRAPHY CONSENT FORM

Qualitative Exploration into the into the Lives of Women

I, (print name) ____ agree to have my photograph taken as a part of a photography project to explore the lived experiences women. I understand that the photographer is participating in workshops where they will take pictures and will tell stories about those pictures to express their perspectives on important issues within the lives of women. I understand that this photo will become the personal property of the photographer and will not be used for any financial gain. I understand that the photographer may choose to share the photo in the workshops as a part of the group discussion. I understand that the photo and narrative may be included in publications (e.g., the dissertation defense to the dissertation committee (defending the study methods, analysis, and findings) and the published dissertation as a written research piece) and subsequent professional publications (e.g., publication of articles in professional/academic journals regarding the study methods, results, etc.), and other exhibits at local, state, national or international health, public or professional conferences to disseminate the findings from this study (e.g., conference posters and in-person or virtual presentations at conferences that involve the use of multimedia (Powerpoint, etc.). I understand my name will not be used under any circumstances if the photo is included. I understand I can withdraw my consent for this photo to be included in any subsequent professional publications or presentations prior to their being printed or exhibited.

This consent form and any information on it will be kept confidentially a password protected document accessible only to the student principal investigator, Lauren Selingo. If I have any concerns or questions about this project, I can contact Lauren Selingo, MS, OTR/L, PhD Candidate, at lselingo@uwm.edu.

I understand I am being given a copy of this consent form to keep for my own records.

______________________________ ____________________
____
Signature of person being photographed Print name
Date

______________________________ ____________________
____
Signature of photographer Print name
Date

Appendix K: Demographic Form Script

Demographic Form Script

Thank you for participating in the study and volunteering your time and experiences. I am going to ask you some questions that will help me further represent your stories in the study findings. This data will be reported anonymously, and please know that you are not obligated to answer any of these questions. If there are any questions that you do not wish to answer, please feel free to say, 'Pass'. If at any time you need a break, please let me know as well. Do you have any questions for me before we begin?

1. What is your age in years?
2. How would you describe where you live? (e.g., urban, suburban, rural)?
3. What is a zip code in your neighborhood?
4. What is your sexual identity (e.g., lesbian, bisexual, pansexual, asexual, queer, questioning, etc.)?
5. What is your gender identity?
6. I am going to provide some annual income ranges, please let me know where your annual income falls within.
    a. Less than $20,000 per year
    b. Between $20,000 and $25,000 per year
    c. Between $25,000 and $35,000 per year
    d. Between $35,000 and $45,000 per year
    e. Between $45,000 and $55,000 per year
    f. Between $55,000 and $65,000 per year
    g. $75,000 or more per year
7. What race(s) do you identify as?
8. What ethnicity(ies) do you identify as?
9. What is your highest level of education?
10. What is your marital status?
11. How many children do you have, and how many live with you?
12. What substance(s) do you use?
13. How often do you use this/these substance(s) per week?
14. How often do you use this/these substances per month?
15. Have you ever received occupational therapy services for any reason? (if need be, provide review of what occupational therapy is)
16. Is there anything in addition you would like to share?
17. Is there anything that you feel I should have asked but did not include in my questions?

Thank for participation and willingness to share.

**Inform participant of next steps in the study. Refer to Communication and Meeting Preferences Form for schedule.

Appendix L: Participant Zoom Resources

Zoom Resources for Participants

Zoom Resources Provided to Participants:

- Joining a Zoom meeting: https://support.zoom.us/hc/en-us/articles/201362193-Joining-a-Zoom-meeting
- Adding your name (in this case, participant ID) to Zoom prior to a meeting: https://www.npsk12.com/cms/lib/VA02208074/Centricity/Domain/6355/Student%20-%20Adding%20your%20name%20before%20joining%20a%20Zoom%20meeting.pdf

Appendix M: Transcript Cleaning Log

Notes for Transcript Cleaning:

- Should clean and include all verbatim words/filler words, "ums" etc. for both me and the participants.
  - E.g. (like...like...like...)
- Speech from the co-researchers and myself should be started with our name/identifier (e.g., Lauren Angela Selingo: or Participant 9:)
- Please include other verbal indicators or pauses prior to the speech being said (e.g., *Participant 9 laughs* or *Participant 9 pauses*)
- Remove time and number stamps across the transcripts
- Long dialogues by myself or the participant can be split into paragraphs
- If it is impossible to hear what someone is saying in the recording, please include (*participant/Lauren muffled* or *participant/Lauren inaudible*) directly in the text of the speech
- For potentially identifiable information (such as city, place of business), please remove phrase/name and insert (*Removed for participant confidentiality) in red
- Can delete initial description of the meeting and demographic collection (said by Lauren)

Please include any notes regarding personal formatting choices below, as well as what transcript they were applied to:

- If co-researchers shared the name of the state they lived in, this information was kept in the transcripts and redacted by the student transcript cleaner, with more detailed information such as the name of one's employment, others' names, the name of where a co-researcher lives also removed from the transcripts to protect confidentiality. Names of the co-researchers were removed by me (Lauren) prior to the student transcript cleaner engaging with the transcripts.