

LGBTQ+ Experiences of the Relationship Between Discrimination and Mental Health Care

By

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Dedication

For Tony.

My job is done if this research can help just one person receive the care you needed.

April 23, 1997 – November 3, 2018

Abstract

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By Elayna Foran

This thesis is an exploratory study which examines the experiences that LGBTQ+ individuals have in receiving mental health care in Nova Scotia, uncovering the concerns of LGBTQ+ individuals within care. The recommendations made hereinafter are intended for mental health care providers in Nova Scotia that are seeking to become more cognizant of LGBTQ+-specific issues. The literature that was used explores how LGBTQ+ people are treated in a system that has a history of pathologizing members of these communities. Participants (N=17) completed an anonymous online survey in which they were asked about their experiences in mental health care in Nova Scotia. Survey respondents noted that sensitivities related to disclosure of LGBTQ+ identity, language use, and culturally competent behaviour impacted the perceived quality of care. The analysis of this data also suggests that barriers, such as socioeconomic status or ability, are relevant to the client-provider relationship as well as to the capacity to seek care, and that accounting for the intersectional nature of a client's identity impacts quality of care, more broadly. Overall, the recommendations presented to providers include understanding their positionality, being mindful of sensitivities related to disclosure of LGBTQ+ identities as well as other aspects of language use, the value of cultural competency training, trauma-informed practices, and understanding the barriers that impact care, such as financial barriers and long wait times.

Keywords: LGBTQ+, mental health care, intersectionality, minority stress, cultural competency

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Chapter One: Introduction

“They won’t do anything,” my late friend had said to me, just days before he passed away, “they didn’t keep me when I was screaming and covered in blood”. The lack of accessibility to mental health treatment specifically for LGBTQ+ individuals in Nova Scotia had combined with the lack of general emergency healthcare, leading to his complete distrust in clinical services. The systemic issues which are faced by LGBTQ+ individuals in everyday life, such as microaggressions or outright discrimination, can be reflected within mental health treatment, or lack thereof. Valuable both to my goals within and external to this study, this research inquires about the situation of LGBTQ+ individuals in a system that has a history of pathologizing those from these groups.

This thesis is an exploratory study which details the experiences of LGBTQ+ individuals receiving mental health care in Nova Scotia, with the aim of revealing their concerns about the care they have received. The recommendations detailed in chapter six are intended for Nova Scotian mental health care providers who want to learn more about the obstructions to care unique to LGBTQ+ people. To understand how individuals who are LGBTQ+ receive mental health care in a system that has a history of pathologizing these populations, I have drawn on literature and theories that examine and provide the potential to unpack such history. LGBTQ+ people (N=17) were surveyed anonymously online about their experiences receiving mental health care in Nova Scotia. The results of this study's analysis reveal that barriers including socioeconomic status or ability contributes to the client-provider relationship as well as in one's overall ability to access care, and that considering a client's intersectional identity has a wider impact on the quality of care. The recommendations given to providers include knowing one's

own positionality, being aware of language use, receiving cultural competency training, implementing trauma-informed practices, and being aware of the barriers to care.

My interest in this field of study comes from both gaps in research and personal experience. As time passes, the need for this research becomes increasingly clear when considering my own experiences and those of people I know. As a member of the LGBTQ+ community, most mental health professionals I have interacted with have not considered how my LGBTQ+ identity impacts my mental health in a unique manner. I have received mental health care treatment in Nova Scotia since I was in my early preteen years. I have gone through many of the publicly and privately available channels and have been through multiple rounds of diagnoses and treatment plans. There were times at which I felt as if I had to beg for help, and this has made me realize that if I am unable to obtain the help I have been asking for, what must it be like for those whose conditions involve greater barriers to help-seeking?

My experiences with my late friend have also shaped the personal knowledge I have about LGBTQ+ mental health. His identity as a transgender man greatly impacted not only his life circumstances, but the social interactions he had every day. Whether it was microaggressions from individuals passing by him in public, or from those in his close social circle, the judgement he faced manifested in the amplification of his pre-existing mental health conditions. His experience in the mental health system was greatly flawed, and he took his own life in November of 2018. He had gone to the emergency room a week prior to his passing for a suicide attempt and was swiftly sent home as a low priority. The main motivation behind my research is to help prevent people like my friend from falling through the cracks of the local mental health system in any way possible. This is not only a failure of mental healthcare, but also generalized healthcare in Nova Scotia. Knowledge of my friend's tragic experience provides a core example of why this

is such important groundwork. Ultimately, I hope that my research will help to prevent the kinds of failures in treatment experienced by him from a young age.

The theoretical resources used to conduct this research have been specifically chosen to uncover boundaries and concerns experienced by LGBTQ+ people in mental health contexts. Using the viewpoints of feminist standpoint theory and queer theory, I have sought to bring feminist literature into mental health spaces. Feminist standpoint theory prioritizes placing the respondents' perspectives at the forefront of the research endeavor, to yield qualitative data that is filtered as little as possible through the lens of the researcher's goals (Cabrera et al., 2020). Queer theory is used to bring into consideration the identity categories that an individual uses to define themselves and question the power structures that define the 'other' (Gedro & Mizzi, 2014). A commonality between these theories is the rejection of the patriarchal structures that are embedded within our societal composition. This is a core value of any feminist research, and I have brought my Women's Studies background into both the creation of the surveys themselves as well as analytic practices. Additionally, the continuation of third wave feminism's inclusion of those who were once excluded by feminist projects, specifically of sexual and gender minorities, is something I pursue in my studies, both inside and outside of this project.

The language which I have utilized to define the populations I have included in this study has been chosen in a specific manner. LGBTQ+ is defined as "an acronym for 'lesbian, gay, bisexual, transgender and queer' with a '+' sign to recognize the limitless sexual orientations and gender identities used by members of the community" (Human Rights Campaign, n.d.). The acronym LGBTQ+, although seen by some as outdated or exclusionary in comparison to the arguably more up-to-date 2SLGBTQIA+, is used within this study to encompass all identities outside of cisgender and heterosexual. I have chosen the acronym LGBTQ+ because it is widely

recognized and more likely to be searched by people looking for information on this subject area due to the shorter acronym. Although it would be a further goal of mine to produce a model for use in clinical practice, being realistic with how much I will be able to achieve within a short time frame is key to having quality findings, and has therefore limited the scope of what I will be able to produce within this study. By utilizing the term trans* (with an asterix), I am including the experiences of all individuals who fall outside of the cisgender category, such as nonbinary and genderfluid individuals (Killermann, n.d.-b). Although there are differing views on including the identities of nonbinary, genderfluid, or other gender identities outside of the binary under the trans* umbrella, this research benefits from a broad definition to include those who are not cisgender, for example, dissecting the concept of gender normativity. When I describe a mental health care provider, I am referring to a professional from whom an individual may seek care for support with mental health issues, such as a counsellor or psychologist. My survey questions ask about all forms of mental health care, even those that are sought from family or friends.

The current literature surrounding LGBTQ+ mental health treatment is primarily centered on the disorders that may be more prevalent for LGBTQ+ individuals (Cochran et al., 2003). Existing research examines themes such as the differential treatment outside and within care (Burton et al., 2020), subpopulations and their respective communities (Dias De Freitas et al., 2019), and provider awareness of LGBTQ+ specific issues (Israel et al., 2008), as discussed in the literature review below. In addition, much research has been done on how LGBTQ+ people experience mental health (Lucksted, 2004), whereas less is known about what may occur within care. Although the field of study is still emerging, there are clear gaps in the research areas of gender non-conformity (described further in the literature review in chapter three) and in Canadian contexts. Most research currently available is conducted in the United States and the

United Kingdom. My research is unique in exploring the smaller demographic of LGBTQ+ people who reside or have resided in Nova Scotia. Differences among healthcare systems are relevant to existing findings as well as my own research. Accessibility factors for mental health treatment differ greatly between countries that have a largely privatized healthcare system, and countries where there are publicly available and free treatment options. Although Canada has a public healthcare system, there are often long wait times and barriers to quality care that are faced in free health care (as opposed to the financial barriers of privatized healthcare, such as specific therapy approaches that are not publicly funded). My research looks at these areas that are not currently covered in the literature.

The language that a researcher chooses to utilize is an important consideration to make when studying marginalized communities. Use of outdated language by researchers or mental health practitioners can result in a sense of rejection for LGBTQ+ individuals. Specific terms have become outdated in rapid succession as social acceptance shifts – such as “transsexual” to refer to transgender individuals. As described in my rationale for using queer theory (See chapter two: Theoretical Framework), language can serve as a trust-building tool, or a microaggression if used inappropriately. Notably, LGBTQ+ communities and individuals can vary in terms of the language they feel is appropriate. When observing earlier articles alongside more recent work, it is clear to see shifts in language considered acceptable. For example, Freedman and colleagues (2002) use terminology such as “transsexual,” which would often be seen as a discriminatory term used for trans* individuals today.

One aspect of this research has been to invite perspectives on language considerations, which emerged as key elements of the nuanced experiences of the participants. More broadly, this study is based on a survey that I created for LGBTQ+ individuals to describe the personal

experiences that they have had in mental health treatment in Nova Scotia. I recruited survey participants through posters across the Mount Saint Vincent University campus as well as through the social media platforms Twitter, Facebook, and Instagram. Although my research was limited by the small number of participants from whom I was able to collect responses, this project allows for a conversation to begin about the mental health care that happens locally in Nova Scotia. I have used thematic analysis to categorize the situations and experiences the survey respondents brought forward in their narratives. To the extent the data allowed, I considered the differential backgrounds of gender and sexual minorities, such as those who fall outside of the binary in gender and/or sexuality. The goal of my research is to answer the following questions:

Research Question One: What are the concerns that are perceived by LGBTQ+ individuals within mental health treatment in Nova Scotia?

Research Question Two: Which issues raised during surveys by participants are relevant across LGBTQ+ identity categories and which are relevant only or mostly to one or some LGBTQ+ identity categories?

Research Question Three: How can the information uncovered be useful to mental health care providers seeking to become more cognizant of LGBTQ+-specific issues?

Observing the inequities and limitations perceived by participants has helped to clarify where there can be progress made to improve the treatment that is accessible to these communities. This research is important in the advancement of LGBTQ+ research, as well as aiding in the betterment of mental health resources that are currently available. My reason for expanding the research area of LGBTQ+ mental health lies in the gaps left in current literature, as well as the rapid evolvment of LGBTQ+ communities themselves. For example, the language that is

applied to identity categories that comprise this acronym is evolving, as reflected in the change in language of the literature itself. This is described further in Russell and colleagues (2005), who state that “the rapid pace of change in LGBT experiences may mean that adult LGBT people who are now in their 50s could be viewed as a “grandparent” generation to teens, while those in their 30s, clearly members of the adult community, are likely to have had different experiences and to have forged different views than have either older adults or teens” (2). Participants in my study were all young adults (19-35), so a relatively narrow age range. For this reason, I had hoped to collect data from participants in different age categories that would have reflected the evolution Russell and colleagues describe; this is an important consideration to keep in mind moving forward in this field of research.

The overall objective of this exploratory qualitative study is to provide insight into the negative and positive experiences LGBTQ+ participants have had with the mental health system in Nova Scotia. By generating a list of recommendations for practitioners, based on what I heard from participants, I aim to provide space for further investigation of what may be done to develop professional strategies for those who are providing care for LGBTQ+ individuals.

Chapter Two: Theoretical Framework

One clear question has been my guide for selecting which feminist theories would be best suited for this study: who are the subjects that feminism is speaking of? I have deployed feminist theories that emphasize and enable the inclusion of marginalized communities such as LGBTQ+ individuals. I have approached my research through the theoretical lenses of feminist standpoint theory, intersectionality, and queer theory. The normative representation of feminists as white middle-class women has been challenged many times, such as by women fighting for Black Feminist Epistemology (Patricia Hill-Collins, 1990) and Lesbian Feminism (Mary Daly and Audre Lorde), but very few theories are open for application across all axes of marginalization. Feminist standpoint theory was one of the first to address the limitations of early feminist writings, which often centered the perspectives of white, middle class, heterosexual, western women. More recently, the notion of intersectionality has been used to identify layers of othering due to the multidimensional nature of identity. Both feminist standpoint theory and intersectionality focus on the multiple aspects of the lived experience of those with marginalized identities. In contrast, while queer theory often intermingles with feminist theory, as is the case in the work of Judith Butler, queer scholarship is focused more specifically on LGBTQ+ identities and experiences, including the social constructs that shape both. Queer theory is used to dismantle the way in which sexual and gender minorities are perceived, and the beliefs that are held about these communities. In what follows, I address the relationships between standpoint, intersectional, and queer theories as well as the specific aspects I have drawn from each.

Feminist Standpoint Theory

As feminism evolves, it is expanding its reach to address all areas of inequality. Feminist justice is growing to address every form of marginalization that intersects with patriarchal oppression. From the perspective of feminist standpoint theory, whereas privileged groups lack the positionality required to understand the nature of power and oppression, “oppressed groups offer an emancipatory standpoint” (Cabrera et al., 2020, p.310). I have endeavoured to unpack hetero and cisnormative axes of privilege by using this theoretical framework throughout my qualitative methodology, while also using a thematic analytic method to explore the potential privileges and oppression. Feminist standpoint theory is “informed by the traditions of radical and socialist feminism, as well as womanism” (Cohen et al., 2022, p. 921). By deconstructing the “relations between the production of knowledge and practices of power” (Harding, 2004, p. 7), this theory and subsequent analytic method fit my goal of giving the power back to the individuals who have been disempowered in mental health care settings. By attending to their voices, my objective is to make power visible to readers of my findings, including mental health care providers. Explored in further chapters, I have aimed to let the participants’ knowledge of their own experiences take precedence in the findings uncovered by this study.

Unraveling the Patriarchal Structures of Marginalization

Like other feminist theories, standpoint theory unravels patriarchal structures such as sexist, homophobic, and transphobic ideologies and actions. These structures, which combine to marginalize the various LGBTQ+ communities, must be unraveled in conducting liberatory research on LGBTQ+ mental health care. Feminist standpoint theory hinges upon the need to reject the sociological perspectives that have centred and privileged white male perspectives and

experiences (Harding, 2004). Within societal context, perspectives of heterosexual cisgender white men tend to be privileged. This translates to the marginalization of those outside of this standard, including those who are LGBTQ+. The privileging of heterosexual cisgender white men's perspectives is evidenced by homophobia and transphobia, both in outward discrimination and microaggressive actions. Research using this theory can provide a space for LGBTQ+ individuals to express their own experiences and insights that have been produced in the context of being "othered". Feminist standpoint theory's engagement of people marginalized within normative power structures brings a unique and empowering perspective to more fully understand the barriers that marginalized individuals (such as those who are LGBTQ+) may face while seeking mental health care.

Objectivity and Neutrality in Research Practice

In contrast to mainstream perspectives on scientific objectivity, feminist standpoint theorist Sandra Harding (2004) uses the term "strong objectivity" to refer to recognition of the positionalities, including biases, of researchers "for scientific and epistemological reasons as well as moral and political ones" (p.136). "Strong objectivity" is not the rejection of internal biases, but accepting and utilizing them to unpack the passion a researcher has for a subject. The problematization of neutrality that this theory provides has allowed me to scrutinize my own internal biases that have inevitably shaped how I prepared and analyzed my survey and its responses. Using the veil as a metaphor, Harding describes how the pretense of neutrality can blur the research that is being conducted, right in front of a researcher's eyes (2004). For example, I am aware that my personal negative experiences of mental health care in Nova Scotia brought me to this area of research, potentially producing a negative bias in my views of the

field. However, my research has allowed me to recognize that some LGBTQ+ people in Nova Scotia have found effective supports within our health care system. In other words, in keeping with standpoint theory, there is an interrelationship between my personal life and research experience that must be reflexively recognized in the context of this study (Harding, 2004).

Producing Feminist Knowledge Through Representation

Through my research on this theory, it has been clear that “feminist standpoint scholars often use diverse qualitative methods to shift the standpoint to knowers whose vantage point has been ignored or discredited for producing knowledge” (Naples & Gurr, 2014, p.25). For this research, it was important that those whom I surveyed could share their knowledge and experience in a setting that is designed for their greatest benefit. Ways in which I have supported this include having the surveys completely anonymous, minimizing anxieties about identifiability; having no time limit as well as being careful of the language that I use throughout the survey. The language utilized throughout the survey, both in questions and accompanying information such as the consent form and mental health resources, was specifically employed for accessibility and readability for those who may be outside of academic settings. “Although the various feminist perspectives question the male hegemony, not all of them have dealt with the deeply different intra-gender situations and experiences of women, for example, according to their race and their social class” (Cabrera et al., 2020, p. 308). In contrast, feminist standpoint theory strives to represent everyone for their own layered identities as opposed to dealing with one identity category at a time. This framework is well suited to accommodate the multifaceted experiences of the participants in my research.

Intersectionality

Another key feminist theory shaping my approach to this research is that of intersectionality. Intersectionality is another example of how literature counteracting the invisibility of multidimensional minority groups is widely expanding throughout feminist research. “In 1989, [Kimberlé] Crenshaw offered intersectionality as a metaphor, and, in 1991, she elaborated it as a ‘provisional concept’ to demonstrate the inadequacy of approaches which separate systems of oppression, isolating and focusing on one, while occluding the others” (Carastathis, 2014, p.305). Crenshaw’s framework supports attentiveness to subpopulations within the LGBTQ+ community that are often minimized, such as the intersection of sexuality and race. The “sociodemographic characteristics” that are detailed within intersectional feminist research, such as race, ability, and social class, are key to understanding the unique perspectives and experiences that each participant brings to the table (Rossman et al., 2017-b, p.3). Indeed, an intersectional lens can be useful in thinking about the diversity that characterizes LGBTQ+ identity itself. Trans* individuals are often grouped in with the rest of the acronym, however their experiences with mental health care are greatly different from those who are a sexual minority. For example, trans* individuals typically seek out healthcare treatment for provisions such as medical transition, whereas those of a sexual minority do not.

Research on intersectional health and mental health differs about how the impact of intersectional identities on one’s health is best understood. Vargas and colleagues explain that:

According to risk models, discrimination is a chronic social stressor that contributes to poorer health and, thus, experiencing more than one kind of discrimination contributes added health burden. Some scholars have suggested that multiple discrimination has an additive effect, meaning that each additional new type of discrimination experienced

worsens health. Others argue that multiple discrimination has an exacerbating effect, such that experiencing two types of discrimination intensifies the impact on health, beyond additive effects (2020, p. 375).

Intersectional analysis is essential to any feminist endeavour. “Intersectionality favours approaches which consider how the systems of domination [...] ‘have reciprocal relationships’, ‘interact and impact’ the identity of people in ways that exceed the mere addition of systems of domination” (Cabrera, 2020, p. 309). It is not just a sole aspect of one’s identity or experience that can be variously constructed or obscured within patriarchy, but the way identity categories interact. Intersectional approaches tend to be more systematic about identification of the relevant identity categories shaping any given social phenomenon than standpoint approaches, whereas standpoint theory can be distinguished by its epistemological claim that society is most fully understood from the margins.

Queer Theory

In contrast with the labels often taken up within LGBTQ+ communities, “queer theory problematizes fixed and stable identity categories, including male/female, masculine/feminine, and lesbian/gay/straight distinctions, and re-thinks notions of plurality, intersectionality, and fluidity in discourse production” (Gedro & Mizzi, 2014, p.450). This branch of theory focuses upon stereotypes and prejudices that are held by individuals outside of and within the LGBTQ+ community, including the individuals who provide mental health care, as they are not immune to the disruptions inherent within these societal expectations.

A concept which I reiterate throughout my thesis is the evolution of language applied to queer identities and practices. Queer theorists reflect on this evolution implicitly by engaging with the term queer itself and its history in discrimination. For example, Dilley (1999) argues

that the intention behind reappropriating the term queer is to push back collectively against discriminatory practices. Although Dilley was discussing queer theory in the context of the year 1999, similar reclamations of “queer” by LGBTQ+ communities continue today. The progression of the term queer from a discriminatory slur to a reclaimed label used by individuals to find their place within the wide group of LGBTQ+ communities is a clear example of how language shifts over time. This is something that is reflected upon in my analysis.

The value of identity categories is something that not all queer or feminist theorists agree upon. This tension is amplified by scholars like Foucault, who see identity categories as politically ambiguous and belonging to power structures through which individuals must situate themselves. When considering the dimensions of power relations which bring identity categories into existence, Foucault states that:

Sexuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries gradually to uncover. It is the name that can be given to a historical construct: not a furtive reality that is difficult to grasp, but a great surface network in which the stimulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, the strengthening of controls and resistances, are linked to one another, in accordance with a few major strategies of knowledge and power (1990, p.105-106).

Seen from this perspective, the sexual and gendered identities of the participants in this study can be understood as historically constructed, in no small part through the workings of medical institutions. For example, as will be seen in chapter three the Diagnostic and Statistical Manual of Mental Disorders (DSM) has constructed categories such as homosexuality and gender dysphoria in ways that have shifted over time, in part responding to organized LGBTQ+

resistance. From a Foucauldian perspective, these shifting constructions have arguably produced the same LGBTQ+ communities that have variously appealed to or resisted the labels in question. One element of the Foucauldian understanding of sexual identity is that “people govern themselves by scrutinizing their own behaviour for signs of sin or abnormality as they are defined by apparatuses of power” (Bevir, 1999, p.350). However, in keeping with “the formation of special knowledges” and “strengthening resistances,” my research aims to articulate and ideally improve the mental health care experiences of individuals who live under the socially constructed rubrics of LGBTQ+ identity categories by listening to their voices. This work is also aligned with feminist scholars such as Cressida Heyes who respond to anti-essentialist critiques by arguing that: “We know that all explanations of experience are partial, interpretive, and contingent, but if feminists reject any criteria for privileging one account over another, they risk playing into forms of subjectivism or extant dominant accounts that will only weaken feminist political goals” (2000, p.48).

Conclusion

Queer theory, intersectionality, and feminist standpoint theory share rejection of standard patriarchal expectations. However, some scholars suggest that queer theory disagrees with feminist standpoint theory when it comes to essentialism. “Various scholars have warned that standpoint theory encourages essentialist or monolithic categories such as ‘women,’ often obscuring important differences” (McClish & Bacon, 2002, p. 29). Kokushkin (2014) has stated that standpoint thinking is essentialist in that it “implies that certain inborn characteristics of a woman define her and take precedent over cultural or historical contexts that she inhabits” (p. 14). Essentialism has often been critiqued within queer theory as an illusion that naturalizes the speaker’s inevitably self-serving assumptions about what exists in the world. In Seidman’s

(1994) terms, “any individual unconsciously assumes as natural and good (i.e., normal, healthy, and right) those aspects of one's life that confer privilege and power” (p.167). As such, essentialist claims can be traced to the “privileged gender and sexual social position” of the person who makes them (Seidman, 1994, p. 167).

Scholars have proposed various ways to walk the anti-essentialist tightrope of striving on the one hand to deconstruct the forms of identity that have been culturally naturalized and on the other hand to avoid theoretically erasing the subject of the emancipatory feminist struggle. One of the founders of queer theory, feminist scholar Judith Butler, is described by Jagose (2009) as seeing the task of anti-essentialism not as including more previously excluded categories of women within the feminist project, but as permanently holding the category of womanhood open in recognition that any closed definition produces exclusions that are ultimately “contrary to feminist aims and values” (p. 163) In my research, I have used these instabilities to create a fluid theoretical framework for identity that is open to the subjects that my participants have brought to the table. Feminist standpoint theory has allowed me to give voice to participants who have been marginalized by and through mental health care institutions, to situate myself within this research, and help to recognize my biases. Queer theory has provided a lens for reflection upon the placement of LGBTQ+ individuals in a wider society. Finally, intersectionality has opened a window on the variety of experiences that fall under the rubric of LGBTQ+ as well as the various axes of privilege and oppression such as age, race, and socioeconomic status, that contribute to the shaping of participants' experiences and perspectives.

Chapter Three: Literature Review

Within this literature review, I discuss the mobilization of concepts such as minority stress and rejection sensitivity, as well as exploring existing empirical research related to my own research. Focus points that emerged within the current literature include the client-provider relationship and its features such as types of disclosure, as well as intersections within the LGBTQ+ community. As discussions of LGBTQ+ individuals within historical presentations of psychology and psychiatry (more particularly, the DSM) have shifted from relatively pathologizing to relatively affirming, rebuilding the trust of LGBTQ+ individuals within professional mental health care emerges as an essential pursuit for providers.

Minority Stress and Rejection Sensitivity

A contextual framework which I have brought into my research is that of minority stress. Originated by Meyer (1995), the term minority stress was originally applied to the experiences of gay men. Minority stress theory discusses how stigma and its internalization impacts members of minority groups, and subsequently manifests into a fear of the negative perceptions of others. The theory of minority stress is found throughout the current literature on LGBTQ+ mental health. However, as I describe later in this literature review, research in this area continues to prioritize gay men.

A second concept that I have mobilized to further my understanding of mental health for LGBTQ+ individuals is rejection sensitivity. The rejection sensitivity model describes how stress can be caused by the way an individual's identity is seemingly perceived by those close to them, or even by the public. "Developed to explain how rejection from significant others can influence thoughts, feelings, and behaviors in subsequent close relationships," this model can point to how LGBTQ+ individuals may be impacted by past experiences (Feinstein, 2020, p. 2248). I drew on

the concept of rejection sensitivity within my study by asking questions that allow participants to explore their own sensitivities that may impact their experiences of mental health care.

As described by minority stress theory, rejection can cause ongoing fear, which can in turn impact many areas of an individual's life. When rejection is experienced early in life, the result may be "hyper-vigilance for [...] and intense react[ions] to perceived rejection" (Feinstein, 2020, p.2248). This model suggests that rejection in individual relationships can lead to a sense of feeling rejected by wider society. This impacts not only the mental health care that one may receive, but reduces the likelihood that an individual will seek treatment. Individuals who identify as LGBTQ+ may feel wary of clinical environments due to long-standing prejudice in psychiatric communities. Within psychiatry, historical "theories of pathology tend to view homosexuality as a sign of a defect, or even as morally bad, with some of these theorists being quite open about their belief that homosexuality is a social evil" (Drescher, 2015, p.566). Minority stress and rejection sensitivity explain two avenues for how being in a minority category (specifically LGBTQ+) can negatively impact one's overall well-being. These models recognize the vulnerability of LGBTQ+ individuals while also highlighting the societal origins of the stressors that impact their daily lives.

Minority stress and rejection sensitivity manifest through an individual's perception of how they are seen by others. "Given that contemporary prejudice often manifests in subtler forms than it did in the past," perceived rejection or stigmatization often involve the subtle and ambiguous nature of microaggressions (Feinstein, 2020, p. 2251). The discernment of these microaggressions can vary between individuals, as each person will perceive a different action as a rejection. These two models point to the importance of research into LGBTQ+ mental health care: if a provider does not take these seemingly small impacts into consideration, desirable

outcomes in mental health treatment may not be realized or an individual's condition may be worsened. In contrast, by supporting clients in understanding their past experiences within care, as well as responding to the needs that clients communicate, mental health care providers may be able to mitigate the effects of past miscommunication (Feinstein, 2020, p.2253). I have used minority stress and rejection sensitivity as sensitizing concepts that have brought awareness to the strains that are placed on LGBTQ+ individuals while accommodating for variance in terms of how those strains are experienced.

Discrimination External to the Therapeutic Relationship

Stereotype threats are perceptions rooted in “social constructs [that] negatively influence an individual's behaviour” and are barriers for all minority groups (Ojeda-Leitner & Lewis, 2019, p.253). The assumptions made by others about an aspect of one's identity, such as their skin colour or sexuality, can be based on demeaning or harmful connotations that can change the way an individual feels about themselves, even subconsciously. Outward societal expectations impact the self-perceptions of LGBTQ+ individuals (Ojeda-Leitner & Lewis, 2019, p.253). Homophobia or transphobia is sometimes internalized by LGBTQ+ individuals (Meyer, 1995). Such attitudes received from society can negatively impact how an individual constructs and shares their identity with others. The source for such negative beliefs is often peer interaction, familial interaction, or culture more broadly, as reflected in media. Heteronormativity is pushed upon individuals through lack of representation or visibility of LGBTQ+ individuals, or through outright homophobia or transphobia. This, in turn, impacts care that LGBTQ+ individuals may seek from their support systems, both external to and within professional mental health care (Meyer, 1995).

Vulnerabilities Within the Therapeutic Relationship

A positive client-provider therapeutic relationship is key to establishing trust and being able to understand and effectively respond to what an individual may be going through at any level of a therapeutic relationship (Rossman et al., 2017-b). Often experienced by LGBTQ+ individuals in everyday life, microaggressions are defined as subtle or offhand remarks or actions that are perceived by an individual of a minority group to be based in discriminatory practices. Microaggressions within mental health care might strain the client-provider relationship to the point that the trust is broken. It is important to distinguish between overt discrimination and (more common) non-affirming mental health care. Non-affirming providers may make assumptions about clients based on cisnormative, heteropatriarchal frames of reference, and therefore address care from these perspectives (Rossman et. al., 2017-a). While overt discrimination is outright, clear, and tangible, covert discrimination such as non-affirming care can result from a lack of attunement to the client's lived experience in relation to their intersecting identities, resulting in a failure to connect. I actively made this distinction when analyzing my participants' responses.

Disclosure and Vulnerability

When discussing LGBTQ+ mental health care, it is fundamental to consider vulnerability and the risk that is associated with it. When a client discloses their identity to a practitioner, there may be constant fears of not “being accepted by healthcare providers, being outed beyond the healthcare relationship, [and] about whether appropriate care [will] be provided” (Smith & Turell, 2017, p.645). One of the key aspects of mental health care is a client's comfort with disclosing their experiences. Identity disclosure is a key function of mental health treatment, and without it, a mental health provider is unable to truly understand and support the client with the

issues they may be facing. Healthcare clients who feel unable to disclose aspects of their identities to practitioners are likely to experience stress as a consequence. This situation may “confound healthcare decision-making when elements of identity are important to diagnoses or clinical management decisions” (Smith & Turell, 2017, p.638). Disclosure of identity was mentioned multiple times both directly and indirectly within survey responses. There may be ways in which a provider shuts down communication with a client without realizing it. For example, microaggressions, such as negative body language, cause discomfort for those seeking mental health care by signalling providers’ discomfort (Schuller & Crawford, 2020).

Rossman and colleagues (2017-b) suggest that the most proactive method for providers to mitigate the impacts that stereotype threats and internalized homophobia or transphobia may have on an individual is to ask their clients about their gender and sexual identities. By not asking questions about something that may play an important role in an individual’s everyday life, the provider may be closing the conversation before it even begins. Similarly, Schuller and Crawford (2020) suggest that asking the individual about their identity and providing a supportive response is a proactive manner of creating a safe space, since the process of ‘coming out’ to a provider is a great act of trust that may not be something they are even willing to share with others unless they are asked. Notably, as will be seen in my results section, not all participants shared this view. Some preferred instead that providers wait for clients to disclose if and when the client is comfortable doing so.

Provider Awareness

Education directed at fostering cultural competency should be made available through required degree programs and/or supplemental training for mental health providers. Lacking resources to further the understanding of LGBTQ+ lived experience can hinder the overall ethos

of the provider's care (Ojeda-Leitner & Lewis, 2019). A key aspect of provider awareness is known in therapeutic communities as cultural competency.

Cultural competence is defined as the ability of the mental healthcare provider to understand the cultural influences necessary to guide the treatment of patients belonging to a specific community. In the context of LGBT patients, cultural competence entails sensitivity about and understanding of important issues affecting the LGBT community. (Whaibeh et al, 2020, p.426)

While research indicates that it is not required for a practitioner to identify as a member of the LGBTQ+ community to provide culturally competent care, it is important for providers, both within and outside LGBTQ+ communities, to be trained on how to identify their own biases and conduct regular self-reflection as to how these biases may impact the care they provide (Schuller & Crawford, 2020). The suggestions that have been made in the current literature focus on LGBTQ+ specific training for mental health practitioners; "Educating staff, providing a LGBTQ friendly environment, and adopting non-discriminatory policies will foster a culture that better serves marginalized communities and increases utilization of mental healthcare services among gender and sexual minority populations" (Ojeda-Leitner & Lewis, 2019, p. 262).

LGBTQ+ Intersections

Subpopulations within LGBTQ+ communities have different experiences within systems of privilege and oppression. When looking for empirical resources on LGBTQ+ mental health, I came across many articles that primarily addressed the identity category of gay men, and very few other members of the LGBTQ+ community. For example, searching "gay men mental health" in Google Scholar retrieves 1,320,000 results, as opposed to searching "bisexual mental health", which uncovers 213,000 results. In contrast, my research has not restricted the category

LGBTQ+ to lesbian, gay, bisexual, and transgender individuals. There are many differing groups that are encompassed by the plus symbol, such as gender non-conforming or asexual individuals, not all of whom are equally represented in the literature.

Additionally, age of LGBTQ+ individuals may be a factor, as the experiences of young LGBTQ+ individuals may vary greatly from those of an older generation. Unlike young heterosexual adults, young LGBTQ+ adults (described by Rossman and colleagues as those aged 18-27) are often seen as not having a defined identity yet, and therefore their positions within LGBTQ+ communities are brushed off as invalid and needing to be reinforced at a later stage in their lives (Rossman et al., 2017-a). This differential attention to fluidity in identity development arguably comes from the heteronormative expectation of a nuclear family, as well as the pathologization of non-heterosexual identities. In some respects, queer theory argues that there is no such thing as a fixed identity, heterosexual or otherwise, citing a “responsive flexibility” within the label “queer” itself. However, the idea that one’s identity may change over time should not be seen as negating the validity of a young person’s emotions and actions (Jagose, 2009). Although my research sample represented a relatively narrow range of ages, drawing on the literature, I have considered how participant age may shape the data I have collected. This consideration is reflected in my methodology and results chapters. One aspect of queer experience that may relate to age-based differences in how community members relate to their identities is the shifts that have occurred in medical conceptualizations of LGBTQ+ communities over time.

The Pathologization of Homosexuality and Gender Dysphoria

Although homosexuality was delisted “as a mental disorder from the DSM,” in 1973, debate about whether same-sex attraction constituted a disorder continued (Toscano & Maynard, 2014, p.249). Moreover,

[I]n ‘homosexuality’s’ place, the DSM-II contained a new diagnosis: Sexual Orientation Disturbance (SOD). SOD regarded homosexuality as an illness if an individual with same-sex attractions found them distressing and wanted to change. The new diagnosis legitimized the practice of sexual conversion therapies (and presumably justified insurance reimbursement for those interventions as well), even if homosexuality per se was no longer considered an illness. The new diagnosis also allowed for the unlikely possibility that a person unhappy about a heterosexual orientation could seek treatment to become gay. (Drescher, 2015, p.571)

The similarly pathologizing label Ego Dystonic Homosexuality (EDH) followed shortly after SOD, appearing in the DSM-III. EDH was in turn replaced by Sexual Disorders not Otherwise Specified, a diagnosis which included the possibility of distress about one’s sexual orientation (Robles et al., 2021). All three diagnoses allowed for delegitimization of homosexuality as an identity, rationalizing the previously mentioned conversion therapy, which was formally made illegal in Canada just last year, 2022 (Drescher, 2015, p.571). These persisting ideologies are not forgotten by those who suffer because of them, and fails to acknowledge societal-level reasons for distress due to ongoing discrimination (Toscano & Maynard, 2014).

Pathologization of gender dysphoria is both similar to and distinct from pathologization of same-sex attraction. The appearance of gender dysphoria in the DSM-5 is eerily familiar to the pathologization of homosexuality in psychology (Dias de Freitas et al., 2019). However, unlike

the now defunct diagnosis of homosexuality, the diagnosis of gender dysphoria is experienced on the one hand as pathologizing and on the other hand as enabling access to medical modalities of transition. Some argue that the DSM criteria are oppressive even insofar as they enable access to “transitioning treatments” in that these criteria perpetuate “outdated stereotypes” which trans-identified clients are compelled to “tailor” their “clinical narratives” in accordance with if they wish to access hormonal or surgical interventions (Davy, 2015, p.1174). Furthermore, as Inch (2016) puts it: “Some trans people ultimately view the label of disorder as the price that must be paid for access to treatment. For some, medical treatment truly is ‘a matter of life or death’, and they fear the removal of it from the diagnostic manual could have devastating consequences” (p.199). Compelled construction of the gender diverse self within the structures and strictures of the medical establishment recalls Foucauldian frameworks introduced in chapter two. More specifically, the requirement to attain a diagnosis by constructing one’s identity around specific medical narratives is an example of how, as argued by Foucault (1990), institutions such as the medical establishment compel subjects to discipline themselves according to particular discourses. At the same time, curating one’s clinical narrative to achieve the desired outcome, such as medical transition, can be read as a form of resistance practiced by the trans* individual.

Transnormativity

In comparison with trans* individuals undergoing binary transition, those who are not categorically transitioning to the other sex are less recognized within research. Nonbinary individuals, or any other type of gender non-conforming identity such as agender or genderfluid, who may or may not experience gender dysphoria, are largely ignored within the mental health research I have reviewed. This gap in the research may be seen as a component of what is referred to as “transnormativity.” As discussed by Murawsky, this term refers to dynamics

whereby “trans people are held accountable to both cisnormativity and a set of criteria unique to transgender people as a group.” Transnormativity normalizes and affirms trans people who have medicalized, binary gender identities, who adhere to stereotypical gender roles, and who adopt ‘born in the wrong body’ narratives. Medicalization is thus an essential part of transnormativity and subsequently a hallmark of ‘authentic’ transgender identity” (2023, p.2). Insofar as, in some countries, the availability of medical interventions may be linked to socioeconomic status, transnormativity may also intersect with classism. Transnormativity is pivotal to understanding the dynamics of gender identity, and therefore my research sought to shed light on the population of trans* individuals whose identities are not binary or who do not choose medicalization. This has been reflected within my results and conclusions found in chapters five and six.

Summary and Overall Review

Overall, an overarching necessity that I have found within LGBTQ+ mental health research is the positive client-provider relationship, otherwise known as the therapeutic alliance. Mental health research in this area pinpoints barriers to access as well as offering recommendations about how to create an environment where the client feels comfortable to share their experiences through self-identification as LGBTQ+ (often referred to as disclosure or ‘coming out’). Another theme within the literature is how changes in the options for receiving care, including increased provider awareness and cultural competency, can generate more positive experiences of care which build clients’ trust over time. For example, Schuller and Crawford (2020) cite earlier studies showing that experiences of mental health care experienced as poor quality by clients may inhibit future mental health help-seeking. There has been much damage done to the LGBTQ+ communities by the psychiatric establishment. However, advances in provider knowledge and cultural competency have been made which, through further

development and continued proliferation, may improve access to and adequacy of care for future generations. At the core of this literature, concepts such as rejection sensitivity highlight that aspects of LGBTQ+ mental health care experience are fundamentally related to external social pressures (Dias de Freitas et al., 2019, p.100). Existing research, both theoretical and empirical, denotes the importance of deconstructing heteronormative biases in research, as well as the heteronormativity and cisnormativity that is prevalent within the healthcare system (Schuller & Crawford, 2020, p.1). Situated in the context of existing literature, this study can be seen as part of a crucial continued expansion of a body of research. It provides insight into how providers can regain the trust of those who have been negatively impacted by mental healthcare in the past, and how to effectively help those who will be receiving mental health care in the future.

Chapter Four: Methodology & Methods

Data Collection

In this thesis I employed a survey-based qualitative research design, utilizing a thematic analysis method to explore and interpret the survey responses. I began by creating an online survey that was available to participants who: identify themselves as belonging to any subcategory of LGBTQ+, have received mental health care in Nova Scotia, and are 19+ years of age. The definition of mental health care was left open so participants could identify the resources that fit this term for them, such as publicly available counselling, private counselling, school/university-based counselling, general practitioner care, pastoral care, or elders for Indigenous care. The age-based inclusion criterion of 19+ was selected to mitigate risks relating to the capacity to consent for research purposes. These inclusion criteria were modelled on those deployed by Ojeda-Leitner and Lewis (2019). The survey was administered and data was recorded through the MSVU-provided Lime Survey platform. This platform allowed me to input the questions that participants received in a clear and organized manner, with the informed consent at the beginning; the survey questions, and mental health resources at the end. Lime Survey allowed me to keep my survey participants completely anonymous; however, it allowed me to assign each respondent an identifier, so that I could look for connections between each individual's responses. This made it possible to analyze the data for intersectional relationships and other contextualized experiences that will be described throughout my analysis. An example of a survey methodology that I have observed within the literature is with Moallef and colleagues (2022), where the sample size was much greater. Their study gave me an example of how survey research can be done cross-culturally, as well as the broader reach that social media recruitment (further described below) can have as opposed to only using physical posters in a particular area

such as on campus. Ojeda-Leitner and Lewis's (2019) research, which was based on an online survey distributed via social media, also provided a useful example. Having these articles to guide my understanding of survey-based methodologies has allowed me to model my own research in a way that was suited for a smaller sample, such as avoiding making broad statements in my results to keep the scope of the interpretation of my findings reasonable.

Recruitment and Sample

I then created a poster to promote the call for participants, which is included in my appendices (Appendix A). This poster detailed the project, the inclusion criteria necessary for participation, and what participation would involve. It had a hyperlink to the survey, as well as a QR code that was linked to the survey directly for potential participants to scan. This poster also had my email address, so interested individuals could contact me directly with any questions. A recruitment post was shared on a variety of social media platforms such as Facebook, Instagram, and Twitter, then re-posted widely from my original posts, including shares from South Shore Sexual Health, an organization specializing in LGBTQ+ care. The post contained a picture of the poster, as well as a link that any person could click on which took them directly to the survey. The post specified that I was "looking for LGBTQ+ individuals who are 19+ and have received mental health care in NS" to participate. I also displayed these posters on bulletin boards throughout hallways on campus at MSVU, increasing the possibility of individuals participating who may not use social media. I displayed the posters across Mount Saint Vincent University, a primarily female-based university with 76% of attendees being women as of 2021, which may have impacted the demographic that responded to the call for participants (Mount Saint Vincent University, n.d.). Social media recruitment may have also had an impact on the sample, since the study was posted through my own personal social media pages. In retrospect, it would have been

beneficial to have a question detailing which avenue led participants to the survey. Participants self-selected into the survey by following the link on recruitment materials. Participants were encouraged to take this survey in a private and safe location as noted on the poster, the consent form, and in the summary provided at the beginning of the survey. While methodological guidelines for small-scale qualitative surveys are difficult to find, Sherrill and colleagues (2022) have relied on the often-cited guideline that 15 respondents in a qualitative interview-based study can provide a sufficient data set for analysis (Guest et. al., 2006) as a rationale for their use of a small-scale qualitative survey. A smaller sample size has allowed me to conduct a thorough and in-depth qualitative analysis of responses within the time constraints associated with the thesis timeline. The ideal number of participants that I determined was 20, based on these relevant findings in the literature. In total, I received 17 completed responses. Nineteen individuals had opened or commenced the survey but had not chosen to submit their responses. Only the latter 17 responses could be used, given that the consent form allowed participants to withdraw by closing their browser at any point before clicking “submit” at the end of the survey. Those who did not complete the survey may have shared some characteristic that shaped the results of this study, although without the ability to access their demographic information this cannot be determined. This number of responses provided a rich and diverse dataset which allowed for insight into a variety of perspectives and experiences that clinicians supporting LGBTQ+ individuals would do well to take into account. A future, broader scale survey accompanied by an interview follow-up could provide a sense of gaps in this dataset as well as the prevalence of views expressed by participants within Nova Scotia's LGBTQ community as a whole.

Advantages and Disadvantages of Survey Method

The survey allowed for the gathering of knowledge that varied in depth and detail based on how the questions resonated with each participant's unique background. The open-ended question format of an online survey fit the nature of this project due to the complexity of the subject matter. Instead of responding in real time, as happens with in-person interviews, each participant was able to take their time to decide on the message they wanted to articulate and to explore its meaning. The survey questions asked about access to and experiences of mental health care, as well as the interaction of LGBTQ+ and other identities with these experiences. The questions deliberately avoided asking about any conditions or experiences that may have led to the seeking of mental health care, although these themes were discussed voluntarily by many participants.

At the beginning of this research endeavour, my goal was to deploy an interview methodology which would have allowed 6-8 semi-structured interviews to take place. However, during the ethics review process, I discovered that the survey method was a lower-risk procedure for an early career researcher like myself. Although initially disappointed that I would not be able to conduct individual interviews, once I began to review the survey responses, it became apparent to me that the survey methodology was well suited for the information I was hoping to gather. The responses that I received made it clear that participants appreciated the opportunity to write about these topics, and the impact that experiences within mental health care had on their wellbeing. The suitability of this methodology was evidenced by the length of many responses, where I often received full paragraphs in answer to open-ended questions. The average time that it took to complete the survey was 44 minutes, which exceeded the expected 30-minute timeframe. Previous authors who have conducted related research, such as Ojeda-

Leitner and Lewis (2019), included sections of demographic questions followed by open-ended questions about care experiences; although their survey was much more detailed (having 116 questions as opposed to my 20), I modelled my survey formatting using a similar organizational structure, specifically involving demographic questions followed by open-ended questions.

Participants may have felt particularly comfortable sharing their experiences in the privacy of a survey format. Since the survey was completely anonymous, it can be discerned that any fear of having their real identities exposed was diminished. Since the survey was web-based, rather than completed on paper, it allowed for a greater level of control for participants, such as being able to reword or change their responses for clarity and accuracy or to alter the amount of information given before submitting. In an interview, this would not be possible, as anything that may have been said would have been recorded and transcribed. Overall, the survey methodology unearthed information that I may not have discovered with a face-to-face interview. This method also allowed me to collect a slightly wider scope of responses. The participants I recruited had greater variations of identity than I would have been able to explore with six to eight participants. Out of 17 respondents, six identified as queer, five as bisexual, two as lesbian, one as gay, one as pansexual, one as panromantic demisexual, and one as aromantic bisexual.

Survey Structure

Participants indicated their consent by checking a box at the bottom of the first page. This was followed by a demographics questionnaire that asked about how participants identified, including whether they considered themselves part of the LGBTQ+ community, as well as their ethnicity, dis/ability, race, and age. This allowed me to analyze the responses in connection with these categorizations of identity. The next page showed the long answer questions that asked about experiences of accessing care, such as specific barriers to access; the age at which

participants first sought care; and experiences of receiving care, such as aspects that made participants more or less comfortable, or body language and terminology used by providers. Other questions asked about the interactions between various aspects of accessing or receiving mental health care and one's LGBTQ+ identity. These questions were specifically worded as follows:

- In which ways, if any, do you think your experience in mental health care has been impacted by your LGBTQ+ identity? In which ways, if any, do you think your experience in mental health care has been impacted by your other identities? (Question 9)
- In what ways, if any, do you think your care has impacted the way you relate to your LGBTQ+ identity? In what ways, if any, do you think your care has impacted the way you relate to your other identities? (Question 10)

The rest of the open-ended survey questions can be found in Appendix D. Finally, there was a closing page thanking the participants for their involvement and providing contact information for LGBTQ+ friendly mental health resources available both in person in Halifax and virtually (Appendix E). My contact information was also included on that page. Notably, no participants reached out to me during their interview process, either in order to safeguard their own privacy or because the survey did not give rise to any questions.

The preamble to the survey discouraged participants from revealing their identities in the survey answers, however I was aware that accidental disclosure was still a possibility. Therefore, when reviewing the data generated, I made sure to replace any identifying information with pseudonyms in the working files. It was not necessary to create a key linking pseudonyms to participants' identities because, as coded by Lime, the participants were identified with ID numbers instead of names. The survey was active from April 25th until May 26th, 2023. Once I

had not received new submissions for two weeks despite reposting the call for participants, I reviewed the answers I had received. Finding that the data I had collected was richer than expected informed my decision to close the survey at that time.

Analysis

The software that I used for my analysis was MAXQDA, titled after the “German sociologist Max Weber [followed by] the abbreviation QDA – which stands for Qualitative Data Analysis” (VERBI, 2023). Available through MSVU in the Seton computer lab, this software helped me in organizing the participants’ responses in a way that was well suited for qualitative analysis. Namely, MAXQDA allows the researcher to code the data, consolidate codes into themes, and add memos to track and streamline their thought process. I have used thematic analysis to examine the data. Compared to other forms of analysis, “thematic analysis moves beyond counting explicit words or phrases and focuses on identifying and describing both implicit and explicit ideas within the data, that is, themes” (Guest et al., 2014, p.9). To begin, as outlined by Maguire and Delahunt (2017), I downloaded each participant’s response into a Word document, and then added these Word documents to MAXQDA individually. This way I could examine each participant’s answers holistically, rather than grouping the responses to each question together and examining them without the context of the participant’s demographic information and other qualitative reflection. Once this organizational step was complete, becoming familiar with the data I had collected was essential to finding the key perspectives presented by each participant. I read the survey responses multiple times as well as reflexively noting what made an impression during each reading.

The initial codes were reflective of the diverse meanings that were derived from the questions by each participant. Participants’ approaches to questions and the time they appeared

to have spent on each question varied. I began my coding process by differentiating the amount of social support that was available to each participant external to mental health care, such as family and friends. This information required relatively less interpretive labour than questions that invoked more narrative meaning. Starting with participants' answers to this question allowed me to become familiar with the process of labelling the data before I began looking more in depth at the remaining responses, which were analyzed simultaneously at the level of each survey, as mentioned above. This made sense given that remaining responses by each participant often referenced or built upon one another within surveys.

Once these codes were created, I began searching for themes throughout the data. These themes related to one or more of my research questions and were “characterized by significance” (Maguire & Delahunt, 2017, p. 3356). When using this phrase in relation to their method of thematic analysis, Maguire and Delahunt (2017) are not describing the importance of one theme over another, but the frequency at which themes appeared in a given qualitative data set. Once these themes were organized and named, I reviewed them to confirm they were mutually exclusive, exhaustive, and sufficiently fine-grained. An example of this within my analysis process was breaking down the category of concerns surrounding the care provider's knowledge of the LGBTQ+ community into specific areas of concern, such as whether an LGBTQ+ provider was necessary for a client to feel comfortable with care. The codes that emerged during this process form the basis of my written analysis and findings, found in chapters five and six.

Quantitative surveys deploying existing scales have been used by researchers such as Moallef and colleagues (2022) to conduct research on LGBTQ+ mental health care. This approach has strengths in terms of facilitating quick analysis and clear presentation of the data collected, although the meaning of responses to participants who select them may not be

provided by the data. A strength of my research is its ability to provide qualitative context. Qualitative analysis should account for the characteristics of the sample the researcher has collected. For example, Ojeda-Leitner and Lewis (2019) noted of their study, “since the sample is predominately white, it might have represented a group of individuals with less experiences in marginalization and discrimination within the mental healthcare setting” (p.260). My analysis includes similar recognition of the representational limits of this study resulting from the small sample size and, relatedly, the fact that many identity groups were not included.

My interpretation of the data changed over time due to the connections I was able to make between responses as I became more familiar with the underlying issues that were being discussed. Using this analytic method alongside the theories mentioned in the literature review and the data collection methods described above, I have striven to organize my data using plain language. Accessible language is important to me and is something that informs my research process. Academic language, particularly surrounding topics like mental health, often is inaccessible for a general audience to interpret. The way I have chosen to label the themes that are presented in my findings involves applying accessible language that is informed by theoretical concepts.

Goal of Analysis

Overall, the goal of my analysis was to identify key issues that are experienced by LGBTQ+ individuals in mental health care so providers can reflect on the meaning-rich concerns brought up by participants as they relate to the providers’ own practices. This list of concerns and recommendations appears in chapter six. I set out to learn about the ways in which mental health practitioners are able to create an open space for LGBTQ+ individuals, encouraging practitioners to explore how their clients’ identities may impact their experiences with mental

health care. Although I could not predict the information that my participants disclosed, I was prepared to identify intersectional links between axes of privilege and the themes I observed. For example, I attended to class differences in accessibility of mental health care and the way other identity categories such as race or disability may impact the care one has received. Making these intersectional connections was a feminist endeavor that unfolded during analysis based on the responses I had received.

Limitations

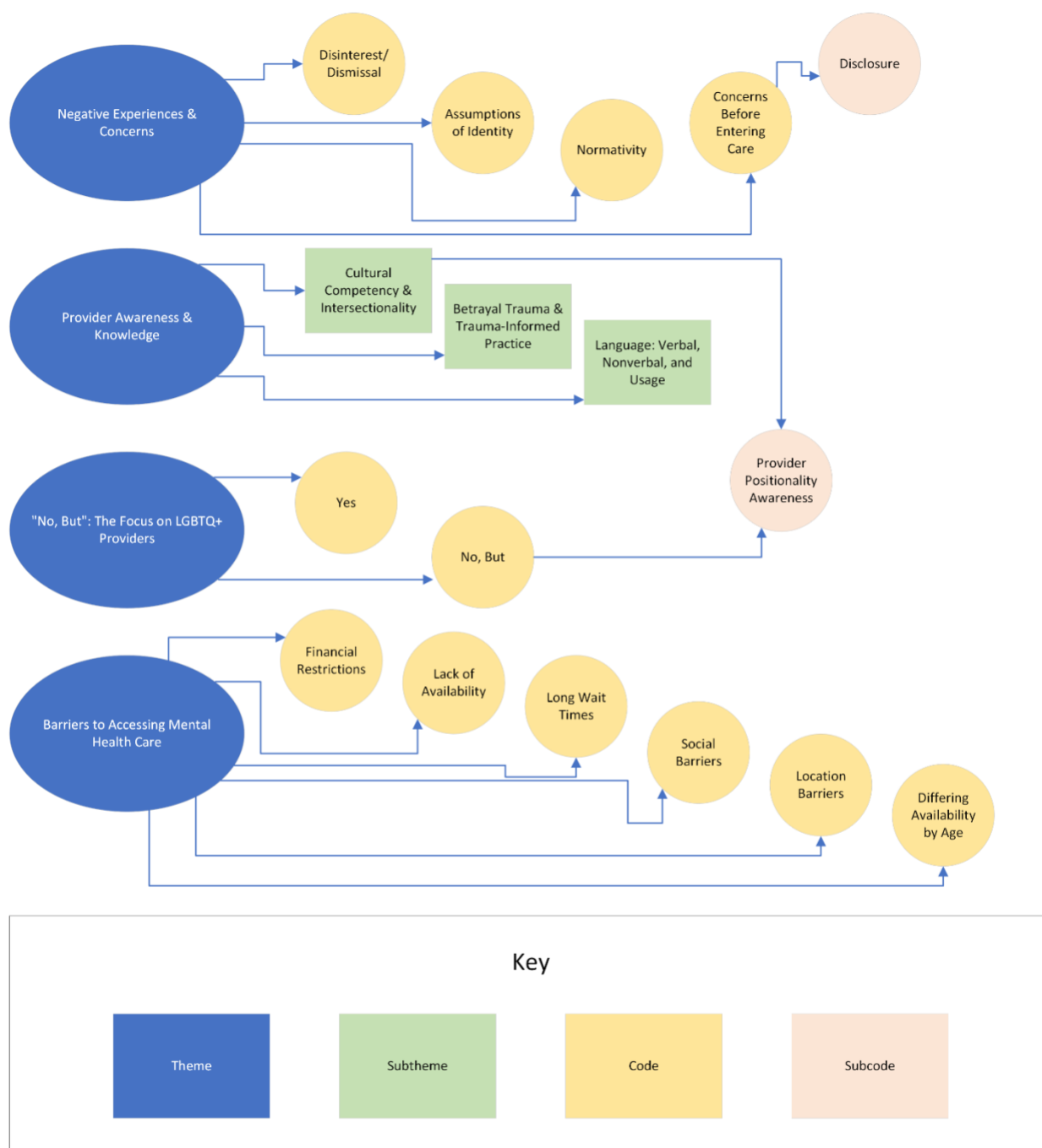
There are many limitations that could impact the findings of my research, and therefore I attempted to recognize and account for them from the beginning. A small-scale qualitative study such as this is not generalizable. I am aware that I was only recruiting participants from one small location in Nova Scotia whose experiences may differ from those of people living in other geographic locations. Considering the identities of the participants who are involved is of importance as well. Given that I only have a small percentage of participants who are racial minorities, the perspectives collected are likely to be particularly reflective of white experiences. Understandings presented by queer individuals cannot be considered representative of the community, because the experience of having a non-normative sexuality or gender is something that varies from individual to individual, place to place, in all its varieties. Furthermore, my research was limited to the individuals who I was able to contact through posters on campus at MSVU and through social media. This leaves out many populations, such as those who are not able to attend university or do not attend MSVU, which creates an immediate concern about class differences within the respondent population. The participants recruited for my study were primarily 21-25 years old, few were 26-35, and none were over the age of 35, with one from 19-20. As mentioned earlier, the findings should be read through the lens of these limitations.

Chapter Five: Results & Discussion

This chapter opens with demographic information collected from participants, then I proceed to analyze data collected in response to each topic area covered by the open-ended survey questions, organized according to codes and themes that emerged through thematic analysis of the data I collected over the course of this analysis. Drawing connections to the literature which framed the design of this study, I consider the clinical and theoretical implications that emerged from my findings. The themes and subthemes presented in what follows relate to experiences of care, reflecting areas of focus in participants' responses. These include:

- Supports external to mental health care
- Negative experiences and concerns within care
- Provider awareness and knowledge
 - Cultural competency and intersectionality
 - Betrayal trauma and trauma-informed practice
 - Language: verbal, non-verbal, and usage
- “No, but”: the focus on LGBTQ+ providers
- Barriers to accessing mental health care

For a further breakdown of the themes, subthemes, codes, and subcodes, that will be elaborated in the remainder of this section, see Figure 1 below.

Figure 1*Themes, subthemes, codes, and subcodes*

Within this analysis, respondents are referred to by their response ID numbers, which were generated by MAXQDA (for example, participant A). In addition, they/them pronouns are used for all participants as an additional measure to protect confidentiality.

Demographic Information

Feminist standpoint theory hinges upon the concept that societal norms (including those baked into mental health theories and practices) have been built upon stereotypical understandings of cisgender heterosexual men's normative perspectives, which in the case of this study is the perspectives of LGBTQ+ people. This theory supports research from the vantage points of marginalized people (Harding, 2004). This research draws not only on perspectives of LGBTQ+ people, who are marginalized, but on perspectives that are marginalized among LGBTQ+ groups. In contrast with much of the currently available research on LGBTQ+ mental health that draws on data from gay men to represent LGBTQ+ individuals (such as the minority stress model advanced by Meyer [1995]), a majority of respondents in this study were bisexual and queer individuals, with no cisgender men as respondents. Moreover, the majority of research on LGBTQ+ experiences in mental health care is conducted in the United States or the United Kingdom. In other words, because this research was conducted in Nova Scotia, its findings come from a unique sample of individuals, including a range of queer identities. As shown in the demographic table below, this sample diverges from the heteropatriarchal norm to create a distinct frame of reference.

Table 1

Demographic information of respondents

Gender Identity		Sexual Orientation		Age		(Dis)ability		Race	
7	Cis Women	6	Queer	11	21-25	8	No	12	White

6	Genderqueer /Nonbinary	5	Bisexual	4	31-35	7	Yes, Invisible	3	No response
4	Trans*	2	Lesbian	1	26-30	1	Yes, Visible	1	Black
		1	Pansexual	1	18-20	1	No response	1	Mixed Race
		1	Gay						
		1	Panromantic Demisexual						
		1	Aromantic Bisexual						

Supports External to Mental Health Care

I derived three codes to participants' responses to the question, "How would you describe your social support system outside of mental health care (family, friends, etc.)?": Ample External Support, Some External Support, and No External Support. Seven participants indicated that they had ample support external to professional mental health care; nine participants specified that they had some external support, such as one or two close friends; and one expressed that they had 'nonexistent' support external to mental health care. Most of the participants who noted that they had ample external support felt this was positive. Their positive evaluations were consistent with the findings of Crabtree and colleagues (2010) that external social support "predicted enhanced self-esteem" (p.562) among those experiencing a decline in mental health. Similarly, Wright and Perry (2013) have explained that with ample external support, over time, LGBTQ+ individuals are likely to "become less psychologically distressed and will be more likely to possess the psychological resources to negotiate complex social relationships with peers and others" (p.88). For example, Participant O specifically used the term "good" when referring to the availability of ample external support, saying that "My social support system is pretty good! I have very understanding friends, and a few family members I can confide in." In contrast,

Participant H described their support as nonexistent. Although this participant did not expand on how their lack of support system impacted their sense of wellbeing, given the benefits of social supports identified by researchers cited above, it seems safe to assume having some social support system would be preferable to none.

At times, participants' responses with regard to external support may suggest connections between minority stress, rejection sensitivity, and the communities surrounding LGBTQ+ individuals. One example of this response is from Participant B, who explained that "family and most friend[s are] very supportive, but all dealing with their own mental health issues, making me want to bug them less when I need support." Rejection sensitivity specific to LGBTQ+ individuals (Feinstein, 2020) may compound their concerns about impeding on others' lives by seeking support with mental health issues and perhaps experiencing rejection as a consequence. Another example of this connection is from Participant K, who stated that their social supports (specifically friends and family) were understanding, "until it comes to the ugly parts that are still stigmatized." In referring to the 'ugly parts' of mental illness, the participant may be describing the experiences in relation to which they have been (or fear being) socially rejected, given that ugliness is a form of negative social perception. Rejection sensitivity specific to LGBTQ+ individuals (Feinstein, 2020) may compound their empathetic and self-abandoning concerns about burdening others' lives by seeking support with mental health issues. Limited availability of social support reported by some participants highlights the importance of professional, effective, and accessible mental health care.

Negative Experiences and Concerns Within Care

One of the overarching themes that emerged from this research is "Negative Experiences and Concerns Within Care." This theme includes aspects of participants' mental health care

experiences that help the reader to understand what has gone wrong in mental health care from the perspectives of LGBTQ+ individuals. Approaches to improving mental health care for LGBTQ+ individuals will be explored under the next theme, Provider Awareness and Knowledge. The first code developed under this theme is “Disinterest/Dismissal” which was discussed by four participants (Participants J, C, D, M). Two respondents expressed concerns about being dismissed by their providers specifically because of their identities. For example, Participant J described “feeling that my concerns were dismissed by some professionals I have seen due to my gender identity.” This participant may experience subsequent wariness of disclosing their gender identity within mental health care due to fear of an invalidating response from a provider. An example of the dismissal that was perceived by participants was providers making assumptions about respondents’ identities, and how their identities impact their lives. In response to the question of terms that made them less comfortable, Participant P indicated discomfort stemming from a provider “asking me, an AFAB¹, if I have a boyfriend”. By describing their experience, this quotation exemplifies the way in which people who are perceived as female may have specific experiences related to societal expectations for young women, regardless of current gender identity. According to Social Learning Theory, children are positively reinforced for “gender appropriate” behaviour, including behaviour coded as heterosexual, and shamed for “gender inappropriate” behaviour, including behaviour coded as homosexual (Kretchmar, 2011, p. 43). This occurs from a very young age, often before an individual’s own sexual or gender identity is established and expressed. Social learning processes also shape the identities we develop and our relationships to them. Internalized gender

¹ AFAB (an acronym for Assigned female at birth) is a term describing an individual that was determined to be female at birth, regardless of current gender identity.

normativity, therefore, is engrained in how an AFAB trans* or gender diverse person (such as self-defined by Participant P) may be affected by or respond to heteronormative statements such as the expectation for AFAB people to have a boyfriend (Rossman et al., 2017-b).

Normativity

An underlying issue relative to the code Disinterest/Dismissal was “Normativity” (Participants I, D, K), a code applied in relation to trans* individuals, specifically those who fell outside of the binary, such as nonbinary and genderqueer individuals. For example, Participant I wrote, “knowing that therapists (in my experience) don't know what to do with us (genderqueers) it feels very othering, like we're somehow beyond help.” Much of the current literature, for example, Tebbe and Budge (2022), puts binary trans* individuals in the same category of research as trans* individuals that identify outside of the binary. Participant I's comment problematizes this, suggesting that the experiences of those outside of the binary differ from those within it in ways that are often not recognized. Drawing on the literature, this can be connected to the concept of transnormativity. As described by the results of Murawsky's study on transnormativity, “non-binary people felt uniquely pressured to ‘pick a side’ of the gender binary to transition toward. Resisting such reductionist transnormative ideologies and practices sometimes increases non-binary people's social dysphoria” (2023, p.6). Social dysphoria occurs when how others perceive one's gender presentation conflicts with how one sees oneself or would like to be seen, or even heard, since voice is a component of gender presentation. To address dysphoria related to one's voice, an individual may undergo vocal training as part of their gender transition. This aspect of dysphoria may also be one motivation for undergoing testosterone therapy, which produces vocal masculinization. Gender dysphoria refers more to one's self-perception but is mutually interconnected with social dysphoria in that social

interactions can positively or negatively affect a person's view of their gendered self (Lindley & Galupo, 2020). The "classic clinical conceptualization of gender dysphoria as based on rejecting one set of (binary) features in favor of the opposite" often leaves those who experience gender dysphoria outside of this dualism, feeling as if their more ambiguous and/or androgynous social identity is less valid (Galupo et al., 2021, p.108). On the other hand, transnormativity can create a pressure to access hormone therapy or surgery among trans* people who might otherwise not medicalize their identities. When translating this to mental health contexts, trans* individuals outside of the binary can feel added pressure to explain (or defend) their identities to their provider, particularly if the provider is not aware of the way their experiences differ from binary trans* individuals.

The Impact of Client Disclosure in the Therapeutic Relationship

Four participants reported fear of being dismissed by their care providers before entering or beginning mental health care, which was coded as "Concerns Before Entering Care". Participant N described being "hesitant to disclose my orientation or discuss my partner for fear of them not understanding our relationship and I am afraid they will misgender my partner." Identity disclosure, a theme also addressed by my literature review, was mentioned in seven responses. Respondents noted a need to take time to open up about their identities due to wanting to be sure of compatibility with the therapist before discussing such a personal topic. Participant E noted that this had resulted in increased anxiety surrounding the care-seeking process, saying that: "I am always nervous [about] if I will feel comfortable opening up to them. I struggle with telling them outright that I don't want to see them because of compatibility so in the past have not gotten [the] help I needed." Not only did Participant E note anxieties surrounding beginning a relationship with a new care provider, but they also noted challenges associated with exiting a

therapeutic relationship that might not be working due to issues of, in the participant's word, "compatibility." Others noted that they felt more comfortable when their identity was discussed at the beginning of the therapeutic process through avenues such as a self-identification questionnaire or direct questioning by the provider. Participant C described that they were most comfortable with "intake forms where it asks you if you're comfortable to share pronouns and/or LGBTQ+ identity." However, in another example, Participant G noted that "as a teen when I began my care these questions would often be posed in front of family members." This situation evidently posed a risk for the young individual seeking care, forcing them to choose whether to disclose their identity to their family or to offer inaccurate information within the client-provider relationship. Research by Smith and Turell (2017) emphasizes the seriousness of such a situation:

Because identity disclosure has been associated with social integration, resiliency, and psychological well-being, the perceived inability to bring one's full identity to the healthcare encounter may further contribute to the stress of healthcare for LGBT persons, as well as confound healthcare decision-making when elements of identity are important to diagnoses or clinical management decisions (p. 638).

Conversely, my findings suggest that disclosing one's identity within a positive client-provider relationship where the provider is culturally competent may have the power to improve one's mental health overall. Risks that may be associated with disclosure, particularly at a young age, were noted by Participant D, who described their experience as follows:

One therapist threatened to out me to my parents before I was ready because he was concerned my depressive symptoms were worse due to being closeted, and that I might be at risk of suicide if I did not come out. At the time, I did not realize that this was not

allowed, given the limits of confidentiality, and this had a negative impact on my mental health at the time. My anxiety was worsened by this experience. He did not understand that coming out to my family may result in me getting kicked out or cut off from the funds I needed to get through school. He did not think my concern was realistic. My parents were initially unsupportive of my gender identity and sexuality, and I was forced to come out before I was ready, which worsened my already poor mental health.

Participant D's experience can be read as an example of something that it seems reasonable to broadly assume that in order for a client to feel safe with their provider, they must be confident that they will not be forced to disclose information about their identity or experiences outside the therapeutic relationship.

Provider Disclosure in the Therapeutic Relationship

Within LGBTQ+ mental health care, disclosure can build trust between the client and provider. When an LGBTQ+ individual discloses or discusses their identity and how it impacts their daily lives, the response that is given by a provider may strongly influence how much an individual is willing to discuss further. For example, Participant M described that:

I think my previous therapists (in and out of Nova Scotia) were uninterested in naming and making space for systemic oppression and how it impacts mental health, and when I tried to do so it wasn't met with curiosity or openness, for example, I did ask one previous therapist if she were queer and she didn't answer but instead asked "does it matter?" and I said "it certainly helps but ultimately, no, it doesn't matter to me" and she never revisited it (and to be fair, neither did I).

In this example, the provider expressed an expectation, perhaps unknowingly, that whether a care provider is a member of the LGBTQ+ community does not matter in the client-provider

relationship. On the one hand, if the individual seeking care places a great value on their identity, and the way it shapes their everyday societal interactions, this kind of dismissal may be seen by the individual as a microaggression, and furthermore, may break the trust that is critical to the client-provider relationship. On the other hand, it can be a testament to the pervasiveness of homophobia and transphobia in wider society if a provider does not feel safe to disclose their own identity due to the potential risks, which may be similar to those faced by clients.

Provider Awareness and Knowledge

A prominent area of focus that was raised by participants is the level of “Provider Awareness and Knowledge” about LGBTQ+ identities and experiences. This theme includes three subthemes. First, my findings suggested that cultural competency (Whaibeh et al., 2020), which emerged as the first subtheme, below, is an approach that promises to improve quality of care. Another therapeutic approach, and the second subtheme under Provider Awareness and Knowledge, is that of trauma-informed care, specifically in how it may relate to betrayal trauma experienced by LGBTQ+ individuals. Language emerged as a third subtheme in this area and is strongly interconnected with both cultural competency and trauma-informed care. This theme was generated from participant responses to a variety of questions throughout the survey.

Cultural Competency and Intersectionality

Cultural competency is understood within mental health care settings as an important form of provider awareness. Participants shared many insights that related to this concept. Six participants noted with specific examples that their provider’s knowledge was part of a positive mental health care experience. Respondents emphasized the need for a provider to understand how intersectional identity plays a role in their mental health, as well as their needs within care. For example, Participant M described how having a provider who is capable of “understanding

the systems of oppression at play in my life and has demonstrated that she understands them in our conversations about them and how they have affected me” (Participant M) allowed them to build a trusting relationship, or “therapeutic alliance” (Schuller & Crawford, 2020). This individual articulated that gender, sexuality, and a visible disability were factors in their experience of mental health care. Race and religion were also mentioned as aspects of identity that shaped participants’ experiences of care, but participants did not expand on specifically how their care was impacted by these factors, or even what racial or religious communities they belonged to. Cultural competency training for care providers aids in “understand[ing] the cultural influences necessary to guide the treatment of patients belonging to a specific community” (Whaibeh et al., 2020, p.426). An intersectional approach to mental health care for providers can help to “identify invisible experiences of subordination or privilege, as well as resistance and oppression, which are incarnated and contextualized in a certain spatial and temporal area” (Cabrera et. al., 2020, p. 309). Drawing on the literature, it can be said that intersectional analysis can help care providers to apprehend connections among power structures that are part of a client’s day-to-day experiences (Cabrera et. al., 2020). Therefore, an intersectional lens is often relevant to cultural competency, which enhances therapeutic effectiveness.

The Issue of Inclusion

Ten participants noted that the knowledge, lack of knowledge, or misconceptions that their provider had of LGBTQ+ experience impacted the quality of their care negatively. This issue of “inclusion” and its potential meanings was also raised by one participant. Participant A asked a question regarding potential care providers that had both ethical and political resonance: “Are they going to be ‘trans-inclusive’ in the Liberal sense or the actual sense?” The term “Liberal” is “employed in a dizzying variety of ways in political thought and social science”

(Bell, 2014, p.682). Riggs and Patterson (2009) suggest that organizations that are perceived or self-defined as liberal sometimes include LGBTQ+ people with the unspoken expectation LGBTQ+ community members will assimilate. This expectation stands in contrast to a more culturally competent preparedness on the part of organizations to welcome and respond to the specific needs and positionalities of LGBTQ+ people. It is perhaps this tendency within liberalism that Participant A was problematizing with their response. In contrast to assimilation, culturally competent LGBTQ+ mental health care recognizes the need for individualized and intersectional modalities within professional mental health care settings that honour and respect difference.

The Problem of Having to Educate Providers

Another aspect of Provider Awareness and Knowledge that was brought forward as a negative experience or concern was the expectation for clients to educate providers on LGBTQ+ identities and experiences, discussed by two participants. Although each LGBTQ+ individual has a different experience navigating their own identity, provider awareness and keeping up to date with growing and shifting identity categories was an expectation that participants expressed. As was described by Participant D: “mostly, I just don't want to have to explain to them what it means to be trans, it's okay to describe what it means to me, but I don't want to have to walk them through the general definition.” From this perspective, developing awareness of LGBTQ identity categories and common ways they are defined is an important action that can be taken by providers to create a comfortable environment within professional mental health care. As described by Participant Q, “they should have a good understanding of aspects of our community.” Further exemplifying this theme, when asked about the way in which their identity impacted their experience of care, Participant O described that “it has made it so that therapists

often ask me too many questions. Instead of being their patient or client, I am instead a wealth of knowledge about trans stuff. Which shouldn't be the case when accessing therapy.”

Patterson and colleagues (2014) have found that “clients who expect the therapist to be knowledgeable and helpful in solving problems will likely have better outcomes than clients who do not have these expectations” (p.679). However, in order to support the better outcomes identified in this research, providers must be knowledgeable about the lived experience of LGBTQ+ individuals. Placing the emotional burden of explaining LGBTQ+ identities and communities on the individual seeking care may take time away from the issues the client was originally seeking to address, arguably compounding the emotional labour already involved in therapy itself. It is therefore disconcerting that participants described experiences of having to educate providers about basic aspects of their identities.

The Intersectional Nature of Disability

Eight participants in this survey self-identified as having a visible or invisible/non-visible disability, with four participants describing that it was relevant to their experience of care. The definition of disability was left open to participants, some of whom noted having disabilities such as a vision impairment whereas others discussed mental health diagnoses such as “BPD [borderline personality disorder], depression, anxiety and dyslexia” (Participant C). Participant K described their experience with disability by stating that “because it’s invisible I have had to pull out proof from my doctor [...] to be believed” by their mental health care provider. Participant K’s comments exemplify how having an invisible disability combined with an LGBTQ+ identity can create a double jeopardy between two characteristics that are not necessarily visible (therefore prone to be disbelieved or unrecognized). Having a provider trust their client is

important in developing a client-provider relationship where the individual seeking care can also trust the provider (Rossman et al., 2017-a).

Predicting Provider Competency

In addition to needing to educate providers, participants expressed that it can be difficult to predict which providers will be culturally competent before commencing a therapeutic relationship. Participant A explained:

“I would say one major barrier as a trans woman is not knowing what services are ACTUALLY trans-inclusive. Most services say nothing about being trans-inclusive, which makes me feel very anxious about them, even if they may turn out to be good. But even when an institution says they are trans-inclusive, I question if they really are until I can experience that inclusion firsthand. This is a barrier because I don't always have the energy to deal with unknown risks.”

This quotation describes the mental and emotional energy that is required to determine whether a mental health care provider has background knowledge of LGBTQ+ experience, which may only be established after sharing personal information about oneself on intake forms and then in the context of one or more therapy sessions. Open showcases of solidarity by providers were seen as potentially positive or negative actions; positive if they are grounded within practice, but negative if misleading.

In another example, it was noted by Participant B that “some [providers] had rainbow stickers on their door, that was nice, ... although more is required to truly be an ally and a safe care provider.” In terms of what was brought forward by participants, being informed, open to discussions surrounding LGBTQ+ identity, and actively using culturally competent practices were examples of positive actions that go beyond performative virtue signaling to make a real

difference. As alluded to by Participant A's discussion of unknown risks when accessing care, a lack of LGBTQ+-specific cultural competency can lead to betrayal trauma or organizational betrayal, which is elaborated in the following subtheme.

Betrayal Trauma and Trauma-Informed Practice

The concepts of Betrayal Trauma and Trauma-Informed Practice, which emerged as relevant to participants' thoughts and reported experiences, are the focus of this subtheme. Experiences of betrayal within mental health care systems have compounded the trauma and alienation of LGBTQ+ people. For example, Participant C noted that they "will not see a male provider because of severe trauma, which makes it harder to get matched. I also am concerned that they will dismiss what I feel because I have had that happen in the past with providers". As described by Burton and colleagues (2020):

Betrayal is a specific trauma that happens when there is a mismatch between expected and actual outcomes, especially when the affected individual is dependent on the betraying agent in some way. When interacting with health care providers, individuals are necessarily seeking a particular type of support that cannot be accessed any other way. If a provider responds negatively, in a discriminatory or judgmental manner, the individual may feel that access to this care is at risk. If more than one provider in an organization responds in such a way, the sense of betrayal can extend to the entire organization—otherwise known as organizational betrayal (2).

Outward showcases of solidarity combined with perceived insufficient provider awareness and/or culturally incompetent actions could lead to an overall negative experience, or in serious cases, betrayal trauma that may impact the client's trust in general mental health care. Betrayal

trauma and organizational betrayal can be linked with the discussion in chapter three of the pathologization of homosexuality and gender dysphoria.

Relatedly, when clients are confronted with the need to educate providers who have presented themselves as culturally competent, as described specifically by Participants D, N, and P, these clients may experience organizational betrayal. Participant P described that they “avoid the topic of romance and sex like the plague because I'm aromantic and asexual and I don't want to explain what that means or be written off.” Whereas previous iterations of the DSM have pathologized those outside of sexual and gender societal norms through practices such as conversion therapy, DSM frameworks for these populations have improved significantly to better “support the provision of accessible and high-quality healthcare services” (Robles et al., 2021, p. 51) for LGBTQ+ people. These changes are not a finite solution, and recognition of the organizational betrayal that is and has been experienced by LGBTQ+ individuals in professional mental health care is a step that must be taken to improve the quality of care currently received. These issues are further explored below within the discussion of whether or not an LGBTQ+ provider is necessary for culturally competent care. Betrayal trauma, and subsequent organizational betrayal, can be mitigated with therapeutic approaches such as trauma-informed practice.

Three participants either mentioned Trauma-Informed Practice directly or mentioned the need for elements of care that, upon analysis, emerged as consistent with guidelines for Trauma-Informed Practice. Participant O specifically named Trauma-Informed Practice as a desired characteristic when seeking a new provider. In response to "Are there concerns that you experience when meeting a new mental health care provider?" they shared that "one big concern is whether or not they are trauma informed, and also how much information they know about

transness and queerness." In this participant's words, "I also feel much more comfortable talking about my mental health issues with people from the community because of how tied into my transness and queerness my trauma is."

Participants discussed the importance of empowering LGBTQ+ people by allowing them to name their own experiences, including experiences of sexual violence, which are widely seen and experienced as gendered. Participant A discussed how their provider "was open to letting me call the harm I faced what I needed to call it, sexual assault, rape, whatever. As a trans woman, this has been deeply empowering."

Indeed, a primary endeavour of Trauma-Informed Practice, as explained in McCormick and colleagues (2018) and Levenson and colleagues (2023), is that of empowerment, an objective that requires providers working with LGBTQ+ clients to "resist pathologizing identities and experiences other than the heterosexual and gender-conforming 'norm.' LGBTQ identities are not symptoms of trauma or problems to be solved" (McCormick et al., 2018, p.167). Rather, it is important to recognize that pathologization and stigmatization are often forms of trauma experienced by LGBTQ+ individuals alongside other forms of trauma. To understand the impacts that trauma-informed care has within LGBTQ+ mental health care experience, McCormick and colleagues (2018) describe that:

"[T]rauma can involve distant events like adverse childhood experiences (ACEs), or disruptive and frightening incidents in adulthood such as victimization, natural disaster, accidents, serious illness, or an unexpected loss. Trauma-informed care (TIC) delivers services in a way that incorporates evidence about the prevalence, neuroscience, and impact of trauma on thoughts, feelings, behavior, health, and psychosocial well-being" (p.134).

Having LGBTQ+ competency inform the way a provider may deploy trauma-informed practice involves understanding the multiple ways in which dynamics such as minority stress and rejection sensitivity impact an individual's "thoughts, feelings, behavior, health, and psychosocial well-being" (McCormick et al., 2018, p. 134). Levenson and colleagues (2023) have further expanded on Meyer's concept of minority stress (previously mentioned in chapter two) by stating that it "can be repetitive and chronic within interpersonal, institutional, and cultural contexts. LGBTQ+ individuals are at heightened risk for victimization and other stressors such as rejection, stereotyping, and de-valuation" (p.135).

When responding to the question of phrases that make them more comfortable, Participant E noted that "a big one is 'I believe you.' As someone who struggles with past issues, having someone believe what I say is important and it felt relieving in that moment." When rejection sensitivity manifests within mental health care experience, this kind of clear verbal affirmation (which is consistent with trauma-informed practice) can be valuable (McCormick et al., 2018). "When stigma, shame, and insecurity are internalized, LGBTQ+ individuals may feel unable to live authentically, which can contribute to negative psychological consequences," and may even present in PTSD-like symptoms (Levenson et al., 2023, p.135). Therefore, trauma-informed practices can be highly relevant in the development of mental health care for LGBTQ+ individuals. Furthermore, participant comments linking trauma-informed approaches to knowledge about the lived experience of LGBTQ+ identity suggest the importance of familiarity with LGBTQ+ linguistic practices. Indeed, language is perhaps the only channel to communicate one's understandings of concepts such as "queerness and transness" (Participant O).

Language: Verbal, Non-Verbal, and Usage

Three of my survey questions provided opportunities for participants to discuss the role of language in their experiences of care.

- Are there terms or phrases that your mental health provider can (or did) use that help you to feel more comfortable? If so, what are they? You may also share any thoughts about why these terms or phrases added to your comfort.
- Are there terms that make you feel less comfortable when they are used in care? If so, what are they? You may also share any thoughts about why these terms or phrases reduced your comfort.
- Is there nonverbal language that has impacted your comfort level with your provider? If so, please tell me about it.

In contrast with the questions surrounding having a LGBTQ+ provider, these questions yielded less qualitative data than I originally anticipated. In fact, the question about body language became the prompt most commonly left blank or with a minimal/dismissive response. For example, Participant D simply answered with “No,” whereas their responses to other questions were paragraph-length. This may have occurred because body language is not an aspect of communication that all people are equally conscious of, whether or not they are subconsciously impacted by the body language used by others. Where participants did provide responses to this question, they mentioned forms of body language that are typically represented as indicators of negativity or closure, such as crossed legs, crossed arms, shaking one’s head, or even frowning.

Issues with verbal communication appeared to be the most common cause of clients feeling uncomfortable within care. The first code generated under this theme was “Language

Sensitivities and Slur Reclamation.” The reclamation of slurs is common within LGBTQ+ communities and has been explored in queer theory. Indeed, the word “queer” itself is just such a reclamation. Ettinger describes reappropriation of slurs as “discursive strategies that reject and transform the categories produced by a hostile and hegemonic heterosexual discourse” (as cited in Dilley, 1999, p. 458). Related to this line of thinking, Participant I noted that their experience was diminished:

“When a cis-het person trie[s] to relate or engage but has to use words like ‘queers’ and stuff. [I] express myself and my trans reality using words like Tranny and Faggot. I want to say those in therapy and KNOW that if I have a cis therapist, they won't use those words reciprocally.”

In reading the first sentence of this transcript passage, it is difficult to tell whether Participant I sees the term “queer” as acceptable or unacceptable when deployed by a straight, cis-gender provider. What is clear is that the participant does not wish for a cultural outsider to mirror their reappropriated use of the other slurs they mention. The response given by Participant I showcases the sensitivities that are involved with repossession of terms that have been widely associated with danger and fear for LGBTQ+ individuals. As with other such reappropriations, a dichotomy is created between outsiders for whom use of the slurs remains culturally prohibited and insiders of a group who are allowed to reclaim such slurs. This section exemplifies how, as elaborated by queer theory in chapter two, individuals’ experiences as members of social identity categories are structured by language, while the ways we refer to and define our identities help to shape social structures.

As suggested in chapter two, constructed categories with which we identify and through which we seek liberation often have roots in and remain essential to the functioning of social

ideologies, institutions, and imbalances of power we aim to resist. Identity categories can be seen as socially constructed inside and outside of queer communities through processes of heteronormative power and queer resistance. Discursive rules about who can and cannot legitimately reappropriate slurs from a marginalized in-group perspective are in one sense a mechanism for constructing the boundaries of the identity category in question. The transcript passage from Participant I, above, may be read to suggest the identity category “queer.” This term has relatively flexible boundaries, in that it is accepted for use by a wider range of people than other slurs that apply to narrower categories of marginalized people, such as used by Participant I. Therefore, this quotation showcases the need for a provider to be aware of the sensitivities involved in the language that LGBTQ+ communities utilize and expect to hear from providers. In some instances, it is preferable for a service provider to mirror language that the client has used for reasons of cultural competency; however, in others, in-group/out-group dynamics make it such that it is not culturally competent to reflect the client’s words.

The fact that most respondents identified as queer, a term that was previously used as a slur, is an interesting finding. The prevalence of participants identifying as queer, rather than as other identities that fall under the umbrella of LGBTQ+, may have been shaped by the fact that most participants were in their teens or twenties. Older members of the community may remain uncomfortable with this category, having personally experienced its use as a harmful term of discrimination. In sum, participants’ responses reported in this section suggested the importance of increasing cultural competency in terms of language usage. They expressed that if a provider is willing and able to make changes in their practices to reflect the beliefs brought into the interaction by those seeking care, it can improve the client-provider relationship overall.

Identity Categories, Language Usage, and Misgendering

An example of language impacting the therapeutic relationship negatively is what I labelled as “Incorrect Pronoun Usage,” commonly referred to as misgendering, a code which emerged under the analytic theme of Language. Misgendering has been defined as “when a person is addressed or described using language (name, pronouns or title) that does not match their gender identity” (Dolan et al., 2020, p. 150). The act of misgendering can have an impact on the level of trust within any relationship, personal or professional.

Participant I described their experience with misgendering by saying that they “had a wonderful therapist before but once I came out as trans she kept misgendering me and I was sad to lose her valuable insights because she is too ignorant to work with trans people.” This contrasts with the experience that was brought forward by Participant D, who said that “my doctor has also used my name and pronouns since the beginning, if he has to refer to certain parts of my body that may be uncomfortable for me to talk about, he confirms which terminology is the most comfortable for me.” Participant input suggested it is important for providers to discuss what language makes the participant most comfortable and continue to implement it in practice.

“No, But”: The Focus on LGBTQ+ Providers

One of the questions that sparked the most interest in participants was as follows: “Does it make a difference to you whether your provider is a member of the LGBTQ+ community? Do you have thoughts about why or why not?” When including this question, I did not anticipate the diversity of responses collected. Of the 17 respondents, 11 expressed that having an LGBTQ+ provider is beneficial in terms of positive experience in mental health care. In contrast, seven initially expressed that it did not make a difference, although as will be described shortly, their explanations often ultimately suggested a preference for a provider who is LGBTQ+. When

observing the reasons behind the positive answers, some elaborated on their thoughts. For example, Participant F explained, “I believe that members of the LGBTQ+ community are much more understanding and empathetic because they have usually experienced more hardship relating to their identity than those who do not identify with the community. I would feel safer opening up to a member of the community over a cisgender, straight individual.” In contrast, Participant K simply stated, “as long as it’s not a cis het male.” Some participants who preferred an LGBTQ+ provider focused primarily on the provider’s cognizance of LGBTQ+ identities and experiences.

“I will see a provider if they are LGBTQ+ or not but I always feel a lot more open and relaxed when they are LGBTQ+, I feel as though it is one less thing I need to explain or get them to understand because I know on some level they will understand what it is like to be part of the queer community.” (Participant C)

As described previously within Provider Awareness and Knowledge, avoiding the expectation for LGBTQ+ individuals to help providers understand their identities is a factor in participants’ preference for LGBTQ+ care providers. Lack of available providers overall in Nova Scotia may help to explain why Participant C stated they would see a provider regardless of the provider’s identity. It seems likely that if it were consistently possible and affordable to see an LGBTQ+ provider when needed, this is what the participant would prefer. Similarly, Participant I said that “so many queers need therapy and there's only so many queer therapists”.

Provider Positionality Awareness

Although there were seven respondents who indicated that having an LGBTQ+ provider would not make a difference to their experience in care, the respondents described that there were considerations that needed to be made by a cis-het provider working with an LGBTQ+

individual. I coded responses fitting this pattern as “No, But.” Although these participants did not believe that a queer provider is required for them to receive culturally competent care, they noted that LGBTQ+-specific cultural competency must be prioritized to improve consistency of care for LGBTQ+ people. Participant D explained this through their own experiences:

“I have had about 7 therapists and not one of them was a member of the community. It does make a difference if they are genuinely informed about LGBTQ+ care. My GP is a gay man, and very trans-competent, so that has been helpful because I have never had to explain my identity or argue with him to provide me with the proper care (HRT, etc.). However, I think the same level of care and understanding could be achieved by a cisgender heterosexual male/female if they were willing to educate themselves about the community and our care.”

The above passage expands on another code that can be correlated with discussions under the theme of Provider Awareness and Knowledge: Provider Positionality Awareness. Part of the theme Cultural Competency, this code was developed to reflect that a provider’s own positionality may have on clients’ experiences in mental health care and the potential for providers to be aware of this impact. Moreover, it is important for a provider to understand experiences outside of a mainstream, heteropatriarchal, and cisnormative framework, as well as to learn how to best support those who have been impacted by living outside of this norm. For example, Participant D described that “both of my providers attend the trans wellness conference annually to educate themselves continuously,” as opposed to relying on their LGBTQ+ clients for education. Similarly, as explained by Participant M, “I think it always helps [for the provider to be an LGBTQ+ person], but I do think a competent, queer-affirming therapist doesn't have to be queer themselves to serve a queer client effectively.”

In the words of one researcher, “In developing an understanding of clients, therapists must gain knowledge of clients’ cultural background, values, and beliefs,” which may be accomplished by taking part in cultural competency trainings to improve quality of care for marginalized clients (Sue, 2006, p. 243). Although the article I am drawing on to support this claim is primarily concerned with cultural competency as it relates to racial identity, it applies equally to other axes of identity. Overall, there is no replacement for shared experience based on common identity, but the baseline expectation for a mental health care provider serving those in the LGBTQ+ community is awareness and knowledge.

Barriers to Accessing Mental Health Care

Another theme that participants explored extensively was Barriers to Accessing Mental Health Care in Nova Scotia. These barriers are generally outside of providers’ control and influence whether potential clients are able to access care in the first place. I had one question that addressed this: “Were there barriers to receiving mental health care? What were they? (Financial constraints, time constraints, location barriers, availability, timeliness, etc.).” The barriers that came across in this study included Financial Restrictions, Lack of Availability, Long Wait Times, Social Barriers, Location Barriers, and Differing Availability by Age. These barriers often intersected with each other and varied for each participant. For example, as explained below, an individual who experiences financial constraints is also more likely to be confronted by long wait times associated with publicly funded care. In another example which will be further developed in this section, one participant reported that availability of publicly funded care can vary by the age of the prospective client.

Financial Restrictions

Twelve respondents explored financial restrictions, which is unsurprising given the cost of psychological services in Nova Scotia (and beyond) as well as the insufficient wages many Nova Scotians receive. When asked about their experience within care, Participant L explained, “I am fortunate that my experience was great but currently I can’t afford to go back.” Similarly, Participant O said that “it does bring about some feelings of not being worthy of care because I can’t afford it.” According to its own website, the APNS (Association of Psychologists of Nova Scotia) “has set the recommended fee for psychological services provided by registered psychologists in Nova Scotia at \$210 per hour,” although this may vary between providers. The APNS goes on to point out that “services are provided through government funding and are usually available at no cost. However, you don’t get to choose whom you see, and the waiting periods are typically much longer.” At minimum wage in Nova Scotia, which was \$14.50 per hour as of August 2023, an individual would need to work at minimum 15 hours (without deductions) to be able to afford one private session with a registered psychologist.

Although many jobs offer benefits that encompass visits to registered psychologists, Participant N stated, “my insurance only covered a certain amount of the cost.” In other words, even if there is coverage, it might not make mental health care financially accessible. Participant O further stated their experience with publicly available (and free) services as follows: “I was experiencing housing insecurity and was low income, and because of that I couldn’t access private services, meaning I had to try public services. Public services are much harder to access as they only accept ‘more at risk’ clients.” An implication of labeling some clients as being “at risk” is that it creates a lack of urgency for treating those attempting to seek care who are not designated high priority. This leaves room for the individual to doubt their own experience,

potentially believing that they are less deserving of mental health care services because they cannot afford them. These passages highlight the relevance of economic disadvantage (lack of financial resources to access care) and classism (which links socioeconomic status to a person's value) as intersections of oppression effecting some LGBTQ+ people experiencing the need for mental health care. They also point to the lived costs of a system that excludes mental health care from health care more broadly. Participant O's comments can also be linked to classism, which is seen by Cavallieri and colleagues (2023) as "a significant stressor that impacts access to mental health services and increases distress," and therefore exacerbates the need for such services (p.435). Ultimately, it became clear that participants, who were eligible to take part only if they had experienced mental health care in Nova Scotia, shared the privilege of having been able to access mental health care in the first place. Individuals who were unable to afford services, ineligible for publicly funded services, or unable to make it to the front of lengthy waiting lists did not fit the inclusion criteria for this study. The benefits of accessing private care, even when the individual is facing other barriers such as lack of financial resources, were brought forward by participants, with Participant D saying that "it was worth it for me [to access private care] because I finally found a therapist that was trans-competent."

Lack of Mental Health Care Availability and Long Wait Times

The most frequently applied code developed under the theme of Barriers to Accessing Mental Health Care was Lack of Availability. Responses of 12 participants were given this code during analysis. The sub-code of Long Wait Times was applied to four participants' responses. This code pointed to the need within mental health care for frequent and timely opportunities to access care when prospective clients are dealing with time-sensitive issues. Participant H discussed their experience with Lack of Availability in a university setting by describing that the

university counsellors “only provide one appointment every month.” From the usage of the term ‘only,’ we can infer that the participant feels once a month is not enough. The need for more frequent care can vary depending on the client’s situation as well as the type of therapeutic approach and treatment plan that is built within the client-provider relationship. Certain approaches to therapy (such as Dialectical Behaviour Therapy, which in its traditional approach requires weekly sessions over a 13-week period) which may be most beneficial to some clients may not be available to them due to restrictions on number or frequency of appointments. Participant O described that they “wish public mental health services were so much easier to access, and that I didn’t have to be at a point of being a danger to myself to be able to access them.” This quote exemplifies how lack of publicly funded care results in individuals being placed in mental health care waiting lines based on prioritization, likely causing not only frustration, but the deterioration of emotional or psychological wellbeing of the prospective clients concerned.

Barriers Impacting Wider Health Care in Nova Scotia

The impact of long wait times is not only relevant to mental health services, but generalized health services in Nova Scotia, where wait times can deter individuals from seeking care (Whaibeh et al., 2020). Wait times between appointments were another form of limited availability that posed a problem for participants. Participant A wrote that “mental health care is far too limited” and that they would “like it to be more frequent.” For two respondents, their geographic location (coded as “Location Barriers”) contributed to “Lack of Availability” of mental health services. Participant K explained that they lived “over an hour away from the closest town,” which made it burdensome for them to access in-person care. With the rise of virtual options such as teletherapy since the outbreak of COVID-19 in 2020, those who live in

more rural areas can more easily access care that they may not have otherwise (Burgoyne & Cohn, 2020).

The influx of individuals seeking care augments the need for publicly available (and free) care, with Participant G recalling that they “couldn’t get in to NSHA in a timely manner.” NSHA (Nova Scotia Health Authority) is the primary service provider of health care in Nova Scotia and is the source of public mental health care. In my personal experience, as well as the experiences of those I know, the wait times for mental health care range from a few months to over a year. Access to NSHA services may also be impacted by age, as suggested by the code “Differing Availability by Age.” Participant O said that “as a teenager I was able to access therapy, but then as an adult trying to access public services it became much more difficult.” The participant did not clarify whether this reduced availability was a result of losing coverage for private mental health care under their parents’ insurance or whether they had been accessing public services all along. In the latter case, it is possible that some age-based bias was built into policy, prioritizing the needs of youth; or that implicit bias intervened on the level of needs assessment. Another possibility is that more therapists were available to youth than to adults. These possibilities are highly speculative based on limited input from one participant and without systematic exploration of how the mental health care system functions or functioned with regard to distribution of care by age. The impact of Lack of Availability when it comes to public mental health care interacts with Financial Restrictions, in that taking on what for some is the considerable financial burden of accessing private care is often the only way to receive timely mental health care. This option is often not available to those of lower socioeconomic status.

The code of “Social Barriers” was developed through five participants’ discussions of external social factors that inhibited their ability to access care. This code primarily captured

parental disapproval of care seeking. Participant C experienced “my parents not believing I needed it” as a barrier to accessing mental health care. Similarly, Participant I stated “[My] parents did not want me to talk to a therapist who might put ideas in my head or validate how I’m feeling, they had ego issues and didn’t want to feel like someone else could do ‘their job’ better.”

Conclusion

The results communicated in this chapter support answers to research questions one and two: “What are the concerns that are perceived by LGBTQ+ individuals within mental health care in Nova Scotia?” and “Which issues raised during surveys by participants are relevant across LGBTQ+ identity categories and which are relevant only or mostly to one or some LGBTQ+ identity categories?”. The answers to these two research questions will be addressed simultaneously within this concluding section of the current chapter. Responses to question three, “How can the information uncovered be useful to mental health care providers seeking to become more cognizant of LGBTQ+-specific issues?” will be presented in chapter six. The direct concerns with regard to mental health care in Nova Scotia that were perceived by LGBTQ+ individuals who participated in this study (as addressed by the first research question) have been presented under the themes Negative Experiences & Concerns within Care, Provider Awareness & Knowledge, “No, But”: The Focus on LGBTQ+ Providers, and Barriers to Accessing Mental Health Care. These concerns are summarized below, with suggestions for responding to them explored in the concluding chapter. As expected, with regard to the second research question, some codes and themes were consistent with experiences that LGBTQ+ individuals overall may have in mental health care, whereas some were more specifically linked to certain LGBTQ+ identities.

The first theme that evolved throughout this study is Negative Experiences and Concerns Within Care. Disinterest/Dismissal is the first code that emerged under this theme. Numerous respondents expressed anxiety about being mistreated within care due to their identities. The second code that developed under this theme is that of Assumptions of Identity. Both codes were relevant across LGBTQ+ identity categories throughout the survey responses. This is also reflected in the subtheme of Language under the theme Provider Awareness and Knowledge below, where individuals problematized experiences in which they were assumed to be straight and heterosexual until providers were told otherwise, which created negative feelings of not being understood. This can be related to the code of Normativity, in which respondents felt that their identities were not understood by their providers in what amounted to experiences of cisnormativity, transnormativity, and heteronormativity. Normativity was referred to across identity categories but was primarily focused on by trans* individuals. The final code that emerged in this theme is Concerns Before Entering Care. This code describes the mental barriers an LGBTQ+ individual may face before seeking or receiving care, particularly if they have previously experienced betrayal trauma, described below in the subtheme of Betrayal Trauma and Trauma-Informed Practice under the theme Provider Awareness and Knowledge. Under the code Concerns Before Entering Care, the subcode of Disclosure emerged. The subcode of Disclosure included multidimensional concerns, including a fear of “coming out,” the way in which a provider may ask for disclosure (e.g., at intake versus later, or in front of family members versus privately), and risks that may be associated with disclosure (such as breaches of confidentiality). Disclosure was discussed across LGBTQ+ identity categories, however, the need to explain one’s identity was mentioned only by those of polysexual orientation (those

attracted to more than one gender, such as bisexual or pansexual) and trans* individuals outside of the binary (such as nonbinary or genderqueer).

The theme Provider Awareness and Knowledge had multiple subthemes which highlighted the ways in which Provider Awareness and Knowledge (or lack thereof) impacted LGBTQ+ individuals' experiences within care. This theme was relevant in some respects across LGBTQ+ identity categories represented by participants, although some codes within this theme were specific to particular identities, as elaborated below in this section. The first code that became apparent was that of Cultural Competency and Intersectionality. Lack of cultural competency was linked in this study to a lack of trust within the client-provider relationship, with relevance across participants' LGBTQ+ identity categories. Intersectionality was not only an aspect of this study's theoretical framework, but also emerged as an applicable subtheme. Respondents differed in the importance they placed on identity categories beyond LGBTQ+ community membership, as well as in the specific positionalities they mentioned, and the level of detail provided. Logically speaking, intersecting identity positions may be experienced as relevant by individuals seeking care across LGBTQ+ communities.

Betrayal Trauma and Trauma-Informed Practice emerged as the second subtheme under the theme Provider Awareness and Knowledge, again impacting participants of all LGBTQ+ identity categories identified in this study. Betrayal trauma can be compounded when experienced more than once and can further descend into organizational betrayal when expectations for culturally competent care are repeatedly met with discriminatory interaction under the auspices of an organization or institution. Through such experiences, LGBTQ+ individuals can lose trust in the mental health care system overall. In contrast, trauma-informed practice is alert to the pervasiveness of trauma in human experiences and seeks to empower

individuals rather than retraumatizing them. Based on the ideas about betrayal trauma, minority stress, rejection sensitivity, trauma-informed practice, and cultural competence presented thus far, it is possible to draw tentative connections between these phenomena. Minority stress and/or rejection sensitivity might augment one's likelihood of perceiving betrayal and/or elevate its impact, whereas culturally competent trauma-informed practice may mitigate these risks.

Connected in some respects to Cultural Competency and Betrayal Trauma, Language is the third subtheme that surfaced under the theme Provider Awareness and Knowledge in the analysis of this project. Notably, respondent discussions of language sensitivities and slur reclamation highlighted the insider/outsider dichotomy; for example, recall that use of terms such as "Queer" may be culturally competent when deployed by community insiders, but culturally incompetent when used by outsiders. The second code that developed within the topic of language is incorrect pronoun usage, or terminology usage more broadly. The specific terms and aspects of communication highlighted by participants as contributing to, or detracting from, their satisfaction with care varied among identity categories. For example, misgendering, social dysphoria, and gender dysphoria (described here as incorrect pronoun usage/terminology usage) uniquely impacted trans* individuals' experience of care.

A theme that developed in response to one survey question is that of "No, But": The Focus on LGBTQ+ Providers. The tensions within participants' responses are highlighted by the "No, But..." code, which describes how a provider does not need to identify as LGBTQ+ to provide culturally competent care, even though an LGBTQ+ provider may be preferred. This theme is contextualized by the fact that, given current availabilities, most LGBTQ+ people seeking mental health care will not be able to access care from an LGBTQ+ provider, leaving them little choice but to "settle" for a community outsider. This theme was discussed across

LGBTQ+ identity categories that emerged among the participants. A code that emerged under this theme is that of Provider Positionality Awareness. This theme considers positionality, a key function of Feminist Standpoint Theory, and how a provider can reflect on axes of privilege and how these axes are viewed and experienced by the individual seeking care. Although similar to the theme of Provider Awareness and Knowledge, this code encompasses the ability of a provider to understand their own biases and sensitivities, which is relevant to addressing the various negative experiences, concerns, and barriers to care identified within this study.

Barriers to Accessing Mental Health Care emerged as an important theme which participants addressed extensively, not only in response to questions that asked directly about such barriers but also in response to questions about experiences of mental health care more broadly. As suggested above, such barriers were often intersectional in their construction. Specific aspects of identity mentioned by participants were Race, Religion, Ability, and Socioeconomic Status. As discussed above, the former two aspects were minimally discussed by participants, whereas the latter two were elaborated upon extensively. Specific barriers detailed by participants generated the codes Financial Restrictions, Lack of Availability, Long Wait Times, Social Barriers, Location Barriers, and Differing Availability by Age. Barriers were relevant across identity categories, though in different ways according to participants' diversely intersecting identities, such as class or ability. Many of the themes, subthemes, and codes presented in this chapter interact with one another due to the intersectional and multidimensional nature of participants' experiences.

Chapter Six: Conclusions & Recommendations

By connecting the information revealed within current literature on LGBTQ+ mental health care with the subjects discussed by participants, this study contributes to expanding the field of LGBTQ+-specific mental health care, especially within the province of Nova Scotia. The recommendations presented in this chapter addresses considerations for those who provide mental health care to LGBTQ+ individuals to examine as part of an ongoing and interactive learning process. This exploratory research project has uncovered not only issues that are experienced within care, but also revealed systemic barriers and issues that are faced by LGBTQ+ individuals who seek mental health care.

My Experience: The Personal is Political

As mentioned in the introductory chapter, I have had extensive experience with many different forms of mental health care in Nova Scotia from a young age. My connection to this topic area has inspired this research and shaped my understanding of LGBTQ+ perspectives in mental health care in Nova Scotia. Engaging with mental health care in Nova Scotia has been a mix of positive and negative for me, which resonates with the findings I have presented. One respondent, Participant K, described their experience with mental health care in Nova Scotia as follows:

“To begin with I was bounced around for almost a year trying to receive care. I went between all the options stated at the beginning [of the survey] just to end up in mental health and addictions [NSHA], who told me in the beginning I wasn’t mentally ill enough. [A mental health care provider] told me I was too mentally ill. All the others told me that was not a right fit for me. It made me feel more hopeless in the system and lost.

Finally, when I did get my first appointment, it took months. And of course, there is a shortage of workers but there was nothing in the meantime.”

Reading this individual’s experiences reminded me very much of my own. Feeling hopeless within a system that is meant in part to relieve the pressure of feeling alone is something I have experienced, as I waited nearly a year for a simple diagnostic appointment with a psychiatrist in Nova Scotia. At the beginning of this research, I had somewhat hoped that the barriers I had encountered were only occurring to myself and those around me. *“It couldn’t be that bad, right?”* This research suggests that there are systemic issues being faced by LGBTQ+ individuals who are seeking mental health care. This project, to expand upon a slogan from second-wave feminist movements, has been informed by and shed light upon my personal experiences, which in turn have been produced by structural and political dynamics that need to change.

The previous chapter presented answers to research questions one and two, sharing participant concerns related to mental health care in Nova Scotia under the themes Provider Awareness and Knowledge, Language, Negative Experiences and Concerns Within Care, Disclosure, Provider Positionality Awareness, Barriers, and Aspects Relevant to the Experience of Care. I also addressed which LGBTQ+ communities each concern was relevant to. The next section offers recommendations for providers to address the concerns that have been identified.

Research Question Three: Recommendations for Providers Supporting LGBTQ+ Clients

Answers to the third and final research question “How can the information uncovered be useful to mental health care providers seeking to become more cognizant of LGBTQ+-specific issues?” reveal the practical implications of the findings of this study. Originally, I intended to present the findings of the final research question as a list of steps providers should take when

interacting with LGBTQ+ clients. However, as my analysis progressed, it became clear that variation among participants' needs and concerns, linked partially to intersectional differences of social location and partially to individual ones of biographical specificity, rendered the idea of a list of steps overly narrow and ultimately unworkable. Moreover, any advice for care providers can only be implemented in the interpersonal client-provider context, where providers deploy varying modalities of mental health care and will therefore draw in different ways on the perspectives presented here. In other words, I am not positioned to predict the concrete ways in which advice offered in this thesis should best be taken up by practitioners. Rather than creating a linear checklist to follow, I have produced recommendations that accommodate diversity among individuals accessing care, and providers administering care, as well as the nuanced, complex, and continually unfolding development of provider awareness with respect to clients who themselves are undergoing change. I have also provided suggestions about some of the ways diversely positioned LGBTQ+ community members may relate to the recommendations offered. Readers of this thesis and the recommendations presented in its concluding chapter should keep in mind the intersectional nature of research on any minority group, as described in chapter two. The experience of having a non-normative sexuality or gender is something that varies from individual to individual. Having an awareness of these variations and encouraging practitioners to investigate how their clients' identities may affect their experiences receiving mental health care is key in connecting the analysis of the surveys with the ultimate goals of this research.

1. Assumption of Identity and Language: “Queers” and Stuff (Participant I)

The first two recommendations generated by my analysis are linked to the themes of Assumption of Identity and Language. A provider’s assumptions about a client’s identity may materialize in more overt ways, such as purposefully misgendering a client, or more subtle inferences, such as asking if an AFAB client has a boyfriend (discussed in detail in chapter five under Negative Experiences and Concerns Within Care). A provider assuming an individual’s identity can reinforce notions of heteronormativity, cisnormativity, and/or transnormativity that the individual seeking care may already be working to combat, therefore negatively impacting the client-provider relationship. Those seeking care are generally in vulnerable situations, compounding the harm that can result from this added labour.

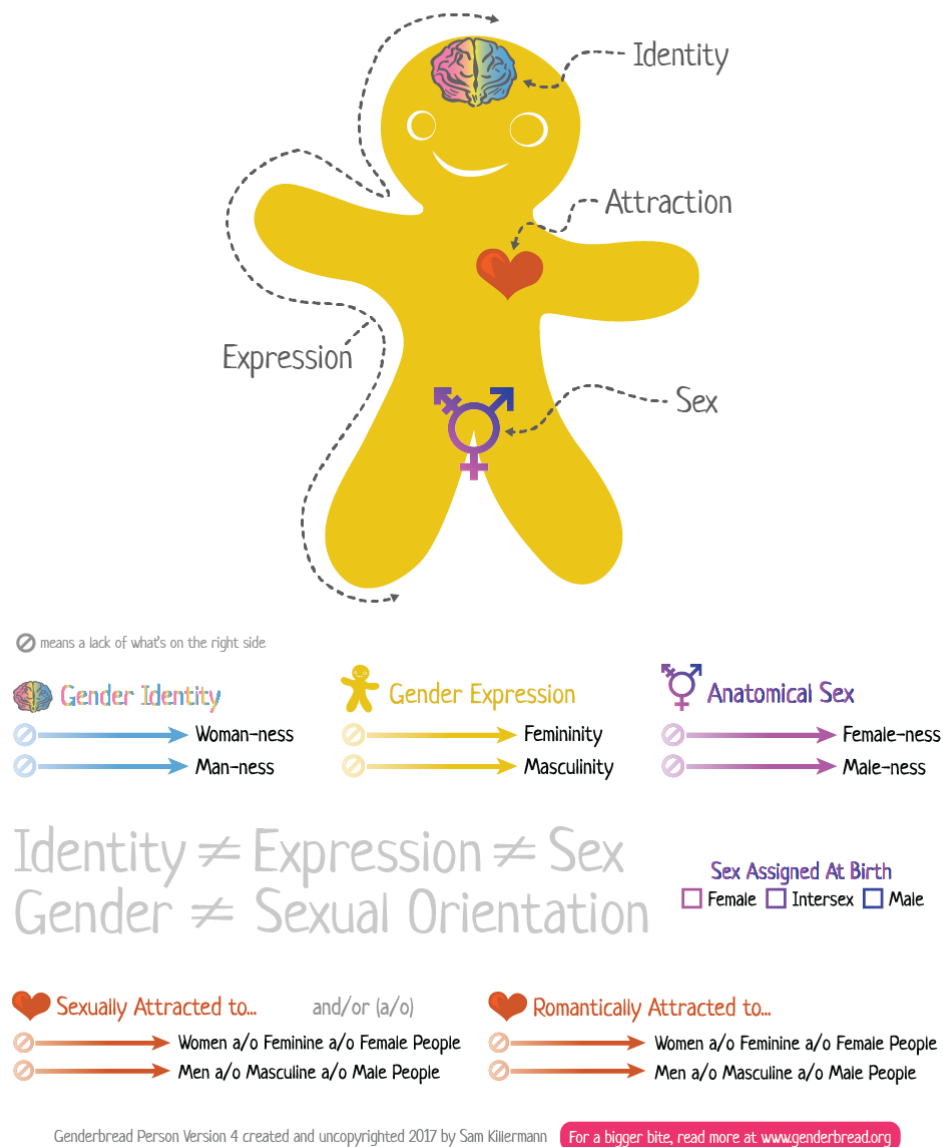
The language that a client prefers mental health care providers use to refer to them and their identity can evolve throughout the client-provider relationship. As noted within the results of this study, using gender neutral language when referring to a client’s identity (such as the term “partner” as opposed to boyfriend/girlfriend) opens space for the client to affirm gender neutral terms or disclose another language preference. Gender neutral language can be beneficial to the client-provider relationship because it avoids references to heteronormativity and cisnormativity that may be experienced as a microaggression. An individual seeking care may also use language that includes reclaimed slurs, as discussed in the previous chapter. For the care provider to be aware of their own situational identity (as further explored in the following section on Intersectionality and Positionality) can help to understand the intricacies of whether one should use (or not use) such language reciprocally. Whereas mirroring language often signals attention or care, stigma-loaded words are likely to be problematic. Reciprocal use of reappropriated slurs

is likely to be acceptable only from members of the marginalized group that has reappropriated the slur in the first place, if reciprocal use of these terms is acceptable at all.

This is an example of how it is important to be aware of the way a client may perceive a situation or discussion surrounding their identity. Being conscious of potential negative and/or positive impacts can minimize the possibility of a client feeling as if their identity is being assumed or potentially rejected within the mental health care setting. An example of a resource that can be used to think about or discuss identity is a tool called *The Genderbread Person*. This graphic, included as Figure 2 below, showcases the multiple aspects of one's gender and sexual orientation that make up one's identity.

Figure 2*The Genderbread Person*

The Genderbread Person v4 by its pronounced METROsexual.com



Source: Killermann, S. (n.d.-a). *The Genderbread Person Version 4*. It's Pronounced

Metrosexual. <https://www.itspronouncedmetrosexual.com/2018/10/the-genderbread-person-v4/>

The distinctions between biological sex, gender identity, and gender expression, as well as differences in sexual/romantic orientation are key to note when looking for areas where assumptions of an individual's identity may occur. Provider self-awareness is key to cultural competency education. Being aware of the multiple facets of one's own identity as a provider in addition to the clients' social position (further described under the heading Intersectionality and Positionality) can provide more informed questioning and dialogue with clients.

Overall, there is one aspect that was agreed upon by respondents when it came to the language that they preferred within care. As described by Participant D, providers should consider asking their clients if there are terms that help the client "feel comfortable and affirmed, then implement these changes to their vocabulary." This can be done in conjunction with using gender neutral language, as asking questions about one's preferred language leaves room for the individual to respond in a way that makes them the most comfortable. Another area to keep in mind with respect to these types of questions is that, like other aspects of a client's thoughts and feelings during the therapeutic process, the answer can change at any time. Allowing clients to know that the conversation can be kept open for a later date may also provide comfort (for example, "this can always be revisited and discussed if your feelings change"). This is one example of a microaffirmation, which are "small acts, which are often ephemeral and hard-to-see, ... [and are] very effective" (Rowe, 2008, p.46). In contrast to microaggressions, when accumulated over time, microaffirmations can bring trust into the client-provider relationship and create an overall affirming environment for the client. Within the survey responses, Participant M said that they would "feel most comfortable if, in a conversation there was a need for correction, if the person took direction well and made an effort to improve after that correction." This, stated as an action item, means that listening to the client's articulations of their wants as

well as listening to their silences in regard to their identities is a way the provider can effectively make change to reflect the client's needs within care. Egale Canada (2023-a) has produced a comprehensive directory of LGBTQ+ terms and concepts that may support development of culturally competent language. Endorsement of these definitions may vary from individual to individual and may change over time.

2. Disclosure: How “Coming Out” Can Impact Client-Provider Relationships

Mentioned by numerous respondents to the survey, anxieties about and responses to disclosure of gender or sexual identity have great impact on how an individual chooses to seek care and the relationships that develop within care. Disclosure of sexual or gender identity, otherwise known as “coming out,” is an ongoing process for LGBTQ+ individuals. When one discloses their identity within a client-provider setting, they may consider potential reactions from the provider or the worry of being outed (having one's identity disclosed without consent) to those around them (as mentioned by Participant D in chapter five). As a result of wanting to be certain of compatibility with the therapist before addressing such a personal subject, some respondents to this survey mentioned that they needed to take their time before outwardly acknowledging aspects of their identities. Disclosure can build trust within the client-provider relationship when the provider responds positively. In such a situation, the vulnerability associated with disclosure can strengthen an individual's self-perception (as noted by Smith & Turell, 2017). A potential client's discomfort with disclosure may deter that potential client from seeking care in the first place. Furthermore, not discussing their identity within mental health care may limit the benefits that mental health care can provide.

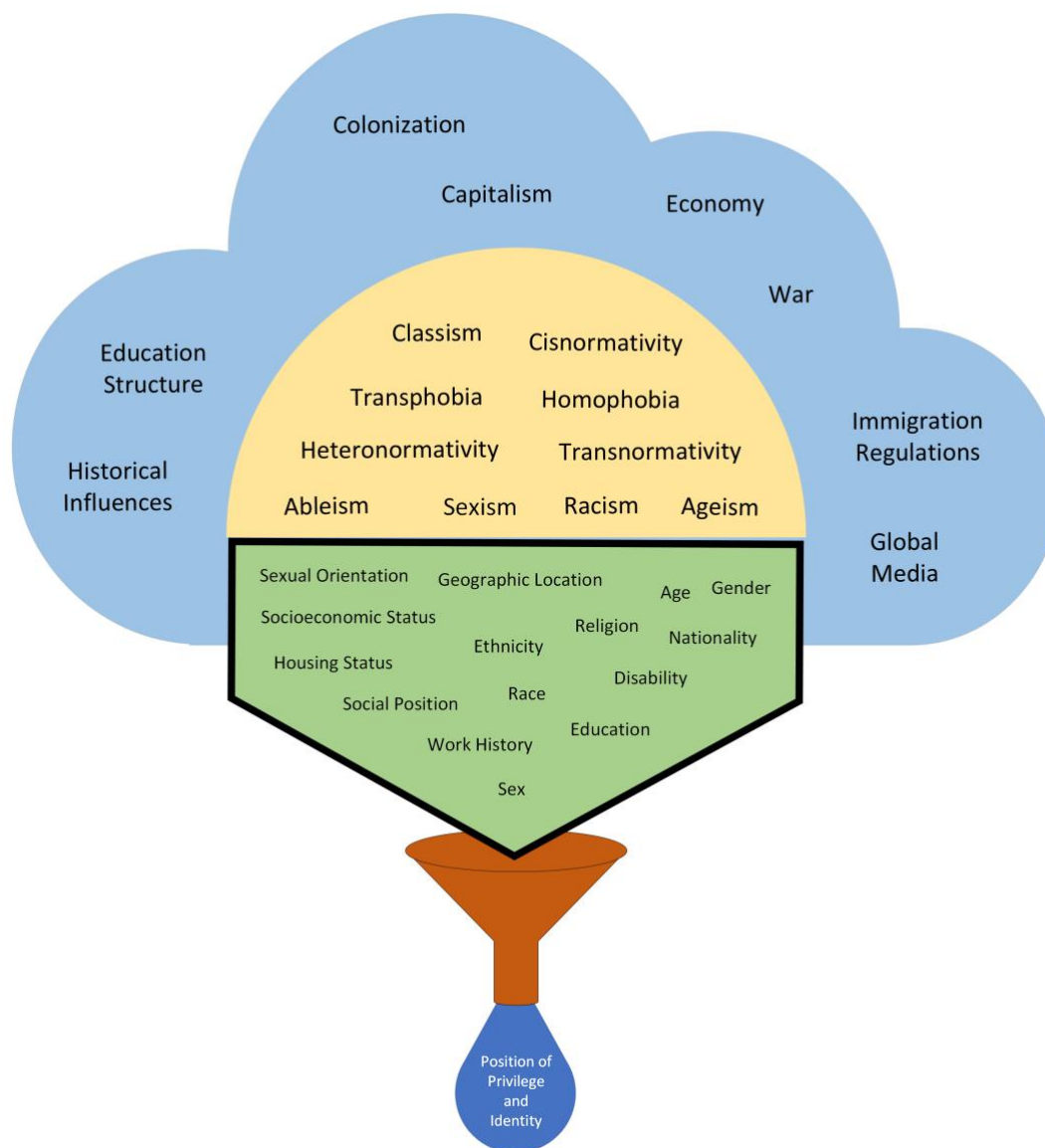
An aspect of disclosure that LGBTQ+ individuals anticipate within the mental health care setting is having to explain one's identity once it is disclosed. As previously discussed under

“Assumption of Identity,” a provider who understands the complexity of identity, and showcases such within the therapeutic relationship, is on the way to creating a comfortable environment for LGBTQ+ clients.

There is not a single means of disclosure that fits best for all LGBTQ+ individuals. For example, some respondents to the survey mentioned that it would be best to have identity factors listed on an intake form, but others preferred to wait and disclose during sessions. A possible solution to this is to provide clients with multiple avenues to disclosure, making it clear, including on intake forms, that all avenues are equally acceptable.

3. Exploring Intersectionality and Positionality: Inside and Out

Intersectionality, a key feminist framework, is useful for understanding structural influences on how LGBTQ+ individuals both experience mental health and receive mental health care. By highlighting the way in which axes of power impact the everyday lives of individuals who exist within them, “intersectionality has proved to be a productive concept” that can be utilized in many theoretical and practical aspects (Cho et al., 2013, p. 787). Intersecting aspects of identity observed in this survey included ability, racial identity, and age. However, there are many other categories that come into play when discerning how one’s LGBTQ+ identity impacts their life. While some modalities of intersectionality have placed focus on race, class, gender, and sexuality as four pillars, there are many factors that can intertwine into one’s intersectional identity, as described in Figure 3 below. I have made this graphic to visually showcase how wider systems of oppression impact an individual’s intersectional identity.

Figure 3*Diagram of Intersectionality and Identity*

Within discussions of intersectionality, those who provide care must be aware of their own positionalities, including the privileges inherent to the provider within a client/provider relationship, as well as other hierarchal structures such as race or class as well. Defined as the way one reflects upon their place within heteronormative, cisnormative, and patriarchal

hierarchies and standards, positionality impacts everyone who seeks or provides care. Often used within academic settings to refer to how a researcher's biases may influence their endeavours, thought processes regarding positionality can be applied to any setting where there is the potential for a power imbalance. "The social position which we occupy ... is inseparable from the analysis of power", and therefore it must be understood to unpack how power impacts the client-provider relationship, even in minute ways (Cabrera et al., 2020, p.313). Understanding one's positionality also provides clues to one's own potential blind spots, since by default, privilege is invisible. In saying this, discovering one's positionality is much like discovering a client's intersectional identity, in that it has the potential to shift over time.

Overall, when considering the importance of intersectionality and positionality, "the important tasks for therapists are to gain an understanding of how clients are conceptualizing the problems" and experiencing their lives, and the way an individual is placed within power structures is key in doing so (Sue, 2006, p.243). To fully understand how a client's intersectional identity impacts their experience with mental health, respondents to the survey expressed that a provider must understand their own intersectional identity. Provider positionality entails understanding the intersecting identities that may impact clients, and becoming responsive to these intersecting identities, without expecting the client to do so. Clients may enter the therapeutic relationship with awareness of their own positionality, and others may not. Summarized, the importance of intersectionality and positionality can be presented in the form of two questions: who is the client that is coming into the therapeutic relationship; and who is the provider that is coming to the table?

4. Cultural Competency Training: Not One and Done

Having Cultural Competence is important for mental health providers who provide care to LGBTQ+ individuals. Cultural competency involves an objective of better comprehending the cultural factors relevant to clinical interactions with patients coming from a given community. As discussed by Whaibeh and Colleagues (2020), “In the context of LGBT patients, cultural competence entails sensitivity about and understanding of important issues affecting the LGBT community. Clinicians are expected to be self-aware of the direct and indirect assumptions, biases, and values that they express to their patients.” (p. 426). On a webpage discussing Diversity, Social Inclusion and Cultural Competence in Health and Wellness in Nova Scotia, the most recent cultural competency guidelines were last updated in 2011, 12 years before this study (Government of Nova Scotia, 2021). These guidelines were noted to be relevant to the delivery of primary health care, but mental health care was not mentioned, and training is not mandatory. Not all clinicians have been exposed to ideas of cultural competency during their degrees, and therefore these trainings may be the only resource for them to receive such information. PrideHealth, a resource for LGBTQ+ Nova Scotians, provides referrals to affirming mental health and addictions providers, among other valuable services (Nova Scotia Health Authority, 2022). However, this relates to the earlier mentioned finding that if organizational betrayal has occurred, it may take more than a provider describing themselves as affirming to gain the trust of a client. Moreover, it is unclear how “affirming providers” were identified for the purposes of this resource or how “affirming” was operationalized.

As stated in the survey responses, one participant wished that “more care providers were required to be educated on the LGBTQ+ community. I wish that they would also listen to members of the community regarding our experiences without invalidating them” (Participant

D). Cultural competency training does not necessarily need to take place in a formal education setting to be effective. Examples of resources and free training programs can be found through Human Rights Nova Scotia (Province of Nova Scotia, *Education & Community Outreach*) and Egale Canada (Egale Canada, 2023-b).

5. Trauma-Informed Care & Betrayal Trauma – What Can We Learn from History

As elaborated in chapter five, the term betrayal trauma is used to describe situations where positive expectations for the outcomes of an interpersonal interaction are met with negative results, especially when the individual is somewhat reliant on the person who betrayed them, such as within a client-provider relationship (Burton et al., 2020). These consequences and subsequent trauma can relate to stigmatization or insufficient culturally competent behaviour and can be linked to further trauma known as Organizational Betrayal. Organizational Betrayal occurs when an individual feels failed by multiple individuals within an organization which leads to overall distrust. These dynamics impact LGBTQ+ individuals in unique ways. The historic and lasting pathologization of homosexuality and gender dysphoria in the DSM, which has perpetuated devaluation of LGBTQ+ identities within and beyond mental health care contexts has negatively impacted the expectations that many community members have for providers. This puts LGBTQ+ individuals in a distinctive position, where there is a level of distrust in the therapeutic relationship before one enters care.

Mentioned specifically by one respondent to the survey, Trauma-Informed Care and Practice can inform LGBTQ+-specific mental health care. By “deliver[ing] services in a way that incorporates evidence about the prevalence, neuroscience, and impact of trauma on thoughts, feelings, behavior, health, and psychosocial well-being," a Trauma-Informed approach can mitigate the risk of betrayal trauma or organizational betrayal impacting the therapeutic

relationship (McCormick et al., 2018, p.134). Trauma-Informed Care specific to LGBTQ+ individuals involves understanding that the pathologization and stigmatization that LGBTQ+ people experience can cause trauma (for example, ongoing minority stress) in addition to other traumas that may be faced unrelated to these identity categories.

6. Barriers to Seeking Care & Barriers Within Care

Lack of available LGBTQ+ identified providers was the main barrier to culturally competent mental health care identified in this study. Most survey respondents indicated that having an LGBTQ+ provider is necessary to receive care that is fully culturally competent. Those who responded that it was not necessary discussed the observations and actions that a provider who is not a member of the LGBTQ+ community must take to provide equitable care. These observations and actions included the previously mentioned cultural competency training, as well as more specifically attending conferences that are focused on professional development relating to LGBTQ+ individuals. Providers who were open with clients about their own identities made respondents more comfortable, whereas, in one example, a provider who did not want to disclose their identity was potentially perceived as microaggressive. While participants felt there was no substitute for shared experience based on LGBTQ+ identity, actively maintaining awareness of LGBTQ+ community dynamics was seen as a minimum requirement for a mental health care practitioners serving the LGBTQ+ population.

While barriers to seeking care should be understood by providers in the interest of LGBTQ+ competency, providers work within a context that is under-resourced, suggesting that some solutions beyond the scope of this thesis must be sought on the level of government policy. Further explored within Implications for Future Research, access to mental health care services in Nova Scotia is influenced by systemic issues and barriers (such as the aforementioned Long

Wait Times and Financial Restrictions) that are faced by all individuals seeking care.

Encountering barriers to access in these areas may impact the way in which a client has perceived the mental health care system (see Organizational Betrayal above) before entering care, as well as the likelihood of seeking and/or receiving mental health care. Overall, these are not issues that must solely be addressed by each individual provider, but the overarching institutions that provide such care. Many systemic barriers to mental health care cannot be fixed by individual providers, but rather must be addressed by the governmental structures funding and regulating such care.

Implications for Future Research

Many of the barriers to mental health care in Nova Scotia that have been uncovered by this research are not only relevant to those who are LGBTQ+, but also to individuals dealing with mental health issues across our province. Particularly given the limited scope of my study, it is critical to continue unpacking the barriers that affect all Nova Scotians. Moreover, barriers such as financial limitations or availability constraints not only impact mental health care, but health care more broadly in Nova Scotia. To further understand these barriers, there must be research examining patient perceptions of generalized health services in Nova Scotia, where barriers to quality physical health care are likely to overlap with those experienced by individuals seeking mental health care. Further exploration and research in this area would benefit from a wider sample that spanned generations and identity categories under the LGBTQ+ umbrella and beyond. Using different or broader samples, future studies could collect additional information on other intersecting identities, such as race and ability.

Limitations

While the sample for this study had the advantages of drawing on a previously unresearched population (LGBTQ+ Nova Scotians) it also involved important limitations. Data collection was limited due to the relatively small sample size of 17 individuals. Furthermore, the sample may have been limited due to the group of potential respondents who were either present on the MSVU campus or viewed social media postings within the extended network that shared my recruitment materials. If posters had been shared more widely throughout HRM and Nova Scotia, the results may have differed. Individual interviews would have allowed me to ask follow-up questions, therefore, could have produced a more thorough exploration of the themes presented here.

There may have been different information uncovered if this study had focused on collecting data from other age groups, rather than collecting input exclusively from participants under the age of 35. For example, LGBTQ+ individuals who received mental health care before homosexuality was removed from the DSM (formally in 1973) likely had different experiences in care than those who currently receive mental health care.

Conclusion

The intention of this exploratory qualitative study was to investigate the experiences that LGBTQ+ individuals have had within mental health care in Nova Scotia. Analysis of the survey results suggested that not only is inclusion necessary for LGBTQ+ individuals to feel comfortable within care, but health care providers must have an active understanding and foster within themselves knowledge of LGBTQ+ experiences. This necessity is argued for by authors such as Nowaskie (2020), who says that providers must be “learners to understand the unique associations between demographics, health risks, and psychosocial factors among the LGBT

population” (p.377). Often provided as training to mental health care professionals, LGBTQ+-specific Cultural Competency involves building a trusting therapeutic alliance. Respondents stressed the importance of a provider's ability to identify how an LGBTQ+ individual's identity affects their mental health as well as the barriers that impact care. Being aware of sensitizing concepts such as minority stress, rejection sensitivity, and Betrayal/Organizational Trauma before entering a client-provider relationship mitigates the possibility of a negative client experience due to subtle (or overt) actions that are perceived by the client as microaggressions or dismissal. As exemplified by responses to the question of whether an LGBTQ+ provider is necessary, each individual seeking mental health care has different needs and expectations for outcomes of care.

While some participants felt that cultural competency could be achieved by community outsiders, others felt it was important to receive care from a provider with shared lived experience as an LGBTQ+ community member. As elaborated in response to my second research question (which issues raised during surveys by participants are relevant across LGBTQ+ identity categories and which are relevant only or mostly to one or some LGBTQ+ identity categories?) different experiences and concerns were reported by those who belong to distinct identity categories, such as those of a sexual minority and those of a gender minority. For those seeking mental health care from an LGBTQ+ provider in Nova Scotia, please view the Queer & Trans Therapists of Nova Scotia (QTTNS) Clinician Directory in Appendix G.

By highlighting the need for cultural competency and bringing awareness to the concepts of minority stress, rejection sensitivity, betrayal trauma, and organizational betrayal, this study can be beneficial to those who are providing mental health care for LGBTQ+ individuals, and by extension, to LGBTQ+ individuals themselves. Some of the findings presented here could also

usefully inform the perspectives and approaches of researchers, teachers, family and friends of LGBTQ+ people. The results of this study have the potential to positively impact the mental health care that LGBTQ+ individuals in Nova Scotia receive, repairing distrust rooted in a deep history of betrayal by mental health care practitioners, organizations, and systems.

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Appendices

Appendix A – Recruitment Poster



**Participants Wanted for
MSVU Student Research**

LGBTQ+ EXPERIENCES OF THE RELATIONSHIP BETWEEN
DISCRIMINATION AND MENTAL HEALTH CARE

***Are you a 19+ member of the LGBTQ+
community who has received
professional mental health care
in Nova Scotia?***

This anonymous survey will take approximately 30 minutes to complete.

The goal of this research is to provide insight into the experiences participants have had with the mental health system in Nova Scotia.

Individuals are encouraged to take this survey in a safe and private location.

Follow the link or scan the QR code below to begin the survey.

INSERT LINK HERE



 **Mount Saint Vincent University**

You may contact the researcher for more information at
Elayna.Foran@MSVU.ca

Appendix B – Informed Consent Form

Informed Consent Form: LGBTQ+ Experiences of the Relationship Between Discrimination and Mental Health Care

Instructions: Please read and fill this form before beginning the survey.

This informed consent form is for individuals in the LGBTQ+ community who are invited to participate in research titled “LGBTQ+ Experiences of the Relationship Between Discrimination and Mental Health Care”. **To complete this survey, you must be 19 years of age, a self-identified member of the LGBTQ+ community, and have received mental health care in Nova Scotia.**

Introduction

I am Elayna Foran, a master's student in Women and Gender Studies at Mount Saint Vincent University, the principal investigator of this project. The supervisor for this project is Dr. KelleyAnne Malinen, of the Department of Sociology and Anthropology at Mount Saint Vincent University. The thesis committee includes faculty from MSVU in the departments of Psychology and Women's Studies.

Before agreeing to participate in this research project, please take the time to read and understand the following information. This document explains the aim of this research project, its procedure and the advantages, as well as risks and inconveniences it may pose to you. **I invite you to ask me any questions you may have by emailing Elayna.Foran@MSVU.ca. If you have questions later, you can ask them of me or of my supervisor, Dr. KelleyAnne Malinen at KelleyAnne.Malinen@MSVU.ca.**

What is the Purpose of the Research?

The overall objective of this study is to provide insight into the negative and positive experiences participants have had with the mental health system in Nova Scotia. I aim to uncover the challenges LGBTQ+ individuals face to improve mental health providers' cognizance of LGBTQ+-specific issues. I also am seeking to understand the ways in which different LGBTQ+ identity categories may be impacted by discrimination within and external to mental health care.

What is the Nature of Your Participation in This Study?

Your participation in this research consists of participating in a one-time survey. You will be asked six questions about your identity and twelve questions about your experiences with mental health care. If you do not wish to answer any of the questions during the survey, you may skip to the next question.

Survey questions are structured to encourage further elaboration. Questions will address the following elements:

- Care sought, age of first contact, and barriers related to mental health care
- Participant support systems and care outside of professional treatment
- Participant experience in mental health care related to identity
- Participant views on language that has been utilized in care

You can maintain anonymity by not offering identifying information. You are also encouraged to complete the survey in a safe and private location. Any identifying information you include will be removed or replaced in passages used in publications.

Results of research will be shared within my written thesis and accompanying thesis presentation, anticipated for late August 2023. A summary of results and link to my thesis will also be shared on the social media platforms used to recruit participants. A checklist of recommendations for care providers may be produced and circulated if resulting data lends itself to this use.

What are the Possible Risks and Inconveniences Related to Your Participation?

Although identifying information will not be shared, others who are familiar with examples you offer might recognize you in written reports. I am asking you to share with some personal information, and you may feel uncomfortable addressing some of the topics. You are not required to answer every question posed. At the beginning and the end of the survey, there will be a list of resources available to you that includes mental health care that is available in person, online, and via phone.

What are the Possible Advantages?

Participating in this research is a chance to reflect upon the mental health treatment you have received. You may learn from these reflections and benefit from the opportunity to share your own thoughts. Your participation may contribute to knowledge about the impacts that discrimination has on LGBTQ+ experiences in mental health care.

Voluntary Participation and Your Right to Withdraw

You are free to participate or not in this research project. You can also end your participation without negative consequences and without any obligation to justify your decision. If you decide to end your participation, you may do so any time prior to survey submission by closing the browser/tab. Closing the browser window will delete the information you have provided. The data will not be saved, and is therefore not part of the study in any way. You must withdraw before clicking the final “submit” button. After this, there is no longer an opportunity to withdraw. Because participants are coded with ID numbers instead of names to protect participant identities, I would not be able to locate and delete your submitted data.

Confidentiality and the Handling of Data

These are the steps I will take to assure the confidentiality of your information and store your data:

- After the survey closes, I will review the data and replace any identifying information with pseudonyms, such as names of people, places, or things.
- Digitized materials such as data will be protected by a computer password.
- Data will be kept for 5 years after the completion of this project, at which point it will be deleted from OneDrive.

- The working file produced by the data analysis program MAXQDA will be password protected.

Duty to Report

There are some situations in which researchers have a duty to report information they have received to authorities. Like all citizens, the researcher is legally obliged to notify the appropriate authorities of any situation of physical or sexual abuse revealed to them which is currently occurring and/or inflicted upon a minor or vulnerable adult. The researcher is also legally obligated to notify appropriate authorities if a participant reveals they may harm themselves or others. These limitations to confidentiality are prescribed by Canadian law.

Additional Information/Questions

If you have questions about this research or your participation, please contact the researcher Elayna Foran at XXX-XXX-XXXX, or via email at Elayna.Foran@msvu.ca, or Elayna's faculty supervisor at KelleyAnne.Malinen@MSVU.ca. If you have questions about how this study is being conducted and wish to speak with someone not directly involved in the study, you may contact the Chair of the University Research Ethics Board (UREB) c/o MSVU Research Office, at 457-6350 or via e-mail at research@msvu.ca.

My Thanks

I extend my sincere thanks for your participation, without which this study would not be possible.

Signatures

For Participants

I freely consent to participate in the research project entitled "LGBTQ+ Experiences of the Relationship Between Discrimination and Mental Health Care". I have read and understood this form and I understand the goal, nature, advantages, risks and inconveniences involved with this research project

[] I indicate my consent by placing an X in this box

Appendix C – Self-Identification Questions

Please indicate how you identify the following:

If comfortable, please indicate your gender identity.	<input type="checkbox"/> Cisgender Woman <input type="checkbox"/> Cisgender Man <input type="checkbox"/> Trans* <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Genderqueer/Non-Binary <input type="checkbox"/> Other/prefer to describe: _____
If comfortable, please indicate your sexual orientation.	<input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Questioning <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Another/prefer to describe: _____
Age	_____
Pronouns	_____
Do you consider yourself to be a person with a disability?	<input type="checkbox"/> Yes, Visible <input type="checkbox"/> Yes, Non-Visible or Invisible <input type="checkbox"/> No
If comfortable, please state or describe your racial identity.	_____ _____ _____

Appendix D – Survey Questions

LGBTQ+ Experiences of the Relationship Between Discrimination and Mental Health Care Survey

Introduction:

- Page 1:
 - Statement that “Participants are encouraged to complete this survey in a private and safe location
 - Informed consent (see Appendix D)
 - Link to support resources (see Appendix E).
- Page 2: Self Identification Questions (see Appendix C).
- Page 3: Main Survey Questions

Main Survey-Questions

- What channel(s) have you pursued mental health care through? (NSHA, private centers, school/university, individual counselling, GP, pastoral care, elders for Indigenous care)
- How would you describe your social support system outside of mental health care? (Family, friends, etc.)
- What age did you first seek mental health care?
- Were there barriers to receiving mental health care? What were they? (Financial constraints, time constraints, location barriers, availability, timeliness, etc.)
- Are there concerns that you experience when meeting a new mental health care provider? If so, please list or describe them.
- Does it make a difference to you whether your provider is a member of the LGBTQ+ community? Do you have thoughts about why or why not?
- Have you felt that you are understood by your provider in terms of your identity? How so and/or how not?
- Are there aspects of your identity other than being LGBTQ+ that have been relevant to your experience of care? (E.g., socioeconomic status, racial or ethnic background, nationality, or disability). If so, please list or describe them.
- In which ways, if any, do you think your experience in mental health care has been impacted by your LGBTQ+ identity? In which ways, if any, do you think your experience in mental health care has been impacted by your other identities?
- In what ways, if any, do you think your care has impacted the way you relate to your LGBTQ+ identity? In what ways, if any, do you think your care has impacted the way you relate to your other identities?
- Are there terms or phrases that your mental health provider can (or did) use that help you to feel more comfortable? If so, what are they? You may also share any thoughts about why these terms or phrases added to your comfort.

- Are there terms that make you feel less comfortable when they are used in care? If so, what are they? You may also share any thoughts about why these terms or phrases reduced your comfort.
- Is there nonverbal language that has impacted your comfort level with your provider? If so, please tell me about it.
- Based on your experience, are there things you would have liked to change about the mental health care that you have received? If so, what are they?

Link to mental health support resources: [See Appendix E]

Appendix E – Mental Health Resources

Mental Health Resources: LGBTQ+ Experiences of the Relationship Between Discrimination and Mental Health Care

If you are at immediate risk of harm to yourself or others, you are in an emergency.

Call 911 or visit your nearest emergency department.

Resources that are explicitly queer inclusive are marked with *.

On-Campus at MSVU

MSVU Counselling Services

- MSVU's Counselling Services team provides free personal and academic counselling to any registered Mount student in a relaxed and confidential environment.
- Appointments are available Monday to Friday by phone, video via TAO, or in-person.
- Email counselling@msvu.ca, call 902-457-6567, or visit the Student Services desk at EMF 108.

Health Office

- The MSVU Health Office provides a variety of services, including but not limited to: Doctors' appointments for medical services (non-emergency), a triage nurse who is available for same day walk-in's, STI screening, IUD insertion and removal, PAP tests, referrals to specialists, and birth control education.
- Book an appointment [through Pomelo](https://www.msvu.ca/campus-life/health-wellness-services/health-office/msvu-student-health/) at <https://www.msvu.ca/campus-life/health-wellness-services/health-office/msvu-student-health/>
- Call 902-457-6354 and select option 0.
- <https://www.msvu.ca/campus-life/health-wellness-services/health-office/>

Campus Security

- Call 902-457-6412 for non-emergencies.
- Call 902-457-6111 for an on-campus emergency, 24 hours a day, 7 days a week.
- <https://www.msvu.ca/campus-life/campus-services/safety-security-at-msvu/>

In-Person Resources in Halifax

Hospital Emergency Department

- 19 years old or above: QEII Emergency Department at 1799 Robie Street, 902-473-2043
- Under 19 years old: IWK Emergency Department at 5941 South Street, 902-470-8888

Provincial Mental Health Crisis Line

- Toll-free: [1-888-429-8167](tel:1-888-429-8167)
- Halifax area: [1-902-429-8167](tel:1-902-429-8167)
- The Mental Health Mobile Crisis Team helps children, youth, and adults manage a mental health crisis, such as intense anxiety, overwhelming depression, and feeling unable to cope and out of control. Crisis support is given over the phone or in person—they will come to you in the Halifax area.
- When you call, the crisis team will provide immediate crisis support and triage over the phone and visit you in person in the Halifax area, if necessary, assess your situation, current supports, and resources, help you access follow-up services, consult with your existing supports and services, and provide short-term crisis management.
- Crisis support is available to anyone who is experiencing a mental health crisis. This includes an individual self-referring, family/friends, community support/service providers, and health care providers.

prideHealth*

- prideHealth works to improve access to safe, coordinated, comprehensive primary health care for people who are part of the 2SLGBTQIA+ community.
- prideHealth provides the following services for the 2SLGBTQIA+ community:
 - Referrals to affirming mental health and addictions providers
 - Information and referrals for gender-affirming care
 - Information about sexually transmitted and blood-borne infection (STBBI) testing and treatment services
 - Information about community resources such as peer support, advocacy, and social groups
- <https://mha.nshealth.ca/en/services/pridehealth>
- 902-487-0470 prideHealth@nshealth.ca

Avalon Sexual Assault Centre

- Avalon Sexual Assault Centre provides a specialized therapeutic counselling program that is available to women, trans folks, and gender non-identified individuals 16 years and older, who have experienced a recent or historical sexual assault, childhood sexual abuse, and/or sexual harassment. They also provide sexual assault nurse examiner services as well as prevention intervention and awareness.
- Call 902-422-4240
- If you have experienced sexual assault in the last 7 days, call 902-425-0122
- <https://avaloncentre.ca/>

Phoenix Youth

- Phoenix Youth Programs include housing support, advocacy, crisis intervention, counseling, parenting support, referral to community and internal resources, health services, financial advocacy, food, clothing, shower and laundry facilities, computer, and phone access.

- Open Monday – Friday, 8:30 am – 4:30 pm at 5880 Spring Garden Rd., Suite 200, Halifax, B3H 1Y1
- 902-422-3105 phoenix@phoenixyouth.ca
- <https://phoenixyouth.ca/>

South House*

- South House is Halifax's only full-time gender justice centre. Includes a digital resource centre, library, and free meeting space for anti-oppressive organizing and gathering.
- 1443 Seymour Street, Halifax.
- <https://southhousehalifax.org/>

Online Resources available throughout Nova Scotia

Healthy Minds NS

- HealthyMindsNS is a suite of online mental health resources, available free to post-secondary students, to complement the mental health supports and services available on campuses.
- <http://healthymindsns.ca/>

Togetherall

- Togetherall is a safe, online community where people support each other anonymously to improve mental health and wellbeing.
- <https://togetherall.com/en-ca/>

Therapy Assistance Online (TAO)

- TAO is an online mental health library with interactive modules to help you understand and manage how you feel, think and act.
- <https://www.taoconnect.org/>

Good2Talk NS

- Good2Talk NS provides free, confidential support available to post-secondary students in Nova Scotia.
- Call Good2Talk NS Helpline for Postsecondary Students: 1-833-292-3698
- Text Good2TalkNS to 686868
- <https://good2talk.ca/novascotia/>

Wellness Together Canada

- Wellness Together Canada provides mental health and substance use support for people in Canada and Canadians abroad. Always free and virtual, 24/7.
- 19 years old or above: Text WELLNESS to 741741 or call 1-866-585-0445
- Under 19 years old: Text WELLNESS to 686868 or call 1-888-668-6810

- <https://www.wellnesstogether.ca/en-CA>

Hope for Wellness Helpline for Indigenous Peoples

- Hope for Wellness Helpline is available 24/7 to all Indigenous people across Canada. It is available 24 hours a day, 7 days a week to offer counselling and crisis intervention.
- Call 1-855-242-3310
- [Online chat](#) available
- <https://www.sac-isc.gc.ca/eng/1576089519527/1576089566478>

Anxiety Canada

- Anxiety Canada is a suite of resources including CBT app, online courses, and online group therapy.
- <https://www.anxietycanada.com/>

Appendix F – CORE Tutorial Completion Certificate



**Appendix G – Queer & Trans Therapists of Nova Scotia Clinician Directory
(Reprinted with Permission)**

Queer & Trans Therapists of Nova Scotia

Clinician Directory



2023

Updated May 2023

Compiled by Kay Jenson-Vinova, MSc, Psychologist & Kat Merwin,
PhD, Psychologist (Candidate Register)

QTTNS Clinician Directory (2023)

contents

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28	Joining QTTNS

Welcome

Hello! We are pleased to introduce The Queer and Trans Therapists of Nova Scotia (QTTNS), a group of 2SLGBTQIA+ identified therapists who focus on providing a safe and affirming therapeutic space for 2SLGBTQIA+ clients. QTTNS is a closed space for licensed mental health therapists practicing in Nova Scotia who identify within the 2SLGBTQIA+ community. We came together in early 2022 and are guided by anti-oppressive, anti-racist, intersectional approaches that acknowledge the detrimental effects that structural oppression and systemic discrimination have on our community's mental health, as well as the impacts these have on access to sexual and gender-diverse competent care.

As therapists who are both part of the queer community and largely serve the queer community, we can appreciate how difficult it is to find queer and trans-affirming therapists. We created the following directory of 2SLGBTQIA+ identified therapists to aid in reducing the amount of labour it can take to find a therapist that is the right fit.

We aim to update this directory annually in the Spring. We are open to feedback and requests for consultations or questions.

Thank you,



Cailin Crosby



Erica Baker-Gagnon



Holly Blunden



Kay Jenson-Vinova

Organizing members of QTTNS

Guiding Frameworks OF QTTNS



QTTNS members recognize that all therapy is political, that there is an inherent power imbalance by positioning the therapist as the "ultimate expert". Furthermore, we hold the belief that maintaining neutrality towards personal beliefs can cause and contribute to direct harm. QTTNS members strive to hold the following frameworks/lenses when acting professionally with other providers and our clients. We encourage you to speak with your therapist about their specific framework.

Anti-ableism identifies inequalities and disparities in how we value and treat individuals with intellectual, mental, and/or physical disabilities. An AA therapist recognizes that a client cannot simply reframe their thinking to find relief of symptoms but rather helps clients challenge internalized ableism, find supports and community, and navigate systems. AA therapists remain critical of their training, how evidence-based therapies are created, and institutional practices to ensure they are not furthering harm to disabled clients.

Anti-capitalist in a sense is working to replace capitalism with another type of economic system, such as socialism or communism. An AC framework in therapy could involve challenging the idea that our self-worth is directly linked to our productivity and what we can earn for others. The therapist may challenge the need for hyper-individualism and help the client learn ways to reconceptualize and engage with their role in their community.

Anti-colonial is a broader term used to describe an awareness and commitment to aid in various resistance movements directed against imperial and colonial powers. A therapist using this lens may center the need to heal from the dehumanizing, life-threatening, and harmful effects the client might have faced as a result of colonization.

Anti-oppressive aims to lessen the effects of oppression and bring equity to those who are more marginalized and affected by oppressive systems. A therapist working with an AO framework may name how there are social differences in treatment and level of access depending on the client's intersecting identities of race, gender, social class, sexual orientation, age, disability, and so forth. AO encourages the therapist to develop a critical consciousness of how they engage with, reinforce, and perpetuate harmful structures of oppression, especially when it comes to how they deliver treatment to their clients.

Anti-racist framework challenges and works to dismantle systematic and institutional racism that is built into our social systems, laws, practices, and treatment of Black people, indigenous people, and people of colour (BIPOC). Working from an anti-racist...

Guiding Frameworks OF QTTNS



... framework may look different for the therapist and client depending on their individual intersections of identities and racialized experience. For example, a white settler therapist treating another white settler client might challenge the client's view of racism and acknowledgment of their privileged experience because they have benefitted from white supremacy. The therapist might also center how the client's lived experience as a racialized person has contributed to their current mental health status, and help the client heal from past and ongoing racial trauma.

Feminist approaches to therapy typically operate from the assumption that marginalized genders and other oppressed groups are at higher risk for mental health issues because of the disparity in how different genders are treated and socially conditioned within our society. A feminist therapist may help the client challenge gender roles, socialization, their self-concept, and empower the client to recognize and change how they are upholding the patriarchy.

Harm reduction aims to reduce the physical, emotional, relational, and/or financial harm of harmful behaviours, such as substance use or self-harm, without necessarily requiring the client to completely stop or abstain from engaging in that behaviour. HR keeps a non-judgemental and non-coercive stance to allow clients to make their own choices to enrich their lives and maintain stability.

Queer and Trans Affirming approach to therapy embraces the client's gender, sexual orientation, and/or relationship orientation. The therapist normalizes change and fluidity within our different identities and lived experiences without imposing there is one correct way to engage with and experience queerness. QTA therapists encourages clients to self-reflect on how cisgender-heterosexual normativity negatively impacts them and others.

Trauma-Informed framework accounts for how the client's traumatic experiences impact their behaviour, health, ability to progress in treatment, and mental health status, regardless if the current focus is on treating underlying trauma or not. TI therapists take active steps to not re-traumatize the client by actively collaborating with the client, receiving competent training, and taking accountability for seeking treatment for and coping with their own traumatic history. A TI approach may involve psychoeducation on trauma responses, helping the client to build awareness of how the here-and-now often is influenced by the client's and others' traumatic history, and teaching coping strategies to establish stability.



QTTNS Clinician Directory (2023)

Each therapist listed here is an openly out member of the 2SLGBTQIA+ community, meaning the therapist has consented to being outed as part of the queer community to the general public. We did not include exact identity labels for each clinician as some members' intersecting identities are fluid or do not simply fit into a fixed box. Identity labels can be both freeing and limiting in that they can communicate a shared lived experience to oneself and others, and sometimes lead individuals and/or groups of people feeling wrongly confined to what that identity label may mean. We encourage you to ask the clinician directly if they have any identity labels they openly identify with such as race, social class, disability, gender, sexual orientation, and relationship orientation.

Additionally, we did not include exact wait times and fees for therapists who work in private practice as both are typically in flux. Instead, we included a website or direct contact information where you can ask those questions. We did note which therapists offer reduced rates or sliding scales. Most clinicians provide both in-person and virtual options for therapy. Please ask the therapist directly whether they offer virtual services and for geographic locations they are licensed to practice in.

For therapists that work within Nova Scotia Health, we included the therapists' department, location, or unit they work in. To connect with a therapist within Nova Scotia Health, please call the General Intake line at 1-855-922-1122. While you can voice your preference to work with a specific therapist and/or to work with a queer and trans competent therapist, please note that this is not always able to be accommodated due to a variety of organizational factors (e.g., clinician availability, licensing, case complexity, appropriate therapeutic modality for presenting concern, etc.).

Please refer to the glossaries on pages 18 to 27 to read the full names and definitions of each acronym referred to in the listing.

QTTNS Clinician Directory (2023)

Dr. Nikki Ali



Ph., Registered Psychologist
NSBEP #R1104

Location: Halifax

Practice: Lesley Hartman & Associates, Inc.

Sliding Scale: No

Populations/Ages: Children, youth for assessment and therapy, adults for assessments

Website:
lesleyhartmanassociates.ca

Virtual Option: Yes

Therapeutic Modalities: ACT, CBT, CCT, DBT, MI

Assessments: ADHD, ASD, Psycho-educational

Main Treatment Issues: Anxiety, mood, emotion dysregulation, neuro-diverse clients, disordered eating, parent-youth connection and communication, self-esteem, body image, typical concerns of adolescence

Provides Clinical Supervision: No

Kiran Awrey

MA, CCC, RCT-C, RCT-C21-072

Location: Lower Sackville

Practice: Lifemark Core

Sliding Scale: No

Populations/Ages: Age 15+, Individuals

Website: lifemark.ca/core-rehab

Virtual Option: Yes

Therapeutic Modalities: CCT, CBT, CPT, DBT

Assessments: None

Main Treatment Issues: Trauma, Post Traumatic Stress Disorder, and Borderline Personality Disorder

Provides Clinical Supervision: No



QTTNS Clinician Directory (2023)

Heather Baglole



MA, RCT-C, Licensing number to be determined

Location: Dartmouth

Practice: Diverse Roots

Sliding Scale: No

Populations/Ages: 13+, individuals

Website: diverserootstherapy.com

Therapeutic Modalities: CCT, ET, NT

Assessments: None

Main Treatment Issues: Gender, sexuality, polyamory, anxiety, depression, relationship issues, attachment issues, issues around sex, neurodivergence, systemic issues

Provides Clinical Supervision: No

Erica Baker-Gagnon

MSc, RCT, RCT-19-004

Location: Dartmouth

Practice: Diverse Roots

Sliding Scale: Yes

Populations/Ages: 13+, Individuals, couples, relational dynamics

Website: diverserootstherapy.com

Virtual Option: Yes

Therapeutic Modalities: IFS, NT, PT

Assessments: WPATH

Main Treatment Issues: Gender, sexuality, mood disorders, anxiety, depression, relationship issues, trauma, attachment issues, issues around sex, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, parenting, chronic illness/pain, systemic issues

Provides Clinical Supervision: Yes



QTTNS Clinician Directory (2023)

Malory Beazley



MEd, RCT-C, RCT-C20-059

Location: Dartmouth

Practice: In the Margins Counselling

Sliding Scale: No

Populations/Ages: 18+, individuals

Website:

inthemarginscounselling.com

Virtual Option: Yes

Provides Clinical Supervision: No

Therapeutic Modalities: CFT, NT, SFBT

Assessments: WPATH

Main Treatment Issues: Women's issues, healthy relationships, anxiety and depression, gender and sexuality, childhood emotional neglect, narcissistic abuse, life transitions, sexual violence, self-worth, emotional literacy, existential concerns (e.g., climate change, late-stage capitalism), stress management

Jey Benoit

MSW, RSW, #8437

Location: Truro/Halifax

Practice: ME Family Therapy & Resource Centre, Halifax Sexual Health Centre

Sliding Scale: No at private practice. At Halifax Sexual Health Centre-WPATH assessments are free

Populations/Ages: Children, youth, families, and young adults

Websites: mefamilytherapy.ca
hshc.ca

Therapeutic Modalities: CBT, DBT, EMDR, TIT

Assessments: WPATH

Main Treatment Issues: Trauma and attachment injury, gender & sexuality; emotional dysregulation, late and self-diagnosed neurodiversity

Provides Clinical Supervision: No

Virtual Option: Yes in NS & NFLD



QTTNS Clinician Directory (2023)

Holly Blunden



MA, RCT-C, RCT-C22-003

Location: Yarmouth

Practice: Ilex Counselling Services

Sliding Scale: Yes

Populations/Ages: 9+, individuals

Contact Info:

hollyannblunden@gmail.com

Virtual Option: Yes

Therapeutic Modalities: CBT, CCT, CPT, DBT, EMDR, IFS, MBT, MSCT

Assessments: None

Main Treatment Issues: Trauma, anxiety, depression, Attention Deficit Hyperactivity Disorder, gender and sexuality, life transitions, existential anxiety, boundaries/codependency, emotional dysregulation

Provides Clinical Supervision: No

Robyn Bolivar

MEd, Registered Psychotherapist in Ontario, #3610. In the process of securing licensing in NS as a RCT

Location: Virtual in NS

Practice: Robyn Bolivar Therapy

Sliding Scale: No

Populations/Ages: 18+, individuals, couples/relationships

Website: Robynbolivarterapy.ca or contact by emailing robynpsychotherapy@gmail.com

Virtual Option: Yes

Therapeutic Modalities: EFT, IFS, MBT, NT, SET, SFBT, ST

Assessments: None

Main Treatment Issues:

Relationships, polyamory and non-monogamy, Complex-Post Traumatic Stress Disorder, attachment, emotional overwhelm, anxiety, sexual and gender identity exploration, authentic self discovery, kink

Provides Clinical Supervision: No



QTTNS Clinician Directory (2023)

Natalia Castellanos



Student in Training for Counselling Therapy

Location: Halifax,

Practice: Private Practice opening in Fall, 2023

Sliding Scale: Yes

Populations/Ages: 18+, individuals

Contact: Natalia.cq@protonmail.com

Virtual Option: Yes

Therapeutic Modalities: CBT, ET, NT

Assessments: None

Main Treatment Issues: Trauma (concluded or ongoing), grief, navigating systemic oppression, relationship to death/dying, feelings of unworthiness, loss of sense of self, disconnect from emotional or embodied experiences

Provides Clinical Supervision: No

Dr. Jacquie Cohen

PhD, Registered Psychologist, NSBEP R0659

Location: HRM

Practice: Mental Health and Addictions, Nova Scotia Health

Populations/Ages: 18+, Individuals

Virtual Option: Yes

Provides Clinical Supervision: Yes

Therapeutic Modalities: CBT, CPT, DBT, PE

Assessments: None

Main Treatment Issues: Borderline personality disorder, post-traumatic stress disorder, obsessive-compulsive disorder, anxiety and depressive disorders.



QTTNS Clinician Directory (2023)

Cailin Crosby



MEd, CCC, RCT, RCT-21-014

Location: Halifax

Practice: Cailin Crosby Therapy

Sliding Scale: Yes

Populations/Ages: 18+ individuals, couples

Website: cailincrosby.com

Virtual Option: Yes

Therapeutic Modalities: CBT, CCT, CFT, MBT, NT

Assessments: None

Main Treatment Issues: Trauma, anxiety, depression, gender, sexuality, relationship issues, life transitions

Provides Clinical Supervision: No

Dr. Shaindl Diamond

PhD, Registered Psychologist, NSBEP R0830

Location: Bedford

Practice: Dr. Leah Clyburn & Associates and Community Mental Health, Nova Scotia Health

Sliding Scale: No

Populations/Ages: 18 to 65, individuals

Website: drleahclyburn.ca

Virtual Option: Yes

Therapeutic Modalities: CBT, EmFT, EMDR, IFS, MBT, SET

Assessments: None

Main Treatment Issues: Trauma-related issues, complex trauma, attachment issues, anxiety, depression, sexuality, gender, life transitions

Provides Clinical Supervision: No



QTTNS Clinician Directory (2023)

Lindsay Elin



MSW, RSW, Registered Psychotherapist in Ontario #818429, Only can see clients who are residents in ON, Offers consultation for NS therapists

Location: Virtual only in ON

Practice: Lindsay Elin Psychotherapy

Sliding Scale: Yes

Populations/Ages: 11+, individuals, couples, families, clinical consultation

Website:
lindsayelinpsychotherapy.com

Therapeutic Modalities: ABFT, BSP, SSP, SP, TIST

Assessments: WPATH

Main Treatment Issues: Trauma (shock, relational, internalized, societal), attachment, family therapy/parent coaching for parents of trans youth, shame, boundaries, structural dissociation, executive functioning, anxiety/depression

Provides Clinical Supervision: Yes

Raquel Griffin

MSW, RSW, #7419

Location: Virtual Only in NS & NB

Practice: Birch Stand Mental Health Services

Sliding Scale: Yes

Populations/Ages: 19+, individuals

Therapeutic Modalities: CBT, IE, NT

Assessments: WPATH

Main Treatment Issues: Disordered eating, anxiety, depression, grief

Provides Clinical Supervision: No

Website: birchstand.ca



QTTNS Clinician Directory (2023)

Shannon Hardy



MSW, RSW, #7403

Location: Halifax

Practice: Hardy Consulting

Sliding Scale: Yes

Populations/Ages: 18+, individuals and couples/relationships

Website: hardyconsulting.ca

Virtual Option: Yes

Therapeutic Modalities: CFT

Assessments: No

Main Treatment Issues: Queer issues, sexual and reproductive issues, anxiety

Provides Clinical Supervision: Yes

Kay Jenson-Vinova

MSc, Registered Psychologist, NSBEP R1092

Location: Bedford

Practice: Dr. Leah Clyburn & Associates

Sliding Scale: Yes

Populations/Ages: 18+ individuals, couples/relationships

Website: drleahclyburn.ca

Virtual Option: Yes

Therapeutic Modalities: CBT-E,

DBT, EMDR, EFT, IE, ST

Assessments: WPATH, Psychodiagnostic

Main Treatment Issues: Gender, sexuality, sexual dysfunction, religious trauma, complex trauma, attachment issues, emotional dysregulation, eating disorders

Provides Clinical Supervision: No



QTTNS Clinician Directory (2023)

Erin Lecky



MA, RCT-C, RCT-C22-009

Location: Dartmouth

Practice: Erin Lecky Therapy

Sliding Scale: No

Populations/Ages: 15+, individuals

Website: erinleckytherapy.com

Virtual Option: Yes

Therapeutic Modalities: CCT, IFS, MBT, YT

Assessments: No

Main Treatment Issues: Anxiety, depression, complex trauma, attachment issues, sexuality, spirituality, substance use issues, relationship issues

Provides Clinical Supervision: No

Julian Manthorne

MA, RCT-C, RCT-C23030

Location: Virtual Only in NS

Practice: Peoples' Counselling Clinic

Sliding Scale: Yes

Populations/Ages: 14+, individuals

Website: pleasantlife.ca

Virtual Option: Yes

Therapeutic Modalities: CBT, CCT, SFBT

Assessments: No

Main Treatment Issues: Anxiety, Attention Deficit Hyperactivity Disorder, depression, trauma history, aging-related issues, gender, relationship issues, attachment, parenting, emotional dysregulation, inner child issues, existential issues

Provides Clinical Supervision: No



QTTNS Clinician Directory (2023)

Dr. Kathleen Merwin



**PhD, Clinical Psychologist
(Candidate Register), NSBEP
C10916**

Location: HRM

Practice: Mental Health and Addictions, Nova Scotia Health (Borderline Personality Disorder Treatment Program)

Populations/Ages: 18+ individuals

Virtual Option: Yes

Therapeutic Modalities: ACT, CBT, CPT, DBT, PE

Assessments: Psychodiagnostic

Main Treatment Issues: Borderline personality disorder, mood and anxiety disorders, eating disorders, trauma- and stressor-related disorders, obsessive compulsive disorder, gender and sexuality issues, sexual dysfunctions

Provides Clinical Supervision: Yes

Ron Nugent

MEd, RCT-C, RCT-C23027

Location: Waverly/Fall River/Bedford

Practice: RGN Counselling

Sliding Scale: Yes

Populations/Ages: Youth, Adults

Contact: rgncounselling@gmail.com

Virtual Option: Yes

Therapeutic Modalities: CCT, CFT, CBT, MBT, NT

Assessments: No

Main Treatment Issues:

Anxiety/Depression, sexuality, relationships, school stress

Provides Clinical Supervision: No



QTTNS Clinician Directory (2023)

Shea O'Bertos



**MSc, Registered Psychologist,
NSBEP R1076**

Location: Halifax

Practice: Green Leaf Psychological
Services Inc.

Sliding Scale: No

Populations/Ages: 18+ individuals

Website:
greenleafpsychological.com

Virtual Option: Yes

Therapeutic Modalities: ACT, CBT,
EFIT

Assessments: ADHD, ASD

Main Treatment Issues: mood,
anxiety, trauma, self-compassion,
attachment, and relationships

Provides Clinical Supervision: No

Dr. Noelle Strickland

**PhD, Clinical Psychologist
(Candidate Register), C10923**

Location: Halifax

Practice: Genest MacGillivray
Psychologists

Sliding Scale: No

Populations/Ages: 18+, Individuals

Website: halifaxpsychologists.com

Virtual Option: Yes

Provides Clinical Supervision: No

Assessments: ADHD,
Psychodiagnostic

Therapeutic Modalities: ACT, CBT,
CCT

Main Treatment Issues:

Trauma/Post Traumatic Stress
Disorder, anxiety, depression,
relationship issues, gender
identity/sexual orientation identity
development, addictions/substance
use issues, Attention Deficit
Hyperactivity Disorder, life
transitions, body-image/eating
concerns, stress and burnout



QTTNS Clinician Directory (2023)

Cynthia Voegeli



MA, RCT, RCT-21-033

Location: Truro

Practice: C & D Therapy

Sliding Scale: No

Populations/Ages: 14+ individuals

Website: cdtherapy.com

Virtual Option: Yes

Therapeutic Modalities: IFS, NT, SBT

Assessments: No

Main Treatment Issues: Anxiety, depression, Trauma/Post Traumatic Stress Disorder/Complex-Post Traumatic Stress Disorder, grief, identity and sexuality, family issues, self compassion, stress, queerness

Provides Clinical Supervision: No

Frederick Voegeli

MA, RCT, RCT-21-027

Location: Truro

Practice: C & D Therapy

Sliding Scale: No

Populations/Ages: 12+ individuals

Website: cdtherapy.com

Virtual Option: Yes

Therapeutic Modalities: MBT, NT, SFBT

Assessments: WPATH

Main Treatment Issues: Gender, sexuality, anxiety, depression, relationship issues, attachment issues, issues around sex, Attention Deficit Hyperactivity Disorder, parenting

Provides Clinical Supervision: No



QTTNS Clinician Directory (2023)

Seth Wahlin-Stern



MA, Registered Psychologist,
NSBEP R0841, RCT-C, RCT-C22-
013

Location: Fall River

Practice: Smith Burke Psychology

Sliding Scale: Yes

Populations/Ages: 5-25 individuals

Website: smithburkepsychology.ca

Virtual Option: Yes

Therapeutic Modalities: CCT, CBT,
MI

Assessments: WPATH

Main Treatment Issues: Gender
identity, school related issues,
executive functioning

Provides Clinical Supervision: No

Licensing/Credential & Degree Guide

Below is a description of each type of licensing/registration and post-graduate degrees a QTTNS therapist might possess. In the directory, we have included each therapist's license number.



Licensing/Credential

- **CCC:** Canadian Certified Counsellor (Canadian Counselling and Psychotherapy Association)
- **RCT:** Registered Counselling Therapist (Nova Scotia College of Counselling Therapists)
- **RCT-C:** Registered Counselling Therapist (Candidate) (Nova Scotia College of Counselling Therapists)
- **Registered Psychologist:** PhD, MA, MSc, or MEd Psychologist who holds full registration with the ability to practice psychology in the province (i.e., registered with the Nova Scotia Board of Examiners in Psychology)
- **Clinical Psychologist (Candidate Register):** PhD, MA, MSc, or MEd Psychologist who is registered to practice in Nova Scotia while under supervision (i.e., registered with Nova Scotia Board of Examiners in Psychology and supervised by a Registered Psychologist)
- **RSW:** BSW or MSW Social Worker who is registered to practice in Nova Scotia (i.e., registered with the Nova Scotia College of Social Workers)
- **Student in Training for Counselling Therapy:** Student currently enrolled in a MA/MSc level program for counselling psychology; completing a practicum placement



Degree

- **MA:** Master of Arts
- **MEd:** Master of Education
- **MSc:** Master of Science
- **MSW:** Master of Social Work
- **PhD:** Doctor of Philosophy

Assessment Glossary

Below is a brief description of some of the different types of assessments QTTNS therapists may offer.

Attention Deficit Hyperactivity Disorder (ADHD) assessment can involve completing a full psychoeducational assessment (please see below for more information) with a psychologist. However, some ADHD assessments are completed with a structure of having several interviews with a psychologist, nurse practitioner, family doctor, and/or psychiatrist. In addition, the client and others in their support circle (e.g., teachers, other providers, family members, and partners) are asked to complete standardized self-report measures (e.g., a survey) in an effort to determine if the client meets the criteria for ADHD. At the end of the assessment, the client may be given a diagnosis of ADHD and specific recommendations for treatment. A lot of times the client will also be screened for other psychiatric disorders such as Generalized Anxiety Disorder. If the psychologist determines the client may meet the criteria for another psychiatric disorder, they may complete a psychodiagnostic assessment or refer you to complete more testing.

Autism Spectrum Disorder (ASD) assessment can differ depending on the age of the client. In general, the assessment consists of the psychologist completing a series of semi-structured interviews with the client, a parent, a family member, a partner (depending on the age of the client), and sometimes teachers and other providers. Depending on the age of the client, the client may fill out self-report measures and/or members of their support circle will. At the end of the assessment, the psychologist may diagnose the client with ASD. Similar to an ADHD assessment, if the psychologist suspects the client may meet the criteria for another psychiatric disorder, they may refer on for more testing.

Psychodiagnostic assessment focuses more on determining if the client meets the criteria for a personality, mood, anxiety, depressive, trauma-related, and/or psychotic disorder. The assessment typically involves the client completing several semi-structured interviews with a psychologist or psychiatrist and filling out one or more standardized self-report measures. At the end of the assessment, the psychologist can typically diagnose the client with one or more psychiatric disorders.

Assessment Glossary



Psychoeducational assessment identifies areas of strength and deficits in a client's learning profile and provides a deeper understanding of the client's educational abilities. Psychoeducational assessments can also help identify possible learning disabilities, ADHD, and intellectual disabilities. These assessments are more often completed with children and adults currently in school. However, sometimes these assessments are completed for other purposes. The assessment typically involves several semi-structured interviews with the psychologist and sometimes with family members, partners, teachers, and/or other providers. The client will also complete a series of cognitive and behavioural tests with the therapist to help assess for topics such as academic aptitude, skills in reading, writing, math, and overall intelligence.

World Professional Association for Transgender Health (WPATH) is a trans health readiness assessment for assessing gender-affirming medical care such as hormone therapy and surgery. The assessment can be completed by a registered counsellor, Master's level social worker, psychologist, or a medical professional with WPATH training. The assessment typically involves meeting with the therapist for 1 or more sessions with the goal of diagnosing the person with Gender Dysphoria and assessing for capacity to make informed consent decisions when it comes to medical transition. If the therapist determines the client meets the criteria for readiness for medical transition, the therapist can write a letter of support so that the client can access much needed gender-affirming medical treatment. To learn more about accessing gender-affirming care in Nova Scotia, visit: <https://library.nshealth.ca/TransGenderDiverse/Home>

Therapy Modality/Orientation Glossary



Below is a brief description of modalities some or all QTTNS therapists use with clients. A therapy modality typically offers a theory to explain why a client may present with certain mental health symptoms and why treatment is structured in such a way to alleviate those symptoms. Modalities can have an overarching theory that guides their practice, may offer specific techniques, are sometimes used in conjunction with other therapy modalities, and are at times limited to a specific age group or population (e.g., children, family, couples/relationships).

We have noted which therapy modalities below are deemed evidence-based, meaning there is substantial peer-review research that demonstrates the effectiveness of the therapy modality. With newer, emerging therapy modalities, they are more often in the early stages of being heavily researched. All to say that if a therapy modality below is not noted to be evidence-based, that does not necessarily mean the client(s) will not benefit from them. We encourage you to ask your therapist more questions about each modality to determine the best fit.

Therapy Modality/Orientation Glossary



ABFT (Attachment-Based Family Therapy) aims to help parents and adolescents repair attachment ruptures in an effort to rebuild a secure attachment to one another. ABFT therapists help families reframe how they relate to one another, build stronger alliances (including with your therapist), repair ruptures, and promote autonomy in the adolescent to responsibly make their own choices while still seeking out support from their parents. ABFT has empirical evidence showing it is an effective treatment for adolescents experiencing depression and suicidal ideation.

ACT (Acceptance Commitment Therapy) is a mindfulness-based therapy focused on practicing self-acceptance of thoughts, emotions, behaviours, and events. It is a behavioural therapy aimed to develop psychological flexibility to help clients emotionally regulate and reduce emotional suffering. ACT is an evidence-based treatment for issues such as depression, anxiety, psychosis, chronic pain, and obsessive-compulsive disorder.

BSP (Brainspotting Psychotherapy) focuses on helping clients access, process, and move past trauma, negative emotions, and pain. The therapist helps the client use specific eye positions to become more attuned and access painful emotions while tending to the therapeutic relationship.

CBT (Cognitive Behaviour Therapy) is an evidence-based treatment for issues such as depression, anxiety disorders, substance use issues, and eating disorders. CBT is a structured, goal-oriented therapy, and time-limited therapy aimed to help clients develop awareness and coping strategies to help shift thoughts, emotions, and behaviours.

CBT-E (Cognitive Behaviour Therapy-Enhanced) is a form of CBT focused on building awareness, disrupting, and shifting disordered eating thoughts and behaviours. It is a structured, time-limited treatment that provides psychoeducation on eating disorders and teaches clients specific behavioural and cognitive strategies to treat eating disorders. CBT-E is an evidence-based treatment for Anorexia Nervosa Disorder, Bulimia Nervosa Disorder, Binge-Eating Disorder and other eating disorders.

Therapy Modality/Orientation Glossary



CCT (Client-Centered Therapy) is sometimes referred to as person-centered therapy and is often integrated into other therapeutic modalities. CCT is a non-directive approach to talk therapy that places the client as the more active party in treatment while the therapist acts mainly as a non-judgemental source of support for the client. Rather than the therapist focusing on alleviating specific symptoms, the approach aims to help clients find their voice to make their own decisions by increasing clarity and improving their self-esteem. CCT has mixed evidence in research literature depending on the mental health issues being addressed in therapy.

CFT (Compassion-Focused Therapy) helps promote emotional healing by encouraging clients to remain compassionate towards themselves and others. CFT teaches clients how to shift from a shameful, critical stance to one of self-acceptance by enhancing mind-body connection. There is some research evidence that it is a modality that reduces depressive, anxious, and psychotic symptoms.

CPT (Cognitive Processing Therapy) is based on CBT and developed specifically to treat trauma symptoms by challenging negative core beliefs clients possess as a result of their traumatic experiences. The therapist provides psychoeducation on the nature of trauma and reinforcing factors of trauma symptoms. The client is typically asked to write a detailed account of their worst traumatic experiences so that the therapist can help the client develop strategies to counter negative thinking (e.g., self-blaming thoughts). CPT is primarily an evidence-based treatment for treating Post Traumatic Stress Disorder. However, there is growing research demonstrating CPT can be effective for treating depression and anxiety.

DBT (Dialectical Behaviour Therapy) teaches clients strategies to emotionally regulate, tolerate extreme distress, enhance their relationship with others, and remain mindful. DBT is traditionally offered with a combination of group and individual therapy. It has strong research evidence for treating Borderline Personality Disorder, Post Traumatic Stress Disorder, eating disorders, and substance use disorders.

EmFT (Emotion Focused Therapy) aims to help clients accept, express, regulate, process, and shift emotions. Using this evidence-based approach, the therapist can teach individuals or couples to nonjudgementally connect with their emotions given that avoiding emotions can lead to more negative outcomes.

Therapy Modality/Orientation Glossary



EFT (Emotionally Focused Therapy) is an evidence-based treatment more commonly used for couples/relationships, though is also offered for individuals and families. EFT draws on attachment theory to help partners de-escalate, express underlying emotions, repair attachment ruptures, and strengthen their connection to one another.

EFIT (Emotionally Focused Individual Therapy) is an EFT approach with individuals centered on processing current and past relationships with the goal of repairing attachment ruptures and building skills to build more meaningful, lasting relationships. The therapist will help the client explore overarching emotions and patterns to uncover underlying attachment needs. EFIT has research evidence for treating depression and anxiety.

EMDR (Eye Movement Desensitization and Reprocessing) is a structured therapy that treats underlying trauma by helping the client to focus, reprocess, and move past traumatic experiences. The client receives gentle sensory input to activate both sides of their brain while they re-experience cognitions, emotions, physical sensations, and memories resulting from traumatic experiences. EMDR is an evidence-based treatment for Post Traumatic Stress Disorder, anxiety, depression, Obsessive Compulsive Disorder, chronic pain, and substance issues.

ET (Existential Therapy) stresses that all individuals have the capacity for self-awareness, each person's identity is known only through relationships with others, and individuals must continually re-create themselves because life is always in flux. The therapist takes the stance that anxiety, depression, and isolation are natural stages of human development. There is some evidence that ET is helpful for improving self-efficacy, overall well-being, and treating anxious and depressive symptoms.

IE (Intuitive Eating) is a framework more often used in treating disordered eating that is rooted in anti-diet, weight inclusive, and Health At Every Size values. IE teaches clients how to honour their hunger cues, reject diet-culture, challenge rules around food and weight, and improve better connection with one's body. IE was developed by two dietitians, Evelyn Tribole and Elyse Resch, and is now commonly used by eating disorder therapists. IE has growing research evidence that it is an effective approach to treating eating disorders.

Therapy Modality/Orientation Glossary



IFS (Internal Family Systems) therapy takes the assumption that all individuals have sub-personalities or "parts". The therapist helps the client become more aware of the role each part of them plays while also encouraging compassion towards each part to reduce emotional suffering, release tension, and resolve internal conflict. Preliminary research studies demonstrate that IFS is an effective form of treatment for substance use issues, anxiety, depressive symptoms, and enhancing self-compassion.

MBT (Mindfulness-based Therapy) is often coupled with approaches such as CBT, DBT, and ACT. MBT teaches clients concrete ways to sit in the present moment without judgment, which aids in reducing emotional suffering and enhancing awareness. Mindfulness as an approach has strong research evidence to help treat issues such as depression, anxiety, and sexual issues, and help improve one's overall mental and physical health.

MI (Motivational Interviewing) is an evidence-based approach that is collaborative, directive, and client-centered that elicits behavioural change. MI is a goal-oriented style of communication focused on strengthening the client's personal motivation and commitment to change by drawing out the client to identify their own reasons for change. MI is more often an approach that is used in conjunction with behavioural approaches such as CBT, CBT-E, and DBT.

MSCT (Mindful Self-Compassion Therapy) aims to help clients turn towards challenging emotions and negative thoughts with a spirit of openness and curiosity. MSCT uses a combination of self-compassion and mindfulness strategies to enhance the client's relationship with their bodies, emotions, and others. Some research studies have been showing that MSCT significantly improves one's ability to remain self-compassionate, reduces anxious and depressive symptoms, and improves one's overall emotional well-being.

NT (Narrative Therapy) helps the client separate themselves from their presenting problem. This externalization of the problem allows the client to better understand how the stories they tell themselves of the problem shapes the client. The therapist will encourage the client to use their own skills to minimize the effect of problems in their lives and help the client identify their own values. Some research has found that NT decreases anxious and depressive symptoms, enhances decision-making and emotional skills in children, and is effective in treating issues around body image.

Therapy Modality/Orientation Glossary



PE (Prolonged Exposure) is an evidence-based therapy that guides clients to approach and process traumatic memories rather than continue to avoid the experiences and symptoms related to their traumatic past. A PE therapist will teach coping strategies to help manage trauma-related symptoms and will then ask the client to talk through the details of their traumatic memories. Using imaginal exposure, the client is emotionally activated and repeatedly confronts the details, cognitions, physical sensations, and emotions related to their traumatic past until their trauma-related symptoms are decreased or eliminated.

PT (Psychodynamic Therapy) is an evidence-based practice focusing on how the unconscious and past experiences shape our current behaviour and sense of self. Using the therapeutic relationship as the central intervention, the therapist will reflect back observed recurring patterns to the client to help build awareness and shift defense mechanisms.

SET (Somatic Experiencing Therapy) works on the principle that trauma is trapped in the body, which can keep clients from fully processing and moving on from traumatic memories. The therapist will help increase a client's awareness and attunement to their own body's sensations in an effort to shift the trauma-related stress responses rather than focusing on thoughts and emotions.

SFBT (Solution Focused Brief Therapy) is a short-term, goal-focused, evidence-based approach that focuses on a person's present and more immediate future circumstances. The therapist will help the client solve problems more effectively and teach coping strategies.

SP (Sensorimotor Psychotherapy) is a body-centered trauma and attachment approach that views the body as an integral source of information and wisdom. Using mindfulness-based somatic techniques and the safety of the therapeutic relationship, the therapist helps the client build internal resources to find relief from trauma symptoms, better manage their nervous system, update beliefs about themselves and others stemming from traumatic and attachment wounding, and gently process trauma stored in the body by working with "slivers" of traumatic memory.

Therapy Modality/Orientation Glossary



SSP (Safe and Sound Protocol) is rooted in Polyvagal theory and involves using specific music that stimulates the vagus nerve. This intervention is typically delivered over 5 hours of listening to music that adds a calming effect to help reduce stress and auditory sensitivity. SSP is more often used to help clients achieve a more balanced physiological state so that they can better integrate other therapies.

ST (Sex Therapy) is an evidence-based practice aimed to address factors that are impacting sexual satisfaction and sexual functioning with individuals and/or couples/relationships. ST treats specific sexual dysfunctions such as erectile dysfunction, low sexual desire, difficulty reaching orgasm, or genital-pelvic pain. A therapist practicing ST may help you reframe how you view sexual challenges, heal from sexual trauma, and deconstruct shame around specific sexual interests. ST typically uses a combination of approaches such as CBT, MBT, and EFT.

TIST (Trauma Informed Stabilization Treatment) integrates mindfulness-based cognitive therapy, SP, ego state techniques, ego state techniques, and IFS to help establish stability before transitioning into a more in-depth trauma therapy. Using a parts-of-self framework, the therapist provides a structure for clients to see their trauma-related symptoms (e.g., flashbacks, nightmares, dissociation) and self injury behaviours as adaptive reactions rather than with shame, which helps to further establish stability and internal secure attachment.

TIT (Theraplay-Informed Therapy) is a child and family evidence-based therapy focusing on enhancing self-esteem, trust in others, and attachment. The therapist provides structured and focused play to help create opportunities for the child and parent/caregiver(s) to have a changed view of the self as worthy and loveable.

YT (Yoga Therapy) is the application of yoga practices to help treat physical and mental health conditions, such as anxiety or depression. A Yoga therapist would build on the principles and structure of yoga to help the client develop strategies for self-inquiry, reduce stress, and enhance the mind-body connection.

want to join QTTNS?

QTTNS hosts monthly peer-supervision meetings and has a listserv for our members. We are hoping to look for more opportunities to give back to our community and further support our members. We have 3 levels of membership for QTTNS:

1. Organizing Member



This type of member would be included in discussions around how the group is run and would make decisions about outreach (making both internal and external decisions). This type of member would also likely contribute in various ways such as advertising, administration, organizing, scheduling, sending out emails, etc. Our current organizing members are Caillin Crosby, Erica Baker-Gagnon, Holly Blunden, and Kay Jenson-Vinova.

2. Peer Supervision Member

This type of member could attend monthly peer supervision as desired (and would still be on the larger referral/listserv) but would not have a say in decisions around how the group is run.



3. Referral/listserv member

This type of member would be included on email chains to the entire group with questions about resources and referrals but would not have a say in decisions around how the group is run.

**WELCOME ✖
to the TEAM**

If you would like to become a part of our network, are the following questions true for you?

- 1) Are you a registered social worker, psychologist, counseling therapist, or student in an accredited social work, psychology, or counseling program?
- 2) Do you identify as part of the 2SLGBTQIA+ community?
- 3) Are you currently licensed to provide social work, psychology, or counseling services in Nova Scotia?



If so, please email: info.qttns@gmail.com