At the Intersection of Sexual Minority and Transgender or Gender Diverse (SM-TGD) Identity

and Mental Illness

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Sexual minority and transgender or gender diverse (SM-TGD) persons experience disproportionately high rates of mental illness, substance misuse, and suicide, which are often exacerbated by experiences of social exclusion and marginalization. While healthcare institutions are increasingly aiming to provide affirming mental health care to this population, many mental health services and practitioners remain unresponsive to SM-TGD individuals' unique identities, needs, and experiences. Despite the fact that mental illness and access to adequate care are pressing concerns for this population, the ways that SM-TGD persons understand mental illness and their experiences navigating the healthcare system have not been adequately studied. Based on data from 12 qualitative interviews conducted in southern Ontario, this study explores the ways that SM-TGD individuals make sense of and contextualize their experiences of mental illness. This study also discusses some of the barriers to care often encountered by this population, and points to the ways that informal barriers such as microaggressions are as impactful as structural barriers, such as wait times. In doing so, this study aims to unveil the complex subjectivities that emerge when exploring the intersection of marginalized identities and experiences of mental illness.

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Chapter 1: Introduction

It is well documented that sexual minority and transgender or gender diverse (SM-TGD)[1] persons experience disproportionately high rates of mental illness (Canadian Mental Health Association [CMHA], 2017; Rainbow Health Ontario [RHO], 2015). Specifically, SM-TGD adults are more likely to experience depression, anxiety, self-harm, substance use and misuse, and post-traumatic stress disorder as compared to heterosexual and cisgender adults (Cochran & Mays, 2007; Diamant & Wold, 2003; McCabe et al., 2010). They are also significantly more likely to attempt suicide as compared to their heterosexual peers, with transgender people being particularly at risk of suicidality (ibid.). For example, a recent quantitative study conducted by Bauer and colleagues (2013) indicated that 43% of transgender adults in Ontario have attempted suicide at some point during their lives, and perhaps even more strikingly, that 32% did not see a health professional after the attempt. This points to the existence of barriers to accessing mental health support for this population.

Similar disparities have been documented between SM-TGD youth and their heterosexual and cisgender counterparts. SM-TGD youth experience disproportionate rates of eating disorders (Watson et al., 2017), depression, anxiety, and substance misuse (CMHA, 2020). They are also more likely to experience suicidal ideation or attempt suicide, and rates of suicide attempts among certain groups of transgender youth in Ontario are as high as 57% (Bauer & Scheim, 2015). Additionally, SM-TGD youth are disproportionately likely to experience homelessness as compared to heterosexual or cisgender youth (Abramovich, 2012), and often encounter homo- and transphobia when trying to access shelter services (Bauer et al., 2013). Support and

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[1] SM-TGD is an umbrella term that encompasses all non-heterosexual and non-cisgender identities. It is an alternative to acronyms such as LGBTQ/LGBTQ2+/LGBTQIA, etc.

acceptance from family and friends are strongly associated improved mental and physical health and well-being among SM-TGD youth, and also correlate with lower rates of mental illness and substance misuse in adulthood (Ryan et al., 2009; Ryan et al., 2010).

Although statistics only provide what queer researcher Zena Sharman (2016) has referred to as "an incomplete and highly oversimplified summary of some of what we know about queer and trans health disparities" (p.17), they nonetheless highlight mental illness and suicide as pressing concerns in SM-TGD communities. Research suggests that experiences of marginalization, stigma, discrimination, and social exclusion contribute to these disproportionate rates of mental illness (Dean, Victor, & Guidry Grimes, 2016; Meyer, 2013), as does a lack of access to economic resources (CMHA, 2017). Specifically, SM-TGD people may experience harassment, violent hate crimes, or bullying in schools (Dauvergne, 2010; Grant et al., 2011); are overrepresented in the lowest income categories (Bauer et al., 2010; Tjepkema, 2008); and may struggle to access stable housing and employment (Gapka & Raj, 2003). Negative social factors such as these are collectively referred to as *minority stress* and can have a detrimental effect on SM-TGD individuals' physical and mental health over time (Meyer, 2003).

This study examines SM-TGD persons' understandings and experiences of mental illness in the context of continued societal marginalization and exposure to various forms of discrimination. In doing so, it investigates the ways that sexual or gender identity intersect with mental illness in potentially unique ways and contributes knowledge about individuals' subjective experiences which are underrepresented in the literature.

Research Problem

Mental health is "rooted in complex structures of privilege and oppression" (Sharman, 2016, p.15). This necessitates that healthcare practitioners and counselors working with SM-

TGD individuals should strive to understand the systemic barriers and forms of marginalization this population faces (Shaughnessy, 2016). Care or therapy that integrates an awareness of the political and identity-specific issues relevant to SM-TGD people and that does not pathologize SM-TGD identities is referred to as *affirmative* (Alessi, Dillon, & Van Der Horn, 2019; Perez, 2007). More specifically, affirmative psychotherapy can be defined as:

> the integration of knowledge and awareness by the therapist of the unique developmental and cultural aspects of [LGBTQ] individuals, the therapist's own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process. (Perez, 2007, p.408)

Affirmative therapy is linked to improved psychological well being for SM-TGD clients (Alessi et al., 2019) and stronger and more positive relationships between SM-TGD clients and therapists (Kelley, 2015).

O'Shaughnessy & Speir (2018) argue that there has been a gradual shift to more affirming mental health care for SM-TGD individuals since the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973. They also note that significant attention has been paid to developing an evidence-base for affirmative therapy (O'Shaughnessy & Speir, 2018), which is reflected in the publication of a number of policy statements establishing guidelines and best practices for mental health professionals working with SM-TGD clients (DeBord et al., 2017)[2]. However, despite these positive shifts, many mental health services remain unresponsive to SM-TGD persons' specific needs, experiences, and identities (Berke, Maples-Keller, & Richards, 2016). SM-TGD persons are more likely than

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[2] See, for example, the position statement from the Canadian Psychiatric Association (Veltman & Chaimowitz, 2014) or The International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) Statement on LGBTIQ+ Concerns (IPsyNET, 2018), which the Canadian Psychological Association has endorsed.

their heterosexual counterparts report unmet mental health needs (Tjepkema 2008) and often face identity-specific barriers in accessing affirming mental health services (see O'Shaughnessy & Speir, 2018, for a systematic review of studies that address these barriers).

Specifically, SM-TGD people often encounter subtle forms of discrimination or microaggressions when they seek treatment for mental illness or mental health concerns (see for example Dean et al., 2016; Kimber & Delgado-Romero, 2011; Nadal, 2013). Microaggressions may take the shape of gaps in practitioners' knowledge, the use of hetero- or gender normative language, assumptions that patients or clients are heterosexual and/or cisgender, or practitioners' assumptions that SM-TGD identity is the source of mental illness (ibid.), for example. While microaggressions may appear trivial, they can have an extremely negative impact on individuals' emotional and psychological well-being when they occur frequently and across a variety of contexts (Dean et al., 2016; Nadal, Davidoff, Davis, & Wong, 2014). Consistently experiencing microaggressions in healthcare contexts can lead to SM-TGD individuals concealing their identities from practitioners or avoiding accessing care, even in the case of serious physical or mental health problems (ibid.).

This study aims to contribute to the qualitative literature on the topic of access to affirmative mental health care that centers the voices of SM-TGD persons as opposed to that of healthcare practitioners or therapists. Understanding individuals' subjective experiences is an important element of developing policies which are truly responsive to this populations' needs, but these perspectives have been underrepresented in the literature. More specifically, a recent systematic review of empirical articles related to affirmative therapy for SM persons published between 2000 and 2015 and found that less than a third of the studies included service users' perspectives (O'Shaughnessy & Speir, 2018). Other authors have also pointed to the relative lack

of studies on the topic of access to affirming mental health care which include SM-TGD client perspectives (Berke et al., 2016), especially in the case of transgender clients (eg. Israel, Gorcheva, Burnes, & Walther, 2008). Zena Sharman (2016) points to "the lifesaving necessity of queer and trans stories" (p.16) and argues that pairing research evidence with SM-TGD people's experiential narratives can be a powerful means of contributing to social change. This study addresses this gap in that it centers the marginalized voices of SM-TGD individuals and includes perspectives from an equal number of cisgender and TGD participants.

In addition to discussing some of the barriers SM-TGD individuals may encounter when trying to access affirming mental health care, this thesis also explores participants' subjective understandings of mental illness and the ways that participants navigate biomedical categorizations of mental illness. Specifically, research indicates that, against the backdrop of continued stigma surrounding mental illness, having experiences which can be classified as mental illness or receiving a psychiatric diagnosis have important implications for individual subjectivity (Ottewell, 2018; Ringer & Holen, 2016; Tucker, 2009). It has also been well documented that individuals often make sense of their experiences of distress in ways that do not align with formal psychiatric definitions (Larson, 2004; Speed, 2006). However, many studies on the topic of individual or discursive sense-making around experiences of mental illness have focused on individuals' relationships to a specific diagnosis, such as schizophrenia (eg. Tucker, 2009) or psychosis (eg. Larson, 2004). This study instead explores processes of sense-making and their influence on subjectivity among SM-TGD individuals without a focus on specific diagnoses. In doing so, it aims to unveil the complex subjectivities that emerge when looking at the intersection of marginalized identities and understandings of mental illness.

Research Questions and Approach

This study offers an in-depth exploration of two facets of experiencing mental illness or mental health challenges as a SM-TGD person: 1) the ways these individuals make sense of their experiences of mental illness and navigate biomedical categorizations of mental illness in relation to their subjectivities, and 2) the institutional and interpersonal barriers SM-TGD people often encounter when seeking affirming mental health care. In doing so, this study asks:

1. *How do SM-TGD persons in southern Ontario relate to biomedicalized framings of mental illness in making sense of their experiences of distress and themselves?*

2. *How does SM-TGD identity feature in these processes?*

3. *What barriers do SM-TGD participants encounter when seeking affirming mental health care in their communities, and how do they perceive and navigate such barriers?*

In addressing these questions, this study takes a constructivist approach, which is attendant to the subjective and contextual meanings individuals assign to their experiences (Costantino, 2008; Charmaz & Bryant, 2016). Constructivism is premised on an acceptance of multiple realities that are socially constructed in interaction (ibid.), which enabled a focus on the ambivalence and conflict (Lupton, 1997) that often characterized SM-TGD participants' linguistic accounts of their experiences.

To address these particular concerns, the study draws on poststructural insights that focus on the role of language in constructing claims to truth and frames subjectivity as fluid, fragmented, and constituted in and through discourse (Fawcett, 2008; Fisher & Freshwater, 2014). In the context of mental illness specifically, poststructural inquiries tend to emphasize the ways in which systems of categorization and labelling are discursively constituted and the impact those systems have on individual subjectivity (Fisher & Freshwater, 2014; Tucker, 2009). In this

sense, poststructuralism is a complementary lens for this constructivist study in that both perspectives reject the essentialization of experience (Constantino, 2008; Fisher & Freshwater, 2014). They allow me, as a qualitative researcher who identifies as queer and who has experienced multiple forms of mental illness, to focus on and theorize participants' complex and at times contradictory processes of sense-making as situated in discourse. A constructivist perspective also enabled me to illustrate the ways that formal or institutional barriers to affirming care may appear external to social practices but are instead constitutive of them (Ewick & Silbey, 1998; Mezey, 2006).

Outline of Chapters

This thesis begins with a background chapter that offers an overview of common issues of access to affirming and high quality mental health care for SM-TGD people. This chapter includes a discussion of both structural barriers, such as wait times, and interpersonal barriers, such as microaggressions, and demonstrates the inseparability of these formal and informal barriers to care. Next, the methodology chapter outlines the methodological features of this study and offers a more detailed discussion of its epistemological and theoretical basis. This chapter also addresses the importance of researcher reflexivity in constructivist research and describes my positionality as a queer woman who has experienced mental illness and the ways that my identity may have impacted the study.

The following two analytical chapters draw on empirical interview data to a) explore the complex relationship between dominant biomedical framings of mental illness and SM-TGD subjectivities, and b) provide an in-depth, experiential account of the barriers SM-TGD people face when seeking mental health support against the backdrop of institutionalized homo- and gender normativity. Specifically, chapter four discusses biomedicine as the dominant discourse

surrounding mental illness in the Global North[3] and explores the ways that participants in this

study took up and resisted elements of biomedical discourse when making sense of their

experiences of mental illness and subjectivities. The chapter illustrates the fractured nature of

subjectivity as it relates to mental illness and focuses on participants' use of language as a

window into the discursive constitution of subjectivity. Chapter five then explores the structural

barriers and microagressions, or instances of discrimination, that participants in this study

encountered in the context of mental health support services. The chapter also aims to illustrate

the mutually constitutive nature (Ewick & Silbey, 1998; Mezey, 2006) of formal and informal

barriers to affirming care and describe the ways that participants tried to mitigate or circumvent

these barriers.

Finally, the discussion offered in chapter six ties these two chapters together to illustrate

the extent to which biomedical discourse around mental illness is hegemonic. The chapter also

briefly discusses medicine's function as an institution of social control as relevant to this study's

findings and explains the reasoning behind my theoretical decisions, which focus on lived

experience as opposed to normalization through medicine. Chapter six concludes by arguing that

normative heterosexuality has come to characterize the modern healthcare system (Fisher, 2013;

Seidman, 2009), and this often leaves SM-TGD people in a double bind where their options for

accessing care are both inadequate and few (Frye, 1983). In doing so, I emphasize the

importance of research that centers the voices and experiences of SM-TGD people in advancing

social justice and health equity for this population.

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[3] *Global North* refers to the historically industrialized and urbanized countries of Europe and North
America (Odeh, 2010; Pike, Rodríguez-Pose, & Tomaney, 2014). These countries are characterized by democracy,
affluence, and technological advancement, and are alternatively classified as First World countries (ibid.).

Chapter 2: Background

As mentioned in chapter one, SM-TGD people in Canada experience both general and identity-specific barriers as they seek mental health support or treatment services. I discuss these various barriers, beginning with an overview of mental health in Canada and structural barriers to care that impact Canadians of all genders and sexualities. Specifically, this chapter first discusses wait times and the cost of therapy as barriers to accessing mental health supports. This chapter then discusses barriers to care which are specific to SM-TGD individuals. These identity-specific barriers often take the form of *microaggressions*, or subtle, often invisible expressions of negative bias that contribute to instances of non-affirming or low-quality care. Such microaggressions tend to be categorized as either hetero- or gender normative (Nadal, 2013; Nadal, Rivera, & Corpus, 2010), and I will discuss several examples from each category.

Mental Health in Canada

Experiences of mental illness can impact all Canadians, regardless of gender, sexuality, age, culture, and socioeconomic background (Mental Health Commission of Canada, 2013). Statistics Canada's *Canadian Community Health Survey - Mental Health* (CCHS) is a large national survey that examines mental health and access to services in the Canadian population (Statistics Canada, 2013). One of the survey's aims is to determine the prevalence of 6 specific mental and substance use disorders[4] among Canadians, and results of the most recent survey (conducted in 2012) indicated that 1 in 3 Canadians met the criteria for at least one of those 6 mood and substance use disorders at some point in their lives (Pearson, Janz, & Ali, 2013). Rates of annual as opposed to lifetime prevalence are somewhat lower (20% of people will experience

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[4]major depressive episode, bipolar disorder, generalized anxiety disorder, alcohol abuse or dependence, cannabis abuse or dependence, and other drug abuse or dependence

a mental illness or substance use problem in any given year, compared to a 33% lifetime prevalence (Smetanin et al., 2011)), but it is clear that mental health is a pressing concern for a relatively large proportion of the general Canadian population.

Research indicates that SM-TGD individuals are not the only minority group in Canada to experience disproportionate rates of mental illness or substance use disorders. For example, Indigenous adults and youth experience significantly higher rates of mental health issues and deaths by suicide than non-Indigenous Canadians (Kielland & Simeone, 2014). This is also the case for racialized Canadians, who are more likely to experience mental health issues than White Canadians (CAMH, 2012; Flatt, 2013). Individuals from these marginalized populations can similarly face identity-based microaggressions in therapeutic contexts and require affirming mental health care that is tailored to their unique needs, identities, and experiences (Sue, 2010). As SM-TGD individuals may also be marginalized based on factors beyond sexual or gender identity, an intersectional approach that considers multiple elements of identity is critical to providing care that is truly affirming (Berke et al., 2016).

Structural Barriers to Accessing Mental Health Care

One of the general or structural barriers to accessing mental health treatment that is relevant to all Canadians is seemingly mundane but nonetheless significant: long wait times (CMHA, 2017). While the length of wait times varies across the provinces and territories, individuals in some provinces face wait times of between 7 months and one year to access mental health services (ibid.). These wait times are not limited to a single form of mental health treatment; individuals may have to wait several months whether they are seeking counselling, in-patient treatment, and/or access to psychiatry (ibid.). Unsurprisingly, long wait times and the

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resultant delays in treatment are associated with poor outcomes among individuals who are experiencing mental health difficulties (Barua & Ren, 2016; Leobach & Ayoubzadeh, 2017).

Accessing private therapy is one means of potentially avoiding excessive wait times, as psychologists or counsellors working in private practice may have shorter waiting lists as compared to subsidized or community services (Israel et al., 2008). However, the cost of private counselling is prohibitive for many Canadians. While hourly rates for private counseling vary across organizations and practitioners, Canadians can usually expect to pay between $60 and $150 per hour-long session (Canadian Counselling and Psychotherapy Association (CCPA), 2019). Some private practitioners charge fees on a "sliding-scale" basis where lower income individuals are able to access services at a lower cost, but this is not the case with all practitioners (CCPA, 2019; Israel et al., 2008). This leaves many Canadians in a position where they must choose between waiting to access a subsidized service or paying out of pocket for more timely private counseling.

Microaggressions as Barriers to Affirming Care

SM-TGD individuals often encounter barriers to care that are specific to their marginalized sexual and/or gender identities. While instances of overt discrimination towards this population have become less frequent in recent decades, blatant prejudice has in many instances come to be replaced by subtler manifestations of negative bias (Nadal et al., 2010). Specifically, research indicates that SM-TGD individuals often experience what have been deemed *microaggressions* over the course of their daily lives and in therapeutic settings (Dean et al. 2016; Nadal et al., 2010; Shelton & Delgado-Romero, 2011; Nadal, 2013). While microaggression may appear trivial, they can have extremely negative cumulative impacts on

SM-TGD persons' psychological and emotional well-being (Dean et al., 2016; Nadal et al., 2014).

Sue (2010) defines microaggressions as "brief and commonplace daily verbal, behavioural, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights to the target person or group" (p. 5). In contrast to overt discrimination or intolerance, microaggressions tend to be invisible and unintentionally conveyed (Dean et al., 2016; Shelton & Delgado-Romero, 2011). This is primarily due to the fact that microaggressions are embedded within broader racist, ableist, heteronormative, and homo/transphobic power structures (Shelton & Delgado-Romero, 2011; Nadal et al., 2010). These power structures position dominant identities (eg. White, able-bodied, straight and/or cisgender identities) as superior, and as the standard against which marginalized identities are compared and deemed abnormal, deviant, and inferior (ibid.)

Since the socially constructed nature of normality and abnormality is obscured, dominant identities are taken for granted as superior and the default (Shelton & Delgado-Romero, 2011). Individuals cannot escape the "grip" of these forms of societal oppression and prejudice (McCullough et al., 2017), which means that biased views about minority individual or groups can operate "outside of immediate awareness", even when they are in direct contrast to the values an individual believes themselves to hold (Shelton & Delgado-Romero, 2011, p. 211). Microaggressions can therefore be enacted unintentionally even by individuals who do not consciously take a negative attitude towards a particular marginalized group, or who are themselves members of that group (Dean et al., 2016; Nadal et al., 2014; Shelton & Delgado-Romero, 2011).

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Many authors have identified microaggressions relevant to SM-TGD populations specifically, focusing on these individuals' negative experiences in daily life, healthcare spaces, and mental health care specifically (eg. Berke et al., 2016; Kimber & Delgado-Romero, 2011; Nadal et al., 2010; Nadal, 2013; Sue, 2010). Many of the microaggressions these authors have identified can be broadly categorized as expressions of either gender normative or heteronormative bias (Dean et al, 2016; Nadal et al., 2010; Shelton & Delgado-Romero, 2011). Such microaggressions are premised on the assumption that all individuals are heterosexual and cisgender until proven otherwise, and that this is the default and normal way to be (Dean et al., 2016; Fisher, 2013). Gender and heteronormative microaggressions can be enacted during interpersonal interactions between SM-TGD individuals and others, as well as be embedded in physical spaces or the media present in those spaces. The remainder of this chapter will outline several common examples of microaggressions that SM-TGD persons often encounter in healthcare contexts.

Gender normative Microaggressions

Using TGD individuals' preferred pronouns is a critically important part of providing affirming care for this population (Dean et al., 2016; Nadal et al., 2010; Nadal et al., 2014; McCullough et al., 2017). The inappropriate use of gendered pronouns when referring to TGD persons is referred to as *misgendering* and implies a gender normative bias because it is based on a healthcare practitioner's assumption that a client is cisgender and/or identifies with a binary gender (ibid.). Some TGD people have encountered practitioners who refused to use their preferred pronouns (Dean et al., 2016), but this is less common than practitioners either not asking clients about their preferred pronouns or continuing to misgender clients even after being informed of their preferred pronouns. Misgendering serves to subtly invalidate or call into

question a client's gender identity and can generate mistrust and a perceived lack of safety in relationships between practitioners and clients (Nadal et al., 2010; Nadal et al., 2014).

Additionally, instances of misgendering do not only occur during interactions between TGD clients and their primary practitioners. As individuals accessing a healthcare service typically interact with at least one additional member of staff before engaging with their primary practitioner (eg. front desk staff, intake nurses etc.), TGD clients are faced with multiple opportunities to be misgendered over the course of a single visit to a healthcare practitioner or therapist (Israel et al., 2008). These clients may also have to disclose their gender identity and pronouns multiple times if that information is not kept on file or relayed to staff members who are likely to interact with the client (Baldwin et al., 2017; Berke et al., 2016). Unsurprisingly, this can generate feelings of anger, distress, hopelessness, and exhaustion among TGD individuals and further compound the emotional distress that led them to seek support services in the first place (Nadal et al., 2014).

The use of preferred as opposed to legal names is a second important means of demonstrating respect for a TGD individual's gender identity (Israel et al., 2008; McCullough et al., 2017; Nadal et al., 2010). Using a TDG person's legal name as opposed to their preferred name, whether intentionally or unintentionally, constitutes a gender normative microaggression (ibid.). Not being called by the correct name can lead to feelings of distress and a lack of safety for TGD individuals as they seek mental health supports (Israel et al., 2008). Conversely, research has demonstrated that being addressed by their preferred name is validating and affirming for TGD persons and contributes to them feeling less guarded in their interactions with healthcare practitioners (McCullough et al., 2017; Shelton & Delgado-Romero, 2011).

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Heteronormative microaggressions

SM-TGD individuals also frequently encounter evidence of heteronormative bias in their interactions with mental health practitioners and clinic staff (Alessi & al., 2019; Berke et al., 2016; Dean et al., 2016; Nadal, 2013). Fisher (2013) notes that "in everyday life, heterosexual status is presumed and accrues privilege, and is regarded as 'natural,' 'normal,' and 'morally superior,' and often not in need of explanation" (p.502). This privileging of heterosexuality is often communicated through the use of heteronormative language, which constitutes a microaggression in the context of interactions with SM-TGD individuals. One key example of this type of microaggression is the use of heteronormative terms for patients' or clients' partners. Terms such as girlfriend, boyfriend, wife, husband etc. imply an assumption of an individual's heterosexuality (as well as an assumption that the person's partner identifies with a binary gender) (Dean et al., 2016; Shelton & Delgado-Romero, 2011).

Heteronormative microaggressions can also take the form of practitioners' inappropriate focus on an individual's sexual and/or gender identity, or assumption that those identities are the cause of the difficulties the individual wishes to discuss in therapy (Berke et al., 2016; Israel et al., 2008; Shelton & Delgado-Romero, 2011). The literature indicates that SM-TGD persons often encounter and are negatively impacted by practitioners who take such a pathologizing attitude towards minority sexual and gender identities or who are poorly educated around the social and political realities that impact SM-TGD people (McCullough et al., 2017; O'Shaughnessy & Speir, 2018). SM-TGD individuals often express a strong preference for highly knowledgeable and experienced practitioners who are able to discern how and when an individual's sexual or gender identitiy should be a topic of discussion (ibid.).

Environmental Microaggressions

In addition to being enacted during interpersonal interactions, both gender normative and heteronormative biases can be embedded in healthcare environments via the physical elements of a space or any printed media present in that space (Berke et al., 2016; Dean et al., 2016; Israel et al., 2008). For example, intake forms, questionnaires, and other screening measures may have exclusively heteronormative response categories, or not have options for clients to indicate their pronouns or preferred named (ibid.). Additionally, pamphlets or brochures offered in clinic waiting rooms may be tailored exclusively to heterosexual and/or monogamous relationships (Dean et al., 2016; Shelton & Delgado-Romero, 2011), or health considerations relevant to cisgender people in heterosexual relationships. These environmental microaggressions signal to SM-TGD persons that they may not be welcome in a space and research indicates that overt environmental indications of inclusivity (stickers, appropriate pamphlets etc.) make many SM-TGD individuals feel more comfortable (O'Shaughnessy & Speir, 2018; Quinn et al., 2015).

Cumulative Impact of Microaggressions

A significant body of literature indicates that while microaggressions may seem trivial or relatively innocuous, perhaps especially from a straight and cisgender person's perspective, their cumulative effect can have an extremely negative impact on SM-TGD individuals' physical, emotional, and mental health (Dean et al., 2016; Nadal et al., 2014). Frequently experiencing microaggressions in therapeutic contexts can generate mistrust between SM-TGD individuals and healthcare practitioners and leave the former feeling anxious, unsafe, and disrespected (Dean et al., 2016; Israel et al., 2008). Microaggressions can also result in SM-TGD persons not disclosing their identities to practitioners, terminating therapeutic relationships, and avoiding accessing care in the future (Dean et al., 2016; Israel et al., 2008; McCullough et al., 2017;

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Quinn et al., 2015;), all of which are associated with decreased health and well being (Baldwin et al., 2017; McCullough et al., 2017). In this sense, microaggressions materialize as significant, if informal, barriers to care.

This Study

Chapter five of this thesis discusses participants' experiences with structural barriers to care and discriminatory interpersonal interactions such as those described here. In doing so, it aims to illustrate the inseparability of these two aspects and demonstrate that interpersonally enacted microaggressions materialize as a significant barrier to care. Chapter four of this thesis first foregrounds this discussion by exploring the ways that SM-TGD participants make sense of their experiences of mental illness, as partially mediated through their interactions with healthcare practitioners.

Chapter 3: Methodology

This constructivist-oriented study offers a situated account of SM-TGD people's

subjective experiences with mental illness that remains attentive to the researcher's role in

knowledge production (Costantino, 2008, Cresswell, 2009). I collected data for this study

through unstructured qualitative interviews and conducted an abductive thematic analysis which

allowed me to strike a balance between rich empirical description and theoretical generalization

(Tavory & Timmermans, 2014). This chapter first outlines this study's epistemological and

theoretical underpinnings and their influence on the research design. It then emphasizes the

importance of reflexivity to qualitative research and addresses my positionality as a researcher.

Finally, this chapter outlines the study's methodology, including sampling and recruitment

strategies, data collection/generation via unstructured interviews, abductive data analysis, ethical

considerations, and the trustworthiness of the project.

Epistemological Approach and Theoretical Grounding

This project is grounded in a constructivist epistemology. Constructivist approaches

reject the notion of a single, independent reality that can be accessed or discovered through

unbiased research (Costantino, 2008; Schwandt, 2014). Instead, constructivism is premised on an

acceptance of multiple realities that are socially constructed in interaction (Costantino, 2008;

Charmaz & Bryant, 2016). Knowledge of these realities is understood to be partial and situated,

and researchers working from a constructivist paradigm aim to remain attentive to the subjective

meaning individuals assign to their experiences as opposed to extracting unmediated truths from

participants (Schwandt, 2014). Constructivist approaches to knowledge production also

recognize that researchers play an active role in knowledge construction during the research

process (Costantino, 2008; Charmaz & Bryant, 2016).

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This epistemological standpoint infused all elements of the study's design (Tavory & Timmermans, 2014). Firstly, I collected data for this study through unstructured qualitative interviews, which focused on the meaning participants assigned to their experiences and generated rich data appropriate for the type of analysis I intended to conduct (Costantino, 2008; Charmaz & Bryant, 2016). I then aimed to remain reflexive about the influence of my positionality on the data I co-constructed with participants (Watt, 2007), as well as the interpretive role I played during the process of data analysis (Lincoln et al., 2018). I used an abductive approach to data analysis that allowed insights to emerge from the data as opposed to imposing a theoretical framework (Tavory & Timmermans, 2014), and finally presented the study's findings as a reconstructed and partial account of social reality that is concerned with subjective as opposed to objective meanings (Denzin & Lincoln, 2018).

This project is grounded primarily in poststructuralism. Poststructural theories "tend to concentrate on the operation of language, the production of meaning, and the ways in which knowledge and power combine to create accepted or taken-for-granted forms of knowledge and social practice" (Fawcett, 2008, p. 666). Specifically, *discourses*, which are embedded in and operate through language, position certain knowledges as dominant while marginalizing others and create taken-for-granted knowledges and social roles that influence social relations, institutions, and individual subjectivities (Berbary, 2017; Fisher & Freshwater, 2014). In the context of mental illness specifically, poststructural inquiries tend to emphasize the ways in which systems of categorization and labelling are discursively constituted, and the impact of those systems on individual subjectivity (Fisher & Freshwater, 2014; Tucker, 2009).

Sampling

   The aims of this study required that I collect rich data on a particular topic from a specific population of individuals. Hence, and as is typical in qualitative research, I purposefully selected research participants whose identities and experiences align with the research problem this study addresses and who were willing to discuss their experiences in significant detail (Cresswell, 2009, Palys, 2008). As this research is based in constructivism and therefore aims to an offer in-depth and situated account as opposed to comprehensive or generalizable results (Constantino, 2008), I did not intentionally seek either a representative or homogenous sample of the local SM-TGD community. I instead used two broad inclusion criteria to select research participants: a queer identity and experience with mental illness or a mental health problem, challenge, or concern.

Inclusion Criteria: Queer Identity

   Queerness as a concept and an identity has undergone significant shifts in recent years and is now employed in a number of different ways. Though queer identities are included in broader definitions of the SM-TGD community (i.e., the *Q* in *LGBTQIA+* stands for queer as well as questioning), queer identities are also sometimes considered distinct from other non-normative sexual and gender identities (ALGBTIC LGBQQIA Competencies Taskforce, 2013). Queer identities were historically understood to transcend specific gender and sexual identities and encompass any non-heterosexual or non-cisgender identity (Watney, 1994). Identifying as queer often also signaled that an individual subscribed to a certain set of anti-oppressive or social justice-oriented politics (ibid.). Queerness is ultimately a complex concept in that exists as a distinct identity, sometimes with certain political connotations, but remains at odds with traditional identity politics in that it does not have a clear set of parameters.

However, *queer* is increasingly being used as an umbrella term for a wide variety of non-normative sexual and gender identities (ALGBTIC LGBQQIA Competencies Taskforce, 2013). I discovered during the interview process that the majority of my participants understood the concept of queerness in this way and used the term interchangeably with a wide range of sexual and gender identities. This necessitated a significant shift in the framing and focus of the entire project and also shed light on how my personal understanding of queerness and the meaning that I assign to my own queer identity informed my original research questions. Specifically, I had initially been interested in the potentially unique and politically informed ways that queer-identified persons understand what it means to experience mental illness. However, as only three of my research participants identified specifically as queer, my focus on queerness as a distinct and politicized identity was no longer appropriate. Reflecting an emergent research design that allows for such shifts over the course of the research process (Cresswell, 2009), I redefined my population of study to include all SM-TGD identities and did not assume that my sample would include individuals who shared a certain set of politics.

Inclusion Criteria: Experience of Mental Illness

One my research aims was to explore the "process of self-formation that is mediated by exposure to discourse and incorporation of those knowledges into a concept of self" (Henderson, 2015, p.326). While I was interested in this process as relative to biomedical discourse specifically, I also hoped to include individuals who understood emotional distress through other frameworks in order to explore the ways that biomedicine may still inform those other ways of knowing. With that in mind, I invited individuals who self-identified as having experienced a mental health problem, challenge, concern to participate in the study (see Appendix B for recruitment materials) and made it clear that a formal/clinical diagnosis was not required. I

hoped that this would allow me to recruit individuals who interpreted emotional distress through

a psycho-social lens (Ringer & Holen, 2016) or who positioned themselves as service users

instead of patients (Speed, 2006), for example, in addition to those who understood distress in

primarily biomedical terms.

Recruitment

I recruited participants through a closed queer Facebook group specific to Kitchener-

Waterloo. As a previously accepted member of the group, I did not need to navigate access or

engage with a gatekeeper (Cresswell, 2009). I had intended to post my recruitment materials in

several other local Facebook groups and also engage in snowball sampling, but my initial posting

garnered responses from 12 interested individuals within 24 hours. Knowing that 12 interviews

would generate sufficient data for the type of analysis I intended to conduct, I did not use any

other means of recruitment. I acknowledge that recruiting participants exclusively through social

media has limitations, but I felt that recruiting more than 12 participants would hinder my ability

to conduct sufficiently rigorous and thorough data analysis given the time constraints of the MA

thesis option program. That said, recruiting participants via this Facebook group was a means of

efficiently accessing hundreds of diverse SM-TGD persons which would have otherwise been

difficult to do given the lack of queer spaces and events in Kitchener-Waterloo.

Final sample

My final sample included individuals who identified with a range of sexual orientations

and gender identities. In terms of sexual orientation, three participants identified as queer, three

as bisexual, three as pansexual, two as lesbian, two as gay, two as asexual or ace, and one as

fluid. Some participants identified with more than one of these categories, and most had

experienced a shift in their sexual identities over time. In terms of gender identity, my final

sample included five trans-identified individuals, one genderqueer individual, and six cisgender individuals. More specifically, the sample consisted of two non-binary trans individuals, one trans man, one trans-masculine individual, one individual who identified simply as trans, one genderqueer individual, five cisgender women, and one cisgender man. I acknowledge that the study does not include the voices of trans women or trans-feminine individuals, which is an important limitation that I hope can be addressed in future research on this topic.

In terms of other demographics, participants in this study ranged in age from 19 to 45, with the majority of the sample falling between the ages of 19 and 30. Seven participants identified as White, one as Chinese, one as Jamaican, one as Brazilian, one as Middle Eastern/Palestinian, and one as Indigenous. Seven participants were students at the time the interviews were conducted and the other five all had some form of post-secondary education. Though higher education is one indication of a middle-class identity, several participants had student loan debt and others mentioned having experienced financial hardship at some point in their lives. Several participants also discussed their financial stability as partially contingent upon family support. Overall, these factors suggest that this is a highly educated but not exclusively middle-class sample.

Although this study primarily discusses SM-TGD individuals as a single population, it is important to acknowledge that this is not a homogenous group. As scholars of intersectionality illustrate (Crenshaw, 1991; Kerner, 2016), various aspects of identity intersect to produce distinct experiences of marginalization and inequality. For example, SM-TGD individuals can experience discrimination and mistreatment as a result of their race, ethnicity, socioeconomic status, age, or ability in addition to homophobia and transphobia (Ghabrial, 2017; Worthington & Strathausen, 2017). It is also well documented that these factors can impact SM-TGD

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individuals' specific needs around mental health services (ibid.). A detailed intersectional analysis was unfortunately outside the scope of this study, but there is a need for future research that is attentive to the way that SM-TGD individuals' experiences with and understandings of mental illness may be impacted by other marginalized elements of identity.

Data collection

Data for this study were collected via unstructured qualitative interviews that allowed me to generate robust data related to participants' subjective experiences and processes of meaning-making (Costantino, 2008). I also wrote fieldnotes after each interview and kept a research journal as a part of the process of data collection and as a reflexive exercise. This section offers an overview of the data collection process as well as a discussion of my positionality as a researcher and my reflexive practices.

Unstructured Interviews

Data collection for this study consisted of unstructured interviews conducted between September and November 2018. Interviews ranged in length from 55 minutes to nearly two hours, and each was held at a quiet location of the participant's choosing. Nine participants chose to meet for the interviews at my office on the University of Waterloo campus and the remaining three interviews were conducted in cafes. Each participant was given a $50 gift card of their choosing in recognition of the time commitment and level of emotional engagement involved in the interview process. I scheduled interviews several days apart whenever possible in order to allow myself time for reflection after each interview (Watt, 2007), as well as to generate detailed fieldnotes and engage in both personal and analytic journal writing. This writing allowed me to make note of emerging patterns as part of an iterative process of data collection and analysis (Cresswell, 2009).

I chose to conduct unstructured as opposed to semi-structured interviews in part because I wanted to avoid posing questions that imposed my own language or conceptual systems upon participants (Pawson, 1996) and in part to leave control of the interview conversation firmly in the hands of participants (Corbin & Morse, 2003). Given the power imbalance often embedded in traditional researcher-participant relationships (Aull Davies, 2008; Liamputtong, 2007), I wanted to position interviewees as experts on their own experiences and give up some of my own power by taking a less active role in the interview (Hoffman, 2007). I allowed participants to "[set] the boundaries of privacy and exposure" (Ewick & Silbey, 1998, p.25) during the interview conversations and aimed to make myself somewhat vulnerable in turn by explicitly acknowledging my own anxiety as an interviewer (Corbin & Morse, 2003). That said, I also let participants know that I could pose direct questions if a more structured interview would be most comfortable for them. Ultimately, some participants discussed their experiences in detail with minimal prompting on my behalf, while my "footprint" (Pezalla et al., 2012, p.9) and presence as a more directive force is visible in interviews with less talkative participants.

After a few warm-up questions intended to build comfort and rapport, I began each interview by asking the participant to "start from the beginning" of their experiences with emotional distress, wherever they understood that beginning to be. In most cases, this led participants to spontaneously discuss their family situations, their experiences coming out and shifts in their sexual or gender identity over time, their interactions with support services and any experiences of discrimination, and any diagnoses they had received. The other question I asked all 12 participants was whether they identified as having a mental illness. Participants' responses to this question typically helped illustrate their relationship to biomedical categorizations without

me having to ask directly and also tended to spark a discussion of how participants felt about their distress and/or diagnoses.

I also anticipated that difficult emotions might arise during some of my conversations with participants and this further informed my decision to conduct unstructured interviews. I did not want to shy away from emotional disclosures or generate data that neglected the importance of emotion, but also aimed to ensure that any particularly emotional discussions were entirely voluntary by letting participants guide the interview conversations. Zena Sharman (2016) writes that "while there is a rich and growing literature on queer and trans health, [it] seems to me that people's stories are missing from a conversation that's often centered on things like research data and guidelines for health care providers" (p. 11). With this in mind, I aimed to use the unstructured interviews to elicit emotional expression as a form of important data (Hoffman, 2007) while still ensuring that any particularly difficult discussions happened on participants' own terms.

Field notes and research journal

I also took field notes and kept a research journal during my fieldwork. I approached this preliminary writing in part as a generative practice (Watt, 2007) or method of inquiry (Richardson & St. Pierre, 2018) that allowed to develop my ideas and engage in an ongoing and recursive process of data collection and analysis. My fieldnotes also allowed me to keep a record of the context in which the interview conversations happened, though I did not consider these notes to be objective descriptions so much as partial accounts mediated by my own perceptions, interpretations, and decisions about what features of the interview interactions were most significant (Emerson, Fretz, & Shaw, 2011). My fieldnotes ultimately included information about the participant's visible emotional state (facial expressions, body posture, tone, etc.), their

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style of engagement and apparent level of comfort with me, and any instances of distress or particularly intense moments.

My research journal was more personal and documented the emotions I experienced over the course of my fieldwork. Overall, the fieldwork entailed a significant amount of emotional labour in that I had to simultaneously make decisions around my own emotional expression and serve as both an interviewer and a supportive ear (Hoffman, 2007). While I did not want to appear indifferent or uncaring when participants discussed difficult experiences, I also did not want to take up too much space during the interview conversations or become significantly emotionally overwhelmed (Dickson-Swift et al., 2006; Hoffman, 2007). Journaling allowed me to think critically about how I was engaging emotionally over the course my fieldwork and also gave me a place to express some of the difficult emotions I experienced in response to participants' disclosures.

Keeping a research journal was also an exercise in reflexivity in that it allowed me to think critically about how my identity, assumptions, past experiences, and current actions and interview techniques were influencing my research. Reflexivity can be defined as the "ongoing analysis of relationships, power dynamics, and purposes of researchers" (Finley, 2008, p.98) over the course of the research process (Leavy, 2014; Lincoln et al., 2018). Constructivist approaches "[lead] researchers to locate themselves within inquiry" (Charmaz & Bryant, 2016, p.350) and are attentive to the ways that researchers' backgrounds, values, and experiences shape research efforts, from the selection of a topic through to interactions with participants and the presentation of a narrative in the final manuscript (Lincoln et al., 2018). Though constructivist researchers do not aim to control for bias or assume that it is possible to produce objective

knowledge, thinking reflexively about the researcher's impact on the research process is a still considered to be a key element of trustworthiness (Pezalla et al., 2012; Watt, 2007).

One key element of reflexivity in the context of qualitative research is positionality (Leavy, 2014). Positionality refers to the "situatedness of knowledge" (Finley, 2008, p.98) and the ways that an individual's "embodied, social, intellectual, and spatial locations" (ibid.) impact their worldview, approaches to knowledge construction (Tisdell, 2008), and political power and social privilege relative to others (Finley, 2008). Given how meaningful and relevant this project is to me and based on my desire to conduct anti-oppressive research, I aimed to carefully consider the role my positionality may have played over the course of my research. I had also hoped to embrace the feminist practice of threading in information about my experiences, emotions, and relationships with participants throughout the thesis (Preissle, 2008) as opposed to simply including a list of my social locations and a few limited musings about their relevance to the project.

However, it became clear near the beginning of my fieldwork that I needed to maintain some emotional distance between myself and my participants, and later, between myself and the data I was transcribing and analyzing, in order to protect my own mental health and be able to complete the project. This was a very difficult realization to come to. I felt like I was not conducting "proper" anti-oppressive research and that erasing my emotional presence from the completed work was doing a disservice to the participants who were willing to share very intimate information with me. I also worried that the credibility of my thesis would be called into question if I did not consistently and transparently discuss the impact of my identity on my work, especially given the postpositivist tendency to view shared identities between researchers and participants as a worrisome source of bias.

So, though I remain reluctant to discuss my positionality in the form of a bounded statement, I will. I am a White, middle-class, highly educated, straight-sized, cisgender woman, able-bodied at present, with typically invisible mental health challenges. My queerness is central to my identity, but I can pass as straight should I choose to. I have the financial resources to access affirming services for my mental illness and acceptance and emotional support from my family. I have experienced discrimination based on my sexual identity, but not physical violence, and the homo- and transphobia I have experienced in my interactions with healthcare practitioners has usually been subtle and has never risked my physical or emotional safety. I also come from an educated and privileged enough position that I am able to advocate for myself as a queer person in healthcare contexts and be taken seriously.

Queer identity and experiences of mental illness or emotional distress are two marginalized characteristics I have in common with my participants. I chose to disclose these two facets of my identity in order to facilitate trust between myself and participants and give up some of the power I am afforded by my more privileged social locations. I also thought critically about the ways my personal experience with mental illness and related interest in the medicalization of distress may have influenced the interview conversations and impacted how I interpreted and represented my research data. I was particularly concerned that I might be interpreting participants' stories through the lens of my own similar experiences and consistently revisited the interview transcripts to confirm that my analysis of certain segments of text seemed to authentically represent participants' intended meanings (Lietz, Langer, & Furman, 2006).

Data analysis

I used a form of abductive thematic analysis to analyze the data for this study. Thematic analysis can be defined as "a method for identifying, analysing, and reporting patterns (themes)

within data" (Braun & Clarke, 2006, p.79), and in my case involved transcription of the interview audio files, immersive reading and generation of individual interview summaries, and writing memos about emerging concepts and themes. Abductive analyses depart from more traditional inductive approaches that privilege emerging empirical insights by avoiding extensive forays into the literature at the outset of a project (Tavory & Timmermans, 2014). Abduction instead assumes "extensive familiarity with existing theories at the outset and throughout every research step" (Tavory & Timmermans, 2014, p.173). While this theoretical knowledge on the researcher's part necessarily informs the research, it is not intended to rigidly determine the direction or limit the scope of the analysis (ibid.). In my case, I was quite familiar with the literature around SM-TGD mental health, the history of biomedicine, and poststructural approaches to subjectivity at the outset of this project. This knowledge was relevant at all stages of the research process and I did not wait until the end of my data analysis to begin theorizing the study's findings. The following section outline the various steps of my analysis.

Transcription

Transcription is a key element of data analysis in that it allows researchers to familiarize themselves with their data and begin the process of pattern-finding and interpretation (Bird, 2005; Lapadat & Lindsay, 1999). To that end, all 12 interviews were audio-recorded with participants' consent and later transcribed verbatim by either myself, in some cases with the help of an automatic transcription software, or by a paid transcriptionist. I acknowledge that using a paid transcriptionist or software adds a layer of complexity to the transcription process since transcription is an interpretive act as opposed to simply a technical one (Bird, 2005; Tilley, 2003). I made the decision to do so when I found that I was consistently struggling to keep up with transcription while also coping with the emotional impact of the interviews. This helped

reduce the burnout I was beginning to experience and allowed me to focus on the more intensive elements of data analysis.

I made decisions about how and what to transcribe that aligned with both my theoretical orientation and the type of data analysis I intended to conduct (Lapadat & Lindsay, 1999; Roulston, 2010). Specifically, I approached the interview data as necessarily situated in the specific dynamics the participant and I co-created (Roulston, 2010) and therefore my transcripts include pauses, laughter, and notes about tone or inflection. Including these non-verbal elements in the transcripts offers a richer and more complex account of the interview conversations by retaining some the context in which the interview talk took place. I carefully compared all the transcripts I had not personally transcribed to the audio files from each interview in order to ensure accuracy and make sure that these non-verbal elements were included. This process of checking the transcripts also allowed me to gain familiarity with the interviews I had not transcribed myself (Braun & Clarke, 2006; Rubin & Rubin, 2012).

Close Reading and Individual Summaries

Next, I conducted a close, immersive reading of each transcript in order to further familiarize myself with the data, make note of patterns I noticed across various transcripts, and identify key quotations that exemplified patterns or were particularly insightful (Braun & Clarke, 2006; Rubin & Rubin, 2012). I also generated individual interview summaries (Rubin & Rubin, 2012) that included an outline of each participant's social locations, their family background, the specifics of their queer identity, the trajectory of their experiences with distress or mental illness, and the types of services they accessed with an accompanying timeline. It quickly became clear during this preliminary analysis that there were a striking number of commonalities across various participants' experiences, so keeping a concise record of each participant's personal

details helped me remain attentive to the distinct personal and emotional contexts in which similar experiences occurred.

Concepts and Themes

After this initial close reading and process of note taking, I began to distill the patterns I had noticed into concepts, or "broad ideas summarized briefly as nouns [or] noun phrases" (Rubin & Rubin, 2012, p.155). I consistently revisited the interview transcripts to identify key quotations and examples for each concept and confirm that the concepts I was identifying and defining were supported by the data (Braun & Clarke, 2006). I then further distilled these concepts into themes, which "[capture] something important about the data in relation to the research question, and [represent] some level of *patterned* response or meaning within the data set" (Braun & Clarke, 2006, p.82). I generated a memo for each developing theme or emerging insight (Tavory & Timmermans, 2014) and recursively compared the data both within and across the themes to identify any that needed to be collapsed or teased apart (Braun & Clarke, 2006).

After having identified a number of well-defined themes, I conducted a more targeted literature review so as to situate my findings within the current literature and engage more theoretically with the themes I had identified (Tavory & Timmermans, 2014). The themes and findings I present in this thesis ultimately aim to "develop a double story: one part empirical observations of a social world, the other part a set of theoretical propositions" (ibid., p.5). In line with a constructivist approach, I consider myself to have played an active role in defining, theorizing, and representing these findings (Braun & Clarke, 2006; Costantino, 2008). My analysis does not seek to "pronounce the last word" (Fisher & Freshwater, 2014, p.204) so much as offer a partial account of participants' stories as I understood and interpreted them.

Trustworthiness

Concepts such as reliability, validity, and generalizability that are typically used to assess rigour in quantitative research are not effective or appropriate when it comes to addressing issues of quality in qualitative research (Lietz, Langer, & Furman, 2006). These concepts are fundamentally incompatible with the epistemological basis of constructivism in particular, which rejects the idea that research can generate knowledge which speaks to a single, objective truth (Constantino, 2008). That said, it is certainly still important to ensure that qualitative research has been conducted with integrity and generates knowledge that authentically represents participants' experiences and stories (Lietz et al., 2006). To that end, concepts such as trustworthiness, authenticity, or transferability have been offered as more applicable alternatives to the quality measurements used in quantitative research (Lincoln et al., 2018; Spencer, Pryce, & Walsh, 2014).

I aimed to ensure the trustworthiness of this study in two ways. Firstly, I aimed to become thoroughly familiar with my data so as to be "immersed enough in participants' experiences so as to credibly represent and interpret them" (Spencer et al., 2014, p.83). Secondly, I carefully considered the concepts of *self-reflexivity* and *transparency* (Tracey, 2010), which emphasize the importance of the researcher critically assessing and then being truthful and transparent about the impact of their motivations, strengths, shortcomings, mistakes, and positionality at all stages of the research process. As mentioned earlier, the writing I did in my research journal was ultimately an exercise in both self-reflexivity and transparency. I recorded the procedural details of the interviews and my developing analysis without glossing over my mistakes and uncertainties. I also wrote quite extensively about the emotional impacts of

conducting the interviews and the ways in which my own mental health at times compromised the thoroughness of my work.

Ethical considerations

My population of study and overall research topic both present important and distinct ethical considerations. Below I discuss some of the key concerns that emerged during the research process, which orient primarily around marginalization, the emotional impact of the interviews, anonymity and confidentiality, and reciprocity.

Marginalization

SM-TGD people remain marginalized based on sexual orientation and/or gender identity despite documented gains in LGBTQ rights (Knauer, 2012), and factors such as socio-economic status, age, ability, religion, or race/ethnicity can further this marginalization (CMHA, 2017; Ghabrial, 2017). Additionally, even heterosexual and cisgender individuals who experience mental illness often experience marginalization and stigma in various contexts (Ringer & Holen, 2016). Ultimately, participants in this study experience several intersecting axes of marginalization which necessitated that I carefully consider any possible harms that could be perpetuated by this study and remain aware of the power imbalance that could exist between myself and less privileged participants. Making explicit my own marginalized identity as a queer woman who has experienced mental illness was one way that I aimed to remain attentive to this issue, as was my use of unstructured interviews which granted participants increased control over the interview conversations.

Emotional impacts

The research topic also posed distinct ethical considerations in that talking about difficult experiences could be distressing or triggering even for individuals who are not otherwise

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marginalized. I aimed to address this risk first through a robust and transparent informed consent

process (Corbin & Morse, 2003). My informed consent form made the topic of the interviews

extremely clear, and I also verbally rearticulated that participants were free to direct the

conversation, decline to answer any question, stop the interview at any time, and ask about my

identity and experiences so that the interview conversation was not one-sided. However, I

ultimately aimed to respect participants' agency and autonomy by trusting that individuals would

only request to participate in the study if they were comfortable discussing sensitive or

distressing experiences with a researcher (Corbin & Morse, 2003; Liamputtong, 2007).

Anonymity and confidentiality

Protecting participants from exposure and adequately safeguarding their data are key

elements of all ethical research (Corbin & Morse, 2003). I aimed to protect participants'

identities and ensure confidentiality to the greatest extent possible through the use of

pseudonyms; secure storage of all audio files, transcripts, field notes, and informed consent

forms; password-protecting documents containing participants' full names and contact

information; and careful selection of any direct quotations to avoid including those that could

contain identifying information (ibid.). Additionally, I chose a transcription software that did not

require me to upload audio files to the cloud and that did not permanently store the completed

transcripts or audio files. The transcriptionist I worked with also signed a confidentiality

agreement and I sent all audio files to her using a secure file share software.

Reciprocity

Finally, I aimed to build reciprocity into the research process whenever possible.

Historically, research has often benefitted those conducting it by advancing their careers or

increasing their status while failing to have a significantly positive impact on participants' lives

(Corbin & Morse, 2003). I did not want to reproduce this trend, especially given the emotional

vulnerability participants demonstrated during the interviews and how critically important issues

of access to healthcare are to SM-GNC communities. I aimed to demonstrate reciprocity firstly

by compensating participants for their time and energy in participating in the interviews. I also

considered the implications of transforming participants' experiences and voices into academic

texts that do not provide translatable knowledge that benefits participants (Abell & Myers,

2008). To that end, I intend to produce and distribute a white paper that summarizes any findings

from this study that are relevant to local and university healthcare services.

Chapter 4: Mental Illness and Subjectivity

This chapter discusses participants' processes of sense- and meaning-making around the nature of mental illness as relative to biomedical discourse, the points of contact between mental illness and SM-TGD identities, and the complex relationship between distress, medicine as a reifying force, and subjectivity. In order to do so, this chapter first discusses poststructural approaches to subjectivity and the development of a biomedical model of mental illness that came to replace previous psychanalytic approaches to mental distress in order to contextualize the study's findings.

Poststructural Approaches to Subjectivity

Poststructural approaches to subjectivity reject historical understandings of the self as stable, unified, and either naturally occurring or constituted automatically based on social roles (Kelly, 2013; Mansfield, 2000). Instead, these approaches are based on the notion that subjectivity is fluid, multifaceted, contextual, and constituted within discourse (Fawcett, 2008; Fisher & Freshwater, 2014). Specifically, discourses, or expert systems of language (Henderson, 2015), "establish meaning that is related to the exercise of power" (Fisher & Freshwater, 2014, p.198) and create taken-for-granted knowledges and social roles that individuals draw upon to constitute their subjectivity (Fawcett, 2008). Discourses and the truths they establish operate through and are maintained within language (Fisher & Freshwater, 2014), and make available various positionings and story lines that shape and constitute subjectivity (Davies, 1992).

Poststructural approaches to subjectivity have sometimes been critiqued as limiting the potential for agency and resistance by casting subjects as little more than passive victims of the operation of power through discourse (Budgeon, 2015; Fisher & Freshwater, 2014; Lupton, 1997). However, other authors acknowledge the impact of power and its attendant norms and

truths on subjectivity but reject the notion that the constitution of subjectivity through discourse is an entirely deterministic process (Budgeon, 2015; Gill, 2008). Such authors instead approach the relationship between discourse and practices of subjectivity as dynamic and characterized by negotiation and resistance as opposed to a totalizing imposition of power (ibid.). This study takes the latter approach and is premised on the notion that subjects "subvert and reconfigure their own discursive subjugation" (Fisher & Freshwater, 2014, p. 204) in ways that involve complex and highly personal negotiations.

The Biomedical Model of Mental Illness

Lupton (1997) argues that from a poststructuralist perspective, "individuals' lives are profoundly experienced and understood through the discourses and practices of medicine and its allied professions" (p.95). Medical knowledge and practices are integral to the constitution of bodies and subjectivities, but this has historically taken on different contours based on the shifting systems of knowledge and related practices associated with various medical paradigms (Foucault, 1975; Lupton, 1997). This section offers a historicized discussion of the rise of biomedicine as the dominant way of understanding mental health and illness in the contemporary Global North. Specifically, it discusses the shift from the psychodynamic paradigm to the biomedical, including the more recent trend towards an increased focus on the organic brain and neuroscience (Rose, 2007).

From the 1900s to the 1970s, "psychiatry's ruling psychodynamic paradigm viewed mental disorders as conflicts of personality and intrapsychic conflict" (Mayes & Horwitz, 2005, p.249). Symptoms of mental disorders were considered to be expressions of underlying psychological problems or conflicts, reactions to adverse life events, or an inability to adapt to one's environment (ibid.). Though mental disorders ranged in severity and presentation, they

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were all thought to be reducible to this same set of psychosocial processes. Accordingly, disorders were considered to exist on a spectrum of normality as opposed to being discrete illnesses and diagnosis did not play a significant role in psychiatry (LaFrance & Mackenzie-Mohr, 2013; Mayes & Horwtiz, 2005). Psychotherapy was the standard treatment for mental disorders across the spectrum of severity and tended to focus on an individual's personality, social environment, and life experiences (ibid.).

However, the 1980s marked a radical shift away from psychoanalytic understandings of mental disorders in favour of a biomedicalized approach (Lafrance & McKenzie-Mohr, 2013; Mayez & Horwitz, 2005). Integral to this shift was the publication of the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980. Instead of being based on psychoanalytic theory as had been the case with the first two versions of the DSM, the DSM-III presented a new biomedical model of mental illness that reframed mental disorders as distinct, clinical entities (ibid.). These disorders were now considered to have identifiable and measurable symptoms which reflected "a conception of specificity in underlying pathology" (Rose, 2007, p.199). Accordingly, diagnosis based on standardized criteria therefore became the cornerstone of psychiatric practice (Mayes & Horwitz, 2005).

The biomedical recategorization of mental disorders also evidenced psychiatry's increased focus on "the somatic underpinnings of psychopathology" (Trimble, 1996, p.19). More specifically, Nicolas Rose (2007) suggests that the decade between the mid-1980s to mid-1990s marked a shift towards an increased focus on the pathologies of the brain. Brain structures, functions, and chemicals that were once "hypothetical, tentative epistemic objects" (p.190) were reconceptualised as facts, established via the results of clinical research and, eventually, scanning

and imaging technologies capable of rendering visible the internal structures and activities of the brain (Rose, 2007; Rose & Abi-Rashed, 2014). These technologies played a key role in the reification of the mind and any mental dysfunction as products of the organic brain, in the sense that "when the mind seems visible within the brain, the space between person and organ flattens out – mind is what brain does" (Rose, 2007, p. 198).

In addition to the changes outlined above, the biomedical recategorization of mental disorders also created new opportunities and incentives for the development of pharmaceuticals targeting specific diagnoses (LaFrance& McKenzie-Mohr, 2013; Mayes & Horwtiz, 2005). The pharmaceutical industry profited immensely from the proliferation of clinical diagnoses as pharmacological interventions came to replace talk therapy as the leading approach to treating mental illness (ibid). The new disorders outlined in the DSM-III were presented as distinct, each with a "unique etiology and prognosis, amenable to a specific kind of treatment" (Rose, 2007, p. 199), which allowed the pharmaceutical industry to develop drugs in tandem with the development of new disease categories (ibid). Moreover, 64% of the stakeholders involved in the development of the most recent version of the DSM (the DSM-5) were associated with the pharmaceutical industry (Lafrance & McKenzie-Mohr, 2013), illustrating the continued inseparability of biomedicalized psychiatry and corporate interests.

Ultimately, biomedical or neurochemical approaches to mental illness have come to hold master status relative to all other understandings of mental distress in the Global North (Lafrance & McKenzie-Mohr, 2013; Mayes & Horwtiz, 2005). Biomedical discourse establishes certain taken-for-granted knowledges about mental illness that "[permeate] our understandings of identity and experience…not because [they] reveal 'truth', but due to [their] ability to construct a particular version of reality" (Lafrance & McKenzie-Mohr, 2013, p.120). In the context of this

hegemonic worldview, the historical circumstances in which biomedical understandings of mental illness emerged and the power, legitimacy, and regulatory capacity they afford the medical professions are rendered invisible (ibid.). As will be touched on briefly in chapter six, this has positioned medicine as a powerful institution of social control with the authority to define and normalize certain behaviours and subjects (Conrad, 1992).

Understanding the Nature of Mental Illness

Biomedical discourse as described above serves as a powerful set of discursive resources that help shape individuals' understandings of mental illness as well as their subjective experiences of mental illness or emotional distress (Lupton, 1997; Ottewell, 2018; Ringer, 2013). This section describes some of the ways that participants made sense of mental illness relative to biomedical discourse and also aims to illustrate the points of contact between these understandings and SM-TGD identity. Though most participants understood and described their experiences in ways that drew upon or upheld biomedical definitions of mental illness, the primacy of biomedical discourse took varied forms across participants' accounts.

At one end of the spectrum, some participants considered experiences of mental illness or emotional distress to be conclusively, though not necessarily exclusively, biologically based. For example, Blythe, a queer, cisgender nursing student who began experiencing mental health problems at the age of 12, expressed the belief that her experiences of emotional distress were fundamentally related to the functioning of her body. In Blythe's words:

> Like yeah, I know that it, there definitely is like a chemical imbalance going on in there [in her brain], for sure. Like there's no doubt that, mental illness, is also, affected by outside factors. But I think it does start, in the brain. Like it starts *in* the body.

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Blythe draws directly and explicitly on biomedical discourse in her reference to brain chemistry and by locating mental illness in the brain (Rose, 2007), and her subjective understanding of the nature of mental illness clearly aligns with dominant psychiatric framings of mental illness.

Quinn, a 24-year-old non-binary trans participant who frequently struggles with anxiety, also spoke about the relevance of the body to experiences of mental illness. Though Quinn attributes many of their mental health difficulties to the trauma of growing up in an "emotionally chaotic home environment" as opposed to pointing to an inherent biological cause, they believe that physiological processes underlie the experience of anxiety itself. For example, Quinn shared a story about a day when their workplace was under construction and the noise left them too anxious to do their usual administrative tasks. They drew on what they referred to as "medical knowledge" about the physiological processes associated with anxiety to describe and make sense of their experience:

> …my brain physiologically, thinks that there is a threat. I am in fight or flight mode, right now. And so, all of my brain energy is hijacked, to, get me to make a decision, about whether, I can take on, this, like, threat. Or whether I need to get out of dodge. And so no duh I can't answer my emails. Physiologically I cannot answer my emails.

Though Quinn does not discuss their experiences of anxiety as starting in the body so much as manifesting there, they draw very directly on biomedical discourse in the language they use around the fight or flight response and in their reference to the brain. Quinn ultimately found "medical knowledge" to be a useful tool in making sense of their experiences and in this case, shifted any blame for their struggle to be productive from the personal to the physiological (Ringer & Holen, 2016).

Other participants accepted the positioning of mental illnesses as biomedical entities but expressed that acceptance in subtler or less direct ways. For instance, Damien, a 24-year old pansexual, transmasculine undergraduate student, stated that:

Like, a lot of, or at least like, definitely like partially, my emotional like instability. Was not just like, thought patterns. *There was something going on* [emphasis added]. And, taking a mood stabilizer has really helped that.

Damien's assertation that a mood stabilizing medication helped address the "something" that was going on and the distinction they drew between that something and thought patterns (as a non-physiological component of mental illness) suggests that what they are referring to is brain chemistry. This in turn implies at least some degree of acceptance that their "emotional instability" can be appropriately categorized as a biological illness. More specifically, the fact that psychiatric pharmaceuticals primarily act on neurotransmitters reinforces the idea that mental disorders are reducible to neurochemical issues (Rose & Abi-Rashed, 2014). Individuals who find that psychiatric medications help alleviate distress may then accept the categorization of their distress as mental illness (Ottewell, 2018) or locate their problems in the brain specifically (Ohlsson, 2016).

Other participants took a somewhat more psycho-social approach in their understandings of mental illness, as is a typical alternative to biomedical discourse in making sense of distress (Ringer & Holen, 2016). Specifically, several participants acknowledged the role biology or physiological processes play in contributing to mental illness but also emphasized the relevance of trauma, lived experience, and social environments. For example, Morgan, a 28-year-old cisgender lesbian social worker, discussed the impact of trauma and social environment in

contributing to emotional distress. When I asked Morgan if she identified as having a mental illness, she replied:

>Some days I want to resist, that. And point fingers at, societal problems and family problems and say, like this [mental illness] doesn't exist, if not for. In other ways like I believe in the brain. And the brain, you know proves time and time again, that, like because of trauma, you know, the brain looks different. And like, there is such a thing as dopamine, and serotonin.

Morgan appears to straddle social and biomedical framings in her understanding of distress which illustrates the fact that biomedicine and less dominant discourses around mental illness are not mutually exclusive (Speed, 2006). Specifically, Morgan clearly attributes significant weight to trauma and adverse lived experience as relevant contributors to distress, but she also draws on elements of biomedical discourse in her reference to neurotransmitters and the impact of trauma on physical brain development. Morgan's comment subtly pushes back against the taken-for-granted nature of biomedical framings of distress but does not categorically reject them.

Nicki, a 45-year-old cisgender lesbian high school teacher and guidance counsellor, took a similarly negotiated stance on the nature of mental illness. Like Morgan, she explicitly discussed the role trauma can play in contributing to experiences of mental illness but did so in a way that still evidenced a degree of acceptance of biomedical framings. When I asked Nicki whether she identifies as having a mental illness, she stated that:

>That's a really good question, cause I feel, the older I get, the more I think that, I don't wanna say that mental illness isn't real, mental illness is real, but I think it's more about unresolved trauma, than it is about any kind of inborn thing. Like I think you can have a

genetic disposition towards bipolar or schizophrenia or whatever it is, but I really think

that you have to have the lived experience that puts that into motion kind of thing.

Similar to Morgan, Nicki emphasizes the importance of lived experience in contributing to

mental illness but identifies physiological factors (in this case, a genetic predisposition) as the

link or mediating factor between experiences of trauma and mental illness. Her categorization of

mental illness as "real" is particularly illustrative in that it implies a simultaneous acceptance of

mental illness as a biomedical entity and rejection of the notion that mental illness can be entirely

reduced to something "inborn" (or in other words, biological).

Mental Illness and SM-TGD Identity

While the literature points to a relationship between mental illness and marginalized

sexual/gender identity insofar as SM-TGD persons are disproportionately likely to experience a

variety of different mental health challenges (CMHA, 2017; RHO, 2015), comparatively less is

known about how SM-TGD individuals themselves make sense of the relationship between their

sexual or gender identities and experiences of mental illness. This section discusses some of the

ways that participants in this study understood the relevance of their identities to their

experiences of distress.

Most participants initially rejected the idea that their sexual or gender identity and

experiences of mental illness were connected. This was somewhat unexpected given the level of

enthusiasm this study generated amongst participants and the political connotation of queerness

as compared to other sexual minority identities. The study as I first conceived of it was premised

on the notion that specifically queer-identified people were likely to be relatively critical of

biomedicine and the historical medicalization and pathologization of homosexuality and

transgender identities by psychiatry. I imagined that individuals recruited for this study might

approach mental illness less as a biomedical entity and more so as a socially produced and defined set of experiences and focus on the ways that oppression can be related to disproportionate rates of mental illness in marginalized communities.

However, as outlined in the preceding section, participants in this study generally understood mental illness through a biomedical lens or emphasized the physiological impacts of trauma as opposed to the ways that systemic oppression and marginalization can function as forms of trauma. Many participants approached the link between mental illness and sexual or gender identity from a similarly individualized position. Though most participants clearly articulated their belief that mental illness is a pressing issue in SM-TGD communities, comparatively few believed that their personal experiences of mental illness and their sexual or gender identities were connected. There was a clear disjuncture between what participants understood to be true at the level of their community and how they discussed the relationship between their individual experiences and sexual or gender identities.

It became clear over the course of the interviews that this disjuncture was in part a product of participants' perception that a relationship between experiences of mental illness and identity would be evidenced primarily by emotional struggle surrounding one's gender or sexual identity or a desire to discuss those identities in therapy. Most participants had not sought therapy to discuss issues related to their identities and therefore stated that they did not consider their identities and experiences of distress to be related. Nonetheless, many participants also discussed the ways that various forms of identity-specific marginalization or social exclusion negatively impacted their mental health. This suggests that many participants did in fact experience their identities and mental health as linked in some capacity, even though a comparatively small number explicitly identified that connection.

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Morgan was the exception to this trend in that she discussed the relationship between mental illness and SM-TGNC identity very directly and emphasized the importance of social factors. She stated that:

> I think it's really hard, to [pause], stay well in a really, homophobic, transphobic society. So it's hard to know what comes first [marginalization or mental illness], but I know they're all connected….when you live in a homophobic and transphobic society, something has to suffer in yourself.

Though Morgan's general understanding of mental illness (as discussed earlier in this chapter) appears to align fairly closely with biomedical framings, Morgan takes a somewhat contradictory stance here and emphasizes the impact of marginalization on SM-TGD people's mental health.

Morgan's point was exemplified in several other participants' accounts, though those participants did not directly identify a link between marginalization and distress in the way that Morgan did. The negative emotional impact of encountering homophobia, transphobia, or microaggressions in daily life was most clearly illustrated in several trans participants' stories. For example, Aaron, a 19-year-old pansexual and transgender student, discussed the fact that being misgendered at work contributes to his depression (or feeling low, as he describes it):

> … it made me sad. Like especially in the past couple years of my job, cause I'm, I was a cashier, um, when customers would tell their kids "Give it to the lady, she'll scan it for you", or call me a pretty girl, stuff like that, my heart just drops … the actual misgendering just gets me low.

Though Aaron did not frame his trans identity and experiences of distress as related, this comment clearly demonstrates that experiencing and coping with transphobic microaggressions can have a cumulative detrimental effect on mental health (Nadal et al., 2012; 2014).

Further, while Robyn, a gay, non-binary trans person, explicitly noted that they never had "problems with" being queer or non-binary, they also spoke quite directly about the emotional impact of not feeling accepted as a trans person and the worries they have around what their identity might mean for their future employment:

> I wasn't ashamed of being trans. But I felt like, I should be? So, it was like [pause], it really changed my, thoughts on like where I fit, in society. And even now like in, the job search like there'll be certain positions I apply for and I'm like I really want this job but I'm, know I'm not going to get it because I'm trans. And, kind of just like, knowing *that*, kind of really affects my mental health.

Robyn's comments point to the contradictory nature of their understanding of the relationship between their queer and trans identities and their mental health. On the one hand, Robyn did not struggle with identifying as queer or trans and did not want to discuss their identities in therapy, so their identities and distress must be distinct. On the other hand, however, Robyn can clearly articulate the ways that transphobia has negatively impacted their mental health. This clearly illustrates the nature of subjectivity and processes of sense-making as "often fraught with ambivalence, irrationality, and conflict" (Lupton, 1997, p.106).

In addition to the negative impacts of transphobia that Aaron and Robyn identified, a lack of familial belonging and support was another point of contact between SM-TGD identity and mental illness for several participants in this study. For example, Aaron described a decline in his mental health after coming out to his family in high school and not receiving their love or support. His mother was not initially accepting of his gender identity and expressed a lot of anger towards Aaron:

And like, then of course I would just get low and shut down and sit there quietly and not

be able to speak. And um, that had a lot of impact? Like especially just it being my mom,

her being so angry… And so just getting in trouble so much, for bringing it up, um I was

called like a problem child, and stuff. Um, so just getting punished and facing

consequences for trying to own up to my identity…

These interactions had a significant emotional impact for Aaron and suggest a second point of

connection between his trans identity and experiences of distress.

Not being accepted by family can also have practical or financial consequences, which in

turn can compromise mental health. For instance, Robyn remembers being worried that they

would be kicked out of the house if their father found out that they were gay. They also

discussed their father's negative reaction to their trans identity and decision to get top surgery

and noted that even though they do not desire a close relationship with their father, not having

his support still has important implications:

And like, even though I've always had mental health issues like, I'm not close to, my

dad, so. It was never something that like, I ever talked about with him? And it's probably

not something that I ever *would*, talk about with him. But, and that's like kind of what

[pause], makes things difficult for me like now at the moment. Where like, I'm having

mental health issues, and my friends are like not really available, because they're like.

Out working their jobs and living their lives, but. I don't have like a family to like fall

back on.

While a lack of familial acceptance and support can itself be detrimental to SM-TDG persons'

mental health (Ryan et al., 2009; Ryan et al., 2010), stories like Robyn's also demonstrate that

not having family relationships as an option for informal emotional support can compound

experiences of mental illness for SM-TGD individuals. Other participants whose families did not accept their gender or sexual identities expressed similar worries about losing familial financial support or access to insurance coverage for therapy and having limited other options to fall back on.

Finally, some participants discussed about the emotional repercussions of keeping their sexual or gender identities a secret from family. For example, even though Anderson, a 23-year-old cisgender bisexual student, was extremely apprehensive about telling her mother she was bisexual, it eventually became emotionally untenable for her to continue to keep her sexuality and her partner a secret:

> …so like, I've had bad mental health for a long time, and I think that, until I came out to my family like fully, it was just like, completely unmanageable to an extent, cause like, I don't know there's like the whole existential side of it, where it's just like, I know who I am, but the people I care about don't know who I am, so like am I really who I say I am, if I'm lying about it to the people who, are like, my links in the world?

Anderson remembers feeling like a "real person" after disclosing her bisexuality, even though her mother's initial reaction was not supportive. As has been documented among other SM-TGD persons (Meyer, 2013), Anderson's mental health has improved now that she is not hiding her identity from such an important person in her life.

Relationships to Medication and Diagnoses

This section addresses participants' experiences with being prescribed psychiatric medications and/or receiving official diagnoses of mental illness, as well as the relationship between those processes and subjectivity. Although individual responses to diagnoses vary widely, experiencing diagnoses as validating and/or legitimizing is quite common (LaFrance &

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McKenzie-Mohr, 2013). Diagnoses also construct illnesses as having an independent reality and reify them as objective biomedical entities (LaFrance & McKenzie-Mohr, 2013; Tucker, 2009). Many participants in this study attributed significant epistemic weight to medication and diagnoses while still integrating their own subjective knowledges into processes of sense-making and understandings of selfhood.

The Role of Medication in Processes of Meaning-Making

Many participants in this study were prescribed medication for mental illness and this took on a variety of different meanings for individuals. For example, for Katie, a 23-year-old cisgender queer student, being prescribed medication carried a very specific type of authority that overrode the subjective meaning she assigned to her own experiences:

> …taking medication really like, legitimized it, like there was no, um, you're just going to therapy and maybe, maybe you're making half this shit up, you know like, um, it was like, it was very like, hard science it felt like.

While Katie could have been "making things up" in interpreting her distress as severe or meaningful, being prescribed medication validated the fact that her experiences were in fact significant by granting them the epistemic weight of science (Ohlsson, 2016; LaFrance & McKenzie-Mohr, 2013).

Damien was a second participant who assessed the severity of their experiences of distress partially in reference to the medication they take. In reflecting on their mental health prior to taking psychiatric medication, Damien stated that:

> Like sometimes I wonder like, do I really need this [their medication] like anymore?
> Like how bad was it? But I'm like, I don't want to, find out how bad it was. Because it

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must have been pretty fucking bad. If I'm on like this dosage, of like this medication. It

must have been pretty bad. So.

Like Katie, Damien's ambivalence towards the severity of their distress was overridden by the

defining authority they granted to medication, based on its association with medical expertise

(Ohlsson, 2016).

For Carlos, a 40-year-old cisgender gay graduate student, taking medication to help him

manage his anxiety did more than just legitimize his distress as significant: taking medication

reified his experiences as mental illness (Ohlsson, 2016). When I asked Carlos if he identified as

having a mental illness, he laughed and implied that it was a somewhat absurd question: he takes

psychiatric medication, so of course he has a mental illness. Medication allowed Carlos to

recognize himself as ill (Ottewell, 2018) and seemed to preclude the possibility of any other

interpretation of his experiences. This is exemplified in how Carlos described introducing

himself to the undergraduate students he teaches:

First thing I say, look I say "Okay, I'm your TA, I am ah, queer, and I'm totally crazy."

And they laugh and I'm like "No, I mean it, I am crazy, I take meds."

Carlos's statement "I am crazy, I take meds" makes it clear that these two things are one and the

same in his understanding.

Finally, Aaron interpreted being prescribed medication as conferring the same legitimacy

to his experiences as receiving a diagnosis would. Aaron's sense-making around the meaning of

medication echoes that of Carlos's in the sense that they both approached medication and

diagnosable mental illness fundamentally inseparable:

I think, cause, because ah like how I said that I didn't think that I qualified, to be

depressed, I think I started using that to describe how I was feeling, um, once the doctor

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prescribed me the medication cause to me, that was in essence a diagnosis. And I felt like

I was actually allowed to ah, use that now.

Being prescribed medication leant "status" to Aaron's experiences (Ohlsson, 2016) by indirectly

categorizing them as mental illness. This new, objective framing of his distress in turn "allowed"

Aaron to take on the label of depression and, as will be discussed below, some of the associated

social benefits.

Diagnosis as a Reifying Force

Once an illness has been diagnosed (or indirectly diagnosed via the prescription of

medication, as illustrated above), it leaves the realm of the subjective and "can be ascribed a

different ontological status as something incontestable and real" (Ohlsson, 2016, p. 12.11).

Several participants approached their diagnoses in such a way, but this was not a deterministic

process. Participants' accounts instead evidence a complex process of negotiation where they

often grant medicine the ultimate authority in defining their experiences but do not do so in a

way that entirely discounts their subjective understandings of their distress.

For example, Katie pointed to the intangible but nevertheless important distinction

between naming her own experiences as problematic and being diagnosed with a specific mental

illness:

Um, but I was like, it felt wild to me, like 'diagnosed'… it's hard to describe, like it just

really felt like huh, like you knew what was coming, and you knew that was the case, but

there's something about like having it like, having someone say like "I would consider

you within this", you know?

Katie's comment that she "knew that was the case" illustrates the fact that she had already

classified her experiences as problematic or atypical. Even though receiving a diagnosis only

confirmed Katie's subjective understanding of her experiences, that diagnosis still served a new "interpretive function" (Ohlsson, 2016, p.12.4) and granted a different meaning to Katie's distress.

Anderson was a second participant whose account illustrated a negotiation between her subjective understanding of her experiences and the biomedical categorization of those experiences. In talking about the process by which she had been given a diagnosis, Anderson stated:

> I'm a – I'm a very like clinical person, I'm a very logical individual, so for me if, when I go talk to my doctor and what I'm explaining to them, they're able to come up with something reasonable and I do the research and that all corroborates and fits then, you know, if the shoe fits, then I'll wear it. It is, it is what it is right?

Anderson questioned how her doctors were able to "quantify" her experiences and pinpoint exactly which illness she had "out of the thousands of things that could be wrong with me", but ultimately accepted that her experiences constituted an objective and diagnosable entity. This process of sense-making illustrates a complex form of resistance where Anderson pushed back against her doctor's authority to place her experiences into specific disease categories but was simultaneously willing to accept the "overlap of objective science" onto her subjective experience (LaFrance & McKenzie-Mohr, 2013). Doing research around the diagnoses her doctor suggested allowed Anderson to retain a degree of authority over her own experience (Tucker, 2009) while still accepting that "it is what it is".

Diagnoses as Dilemmic

In addition to reifying certain experiences as illnesses, psychiatric diagnoses also confer stigma upon their recipients (Ottewell, 2018). In this context, Tucker (2009) points to the

dilemmic nature of "seeking to account for distressing events in one's life whilst recognizing that a psychiatric explanation brings with it identity-threatening connotations" (n.p.). In other words, taking on the label of mental illness validates and legitimizes one's experiences but is also stigmatizing (Ringer & Holsen, 2016). Participants' various responses to and feelings about their diagnoses evidenced both sides of this dilemma.

On the one hand, some participants experienced their diagnoses as a "welcome explanatory tool" (Tucker, 2009, n.p.) that validated their distress as real and significant enough to warrant care or allowed them to better understand their experiences. For example, Kelly, a 34-year-old queer and genderqueer university staff member, initially felt angry about receiving a diagnosis of episodic major depressive disorder (MDD) and was not interested in the single benefit they thought the diagnosis made available to them: medication. Kelly stated:

> I was sort of mad about it. Because [pause]. It was clear, like it was bad enough that it was clear to me that there was something very wrong with me [pause]. And being able to put a label on it didn't really impact anything because [pause]. With the diagnosis they could give me the option of [pause], of, getting a prescription. But [pause], at the time I wasn't really ready for that.

However, Kelly eventually experienced the diagnosis as legitimizing and practically useful:

> It helped me understand [pause]. Later on I was happy, to [pause], know that it wasn't all in my head do you know what I mean? Like I was happy to, to be able to say like I understand [pause], how, this works. And be able to [pause], contextualize [pause], episodes in the future.

Receiving the diagnosis of MDD ultimately granted Kelly's experiences an objective and understandable reality (LaFrance & McKenzie-Mohr, 2013; Ohlsson, 2016), which shifted their relationship to the label.

Aaron also experienced his diagnosis of depression as useful in the sense that it could help other people understand his experiences. More specifically, labeling experiences as mental illness "facilitates the communication of the experience" (Ohlsson, 2016, p. 12.6) and can remove notions of personal responsibility or blame for behaviour (LaFrance & McKenzie-Mohr, 2013; Ohlsson, 2016), both of which were relevant to Aaron. In talking about how the shift in how his friends interpreted his behaviour once he attributed it to anxiety or depression, Aaron stated that:

> Um, and they'd always write that off as oh he's so emotional, he's so reactive, like he's a drama queen, ah was the big one, but being able to ah, come back and be like, actually, this is not just me being a drama queen, like this is because of anxiety or depression, and um, I'm sorry that you ah, thought I was being too much, but just to explain myself, this is what happens. And I mean then, they're all like "Oh no you don't have to apologize for that!" But, I think it certainly helps, identifying to ah, combat what people say.

That said, Aaron also drew a distinction between the weight he personally assigns to the label of depression and the social weight that label carries:

> …so yea I think just in terms of using that as a label was helpful socially. For myself, I don't know if I put too much weight on it, actually calling myself depressed, I don't know if it um means anything super large to me. It's not like I am depressed, that's not who I am, um, so I think it has more of a social weight to it.

However, it is important to note that mental illness is not a homogenous category. Different diagnoses connate varying levels of stigma and hence have different implications for individual and social identities (Ohlsson, 2016; Ottewell, 2018). Though participants like Kelly and Aaron ultimately found their diagnoses to be useful, other participants categorically rejected the diagnoses they received based on concerns around stigma. Specifically, diagnoses of anxiety and depression tended to be relatively well-received by participants while diagnoses of bipolar disorder or borderline personality disorder were often met with great resistance. These highly stigmatized disorders seemed to connote deviance and pathology to a degree that other diagnoses did not, and along with schizophrenia, are often contrasted with "normal" mental illnesses like as depression (Ohlsson, 2016; Ottewell, 2018).

Blythe articulated this distinction very clearly:

Because you know, like we live in a world, where mental health *is* talked about more. And even though there is stigma, it is it's talked about. You know, a lot of people, talk about their depression. A lot of people talk about their anxiety. Even obsessive compulsive. But bipolar, it's just one of those, that like. It's a bit scarier… Like people don't talk about, bipolar. People don't talk about borderline. Because they're almost seen as those like mental illness that are like, "Hmm. Can't trust that person." You know [laughs].

Other participants described these two disorders as heavy, severe, complex, serious, frightening, and "not something that you like to tell people". One participant even went so far as to reassure me that they had not been diagnosed with bipolar disorder after mentioning that they have experienced rapid mood swings in the past. These responses clearly illustrate the extent to which bipolar disorder and borderline personality disorder are highly stigmatized, and also demonstrate that participants were selective in which diagnoses they were willing to take up. Many appeared

to perform a cost-benefit analysis, so to speak, and only accepted a diagnosis when the ratio of stigma to personal or social benefit was favourable.

Mental illness and the Self

Ringer and Holen (2016) argue that determining the boundaries between illness and subjectivity is a "core ambivalence that many psychiatric patients experience with the construction of diagnostic identities" (p. 167). Mental illness can be positioned as external to or part of the self (Ohlsson, 2016), and participants in this study navigated this distinction in a variety of different ways. The frequency of symptoms or instances of distress was one factor that several participants took into consideration when deciding whether or not to adopt the label of mental illness or integrate mental illness into their sense of self. For instance, Quinn views their illness as something that continues to exist and remains a part of them even though their experiences of distress are intermittent and have improved significantly in recent years. When I asked if they identified as having a mental illness, Quinn stated:

> I do, yes. Yeah. I [pause]. I still definitely, even though the patterns are like much less, [pause] active, it's definitely still something that I, like struggle with to varying degrees. Like on a pretty daily basis…I don't want to just like, come out this, like the other side of this whole thing and be like, well that's done. Because like it's not done. I live in a different way, I interact with the world in a different way. Because of all this shit…like it doesn't really make sense for me to be like, I don't have a mental illness. Except I get triggered…That's like always there. That's always a part of me.

Quinn appears to find it non-sensical to accept that they have ongoing experiences of distress but deny that those experiences constitute a mental illness, which illustrates the extent to which they have internalized biomedical framings of distress. However, Quinn also points out

that they "interact with the world in a different way" based on their experiences and that non-normative way of moving through the world also appears to carry weight in terms of characterizing or constituting mental illness as they understand it. Quinn has not passively accepted that they have a mental illness simply or entirely because dominant biomedical discourse frames their distress as an illness. They have instead combined psychiatric definitions with their subjective knowledge and understandings of their experiences in choosing to define their distress as mental illness (Tucker, 2009).

Other participants attributed very different meanings to intermittent symptoms or periods of distress, which illustrates the extent to which "the materials that are used in the configuration of identities may share many commonalities, but the configurational acts themselves are highly personal" (Fisher & Freshwater, 2014, p. 202). For instance, Kelly rejects the notion that the discrete periods of distress they experience constitute a mental illness. Instead, they draw on the concept of being "predisposed" to mental illness to make sense of their experiences:

> If I had to identify, I'd probably [pause], identify as being predisposed. But not actively, like, constantly actively, having a mental illness. Because [pause]. It's sort of like [pause]. Nine times out of ten I don't. Except when I do.

Though Kelly's distress could be classified as a mental illness (and was when they received a diagnosis of MDD), Kelly has rejected a purely biomedical framing of their experiences in favour of a subjective understanding that both acknowledges and subtly pushes back against a biomedical reification of their experiences. Specifically, Kelly has not rejected the label of mental illness outright in that they do identify as predisposed to mental illness. They are also amenable to the diagnosis of MDD, partially because it helped them contextualize and

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understand their distress. However, they are not willing to accept the label of mental illness in its more totalizing sense or integrate their experiences of distress into their sense of self.

The contextual nature of meaning-making also becomes quite clear in Kelly's case in the sense that part of their rejection of the label of mental illness and desire to keep their distress separate from their subjectivity appears to be based in a comparison to others' experiences. Kelly stated that:

> "Like a lot of it is in comparison to, to my wife. Like whose struggle is basically constant every day [pause]. It's, like, if they have a mental illness what I have, is not the same scale you know. So."

Kelly's comment illustrates how they have come to understand to their experiences in a highly relational way. Specifically, Kelly has used their wife's experiences as opposed to clinical definitions as a reference point for what constitutes mental illness, ultimately drawing on both externally assigned and subjective knowledges to categorize and assign meaning to their distress.

Finally, other participants developed entirely unique ways of describing their experiences that avoided the label of mental illness altogether and positioned distress as separate from selfhood. For instance, when describing how he thinks about his experiences of emotional distress and how they relate to his subjectivity, Jesse, a bisexual transgender student, stated:

> I tend to call it my anxiety goblin and my depression goblin. But I really, am still working on like, not, holding on too tightly to the thoughts that they present me. I know that, they are, separate, like, they are within me but they are separate from *me* the person.

Jesse has clearly objectified his distress in a way that allows him to "represent it as something separate and alien from the self" (Ohlsson, 2016, p. 12.9). However, he has not done so in a way that resists the medicalization of his distress, as is evident in his use of anxiety and depression as

biomedical terms. Ultimately, Jesse seems to be willing to accept that his experiences constitute

a medicalized entity but is resistant to incorporating those experiences into his sense of self.

Concluding Thoughts

      Ohlsson (2016) notes that "mental illness presents two interrelated challenges to a person

that is tying to understand and make sense of their experiences and problems" (p. 12.4). The first

"concerns the abstract, subjective, and often elusive nature of mental phenomena" (Ohlsson,

2016, p. 12.4), or in other words, how to make sense of what mental illness is in an ontological

sense. The second challenge relates to the fact that mental illness "actualizes questions about self

and identity" (ibid.) and opens one up to stigma (Ottewell, 2018; Tucker, 2009). This chapter

addresses both of these dimensions. The findings outlined in this chapter suggest that the

majority of participants understood distress or mental illness primarily as a biomedical entity and

experience medication and diagnoses as reifying forces. However, this chapter also aims to

highlight the ways that processes of sense-making around mental illness are not fully determined

or constrained by the operation of biomedical discourse. Participants often combined psychiatric

and subjective knowledges in defining their experiences and were selective and intentional in the

ways that they took up the label of mental illness.

Chapter 5: Constitutive Barriers to Care

As outlined in chapter two of this thesis, SM-TGD persons may experience a variety of different barriers to accessing high-quality and affirming mental health care (McCullough et al., 2017; O'Shaughnessy & Speir, 2018). Some of these barriers are structural or institutional in nature, while others are informal and manifest in interpersonal interactions between SM-TGD people and the healthcare practitioners with whom they engage. Frequently encountering these barriers negatively impacts SM-TGD individuals' psychological well-being and can result in fewer health seeking behaviours (Quinn et al., 2015) or individuals forgoing care altogether (Dean et al., 2016; McCullough et al., 2017; Nadal et al., 2014). This chapter outlines several of the structural and interpersonal barriers commonly encountered by participants in this study and aims to demonstrate that these barriers are overlapping and constitutive.

This chapter first outlines the constitutive approach as advanced by Ewick and Silbey (1998) as a means of framing the relationship between the structural and interpersonal aspects of barriers to mental health care for SM-TGD people. Specifically, Ewick and Silbey (1998) argue that while social structures "appear to have an existence apart from their continuing production" (p.41), they are in fact an emergent feature of social relations. This concept helps shed light on the ways that formal or institutional barriers to affirming care may appear external to social practices but are instead constitutive of them. This chapter then discusses participants' experiences with formal barriers to care, including wait times, a lack of access to long-term therapy, and issues of service affordability, before turning to an exploration of participants' interpersonal engagements with healthcare practitioners. In doing so, this chapter aims to demonstrate that microaggressions or non-affirming interactions materialize as barriers to care in

their own right and also interact with structural barriers in ways that serve to intensify issues of access to care for SM-TGD persons.

Constitutive Theory

In describing a constitutive theory of law, Ewick and Silbey (1998) argue that "social structures, while they confront us as external and coercive, do not exist apart from collective actions and thoughts as we apply schemas to make sense of the world" (p.41). Social structures are both embedded in and an emergent feature of social relations, meaning that these structures are contingent upon and also serve to constrain social practices and individual actions (Ewick & Silbey, 1998; Mezey, 2006). Specifically, "the local and minute social practices that contribute to the making and remaking of the larger social structures…are in turn informed and constrained by the meanings and opportunities available to them by those very structures" (Mezey, 2006, p.152). Though social structures appear as reified and external, they are in fact an accumulation of small, repeated social actions and processes of individual and collective meaning-making (Mezey, 2006).

Though Ewick and Silbey (1998) and Mezey (2006) discuss constitutive relations specifically in the context of law, this approach to the relationship between structure and social action or interaction is applicable in other institutional contexts. For example, in theorizing the clinical encounter, medical sociologist Carl May (2007; 2011) has emphasized the importance of acknowledging the "flow of knowledge and practice from macro-level structures into locally formed encounters that take place in private time and space" (May, 2007, p.36). A constitutive approach then helps extend May's ideas about the relationship between the clinical encounter and the broader institution of medicine and illuminates the ways that these "locally formed encounters" aggregate to shape the institution by which they are also constrained (Mezey, 2006).

Structural Barriers to Care

The first structural barrier that was relevant to participants in this study was the length of wait times to access services. In line with general trends around typical wait times to access mental health services in Canada (CMHA, 2017), many participants reported that they waited upwards of six months to access community mental health services and up to a year to access a psychiatrist. Participants went through a variety of different channels to try to gain access to services, but the length of wait times did not vary significantly whether the participant personally reached out to community or university services, obtained a referral from their family doctor, or called the regional mental health and addictions services hotline and asked to be put on a waiting list.

Going without needed supports during those waiting periods can be very emotionally difficult (Barua & Ren, 2016; Leobach & Ayoubzadeh, 2017) and several participants in this study discussed feelings of stress and hopelessness related to being unable to access support services or practitioners for long periods of time. For example, Robyn described their experience of being in crisis and exploring every avenue available to them to in an effort to gain access to support. Robyn reached out to two community services as well as their local CMHA office to request a referral for counseling but was still unable to get the support they needed. Robyn stated that:

> I was working, but then like, I ended up having to like quit my job because like I couldn't function. It was really stressful, and I like I reached out to like, every mental health place I could possibly think of, and just like couldn't get help from anywhere. So, it was like, a difficult time that I think I'm still recovering from.

After eventually being able to access a counseling service but having non-affirming experiences with several counselors, Robyn described feeling as if there was no one who would have the skills to help them navigate their mental illness or who would be able to understand their specific experiences. They ultimately decided to give up on seeking formal supports altogether and have "figured out how to deal with it on [their] own".

While Robyn expressed feelings of hopelessness and resignation around their experiences with care services, other participants experienced frustration or anger related to their experiences trying to access supports. For instance, Blythe, who moved to Ontario from a smaller province, had expected that it would be easier to access practitioners and services in Kitchener-Waterloo than in her home province. Instead, she has struggled to access mental health supports or a family doctor and is very disenchanted with the local mental health system:

> I just, I think that you definitely know that healthcare, like access to mental health services here are just awful [laughs]. Truly, you know, just the stories I've heard from people and like my own experience. It's just so hard….it's just a sad, it's a very sad system to me.

Blythe has taken steps to manage her own mental health in the context of a "sad" local system which has proven inaccessible. Specifically, Blythe has kept various resources from previous treatment services and support groups and now refers back to those resources when she finds herself struggling with her mental health. While Blythe's resilience and creativity in this capacity are admirable, the fact that she has developed this strategy for managing her own mental health illustrates the extent to which her options for formal support are limited.

Further, and as mentioned, the wait times participants encountered to access services did not vary significantly based on context. For instance, though most universities now offer

dedicated mental health services to students and are increasingly being called upon to improve

the quality and accessibility of those services (Jaworska, De Somma, Fonseka, Heck, &

MacQueen, 2016), the majority of participants who were students at the time of the interviews

expressed frustrations around issues of access to university mental health or counselling services

that echoed those of non-student participants. This aligns with broader trends in the literature

which suggest that wait times remain a significant problem on university campuses as well as in

the community (Giamos et al., 2017; Jaworska et al., 2016). Some student participants in this

study were so frustrated and disillusioned with their university's support system that they did not

even begin the process of trying to access services after hearing about excessive wait times.

Similar to Blythe, several student participants who struggled to access on-campus

supports took individual action in an attempt to find alternative ways of protecting their mental

health. Specifically, several participants mentioned that their university's LGBTQ+ centre offers

peer counselling for SM-TGD students and can help fill in the gaps if primary university mental

health services are not readily available or well-suited to supporting SM-TGD students. Damien

was one such student who described their university's LGBTQ+ peer counseling service as a

helpful resource in light of a lack of other affirming support options. Damien stated:

> Just having someone, that knows what you're talking about. Just talking to you. While
>
> also kind of being trained, slightly. So, yeah, it sucks that there aren't, more and more
>
> obvious resources for, queer students. That really sucks. But there are ways around it.
>
> Even though there are not many. It is what it is, honestly [sighs]. So, might as well just
>
> figure out what you can do with it.

The literature on marginalized students' access to mental health supports indicates that it is quite

common for SM-TGD, racialized, and Indigenous students to access student-led groups or

centers if they do not have access to affirming formal campus services (Jaworska et al., 2016). However, it is important to note that access to this kind of workaround or informal option may also be limited in certain cases. For instance, Kelly was previously employed at the same university Damien attends and emphasized that access to care is an even more significant problem for university staff. Specifically, as a staff member, Kelly did not have access to on-campus mental health services and was also ineligible for peripheral or informal campus supports such as mental health research centres or LGBTQ+ centres.

A second structural barrier to adequate care that negatively impacted participants in this study was a lack of access to long-term services and associated issues with continuity of care. Specifically, several participants expressed frustration that some of the primary publicly funded counseling services in Kitchener-Waterloo only offer between eight and ten therapy sessions, after which, in Robyn's words, "they kind of want you out". A limited number of sessions with a counsellor made it difficult for participants to fully delve into the mental health or emotional issues they were experiencing, especially if those issues were grounded in trauma and necessitated an in-depth understanding of the participant's past experiences.

Additionally, several local community services offer drop in appointments that allow individuals to gain same-day or same-week access to supports, but participants in this study did not find this to be a useful solution to the issue of long wait times. For instance, Blythe found it difficult to establish trust and connection with counselors she did not see regularly. She stated:

> There are like free drop-in, groups but. It's just not, those weren't for me. I tried them. They just weren't. I have a really hard time, warming up, to somebody if I'm like, if I'm going to go to a drop-in therapy appointment. And talk to somebody one time. That doesn't work for me. Like I need to create, the good relationship with somebody. I need

it. I need them to like, understand my history. And, you know. I'm not looking for, just

one-time advice.

Blythe's comment highlights the importance of access to care that is both timely and ongoing in

order to facilitate trusting relationships between clients and counselors. Though Blythe did not

refer to her queer identity in discussing her preference for longer-term counseling, it is plausible

that this may be an especially salient concern for SM-TGD individuals who must trust that

counselors will be non-discriminatory as well as empathetic and competent (Alessi et al., 2019).

Some participants experienced issues around continuity of care even when they were able

to gain access to ongoing counselling. For example, Kelly described their annoyance when they

met with a certain counselor for an intake appointment during their undergraduate degree but

were then assigned a different counselor once their regular appointments began:

It was very frustrating for me to like go in for an intake meeting, with counselling

services, and like, I felt like I had a good connection with the intake person but that's not,

not allowed, and so. You, get booked off for like, another, meeting, like a month and a

half later.

Though Kelly was able to access university counselling that was not limited to a certain number

of sessions, having to see multiple different practitioners and wait several weeks in between

appointments resulted in them deciding not to access the service. Unsurprisingly, going without

the resources they needed negatively impacted Kelly's university experience. They described

themselves as "bouncing along at the bottom" and "toughing it out" as they tried to manage their

mental health without adequate support.

Financial constraints were a third structural barrier to care that was relevant to several

participants in this study. It also became evident that wait times, a lack of long-term options, and

issues of affordability are often interrelated. Specifically, psychologists or counsellors working in private practice may have shorter wait times, are often able to work with individuals for longer periods of time, and may in some cases be better equipped to provide affirming care (Baldwin et al., 2017; Israel et al., 2008). However, private counselling is also much more expensive than university or community-based services (ibid.). In the context of this study, participants who had non-affirming experiences with community services but did not have significant financial resources were left in a particularly damaging situation. For example, paying out-of-pocket for therapy seemed to be Kelly's only option for accessing affirming therapy after they had a negative experience with their subsidized counsellor. Unfortunately, accessing private counselling was not a feasible option for them:

> Like, at the time, like we weren't doing super well financially so I couldn't, straight up pay for, regular therapy. And I didn't fit any of the, the, boxes of like groups that have, extra funding for like, for, walk-ins and things like that, like… It was sort of like, I, it was a matter of like I don't know where to turn… That kind of thing, like it makes it really, difficult to balance and when you're in sort of that, that state, it's really hard to deal with that additional, level of complexity.

Kelly's experience is one example which clearly illustrates the inseparability of structural and interpersonal aspects of care for SM-TGD people. Specifically, Kelly's only option for affordable counselling was non-affirming, which, based on their lack of financial resources, left them in the position of having to cope with discrimination or forgo counselling altogether.

Carlos had a similar experience where issues of affordability and discrimination intertwined to leave him in a very difficult position. Carlos first described his experience of being referred to a practitioner whose fees he could only just afford:

So I asked my teacher, I – I told her I say look, I'm having this, this confusion in my mind. She says "oh go see a psychoanalyst, can you pay for it?" "No, I'm poor." "Okay but, talk to her, tell her I referred you." So, she gave me a nice price. I had to pay for it, was not easy but, it afford. And then, yea that's once a week, cause I could not afford more than this. But – but there – that's – it helped me a lot, a lot yea.

Despite benefitting from his relationship with this therapist, Carlos eventually found himself in the position of being unable to pay for her services outright. He had no option but to switch to a community-based service that was less expensive but that he also found less helpful, and where the first counsellor he was assigned was blatantly homophobic. Carlos's experience further illustrates the extent to which the structural and interpersonal are constitutive and experienced as inseparable. Like Kelly, Carlos was left in a position where formal and informal barriers overlapped in a way that reduced his options to either unaffordable care, non-affirming care, or no care at all.

The complex relationship between issues of affordability and institutionalized hetero- and gender normativity was also illustrated in several participants' experiences working with student practitioners at subsidized mental health services. Specifically, several participants found that while subsidized community mental health services are more affordable than private practitioners, they are also more likely to be staffed by less experienced psychology or social work practicum students. This added an additional level of complexity to the process of accessing high quality care in the sense that affordability once again came at the expense of affirming care. While participants were careful to acknowledge that practicum or placement students can be just as skilled as more experienced practitioners, several participants had non-

affirming experiences with students that further complicated the process of navigating barriers to accessing support.

For example, Robyn agreed to work with a placement student at a local community mental health service because they were tired of being on a waiting list and this was the first option presented to them. Unfortunately, they found that the student counselor did not have the knowledge or expertise to engage with Robyn's experience of abuse and sexual assault in the context of a non-heterosexual relationship. Robyn stated that:

> With that particular therapist like, she would slip up on my pronouns, and call me female. And then, my abuser, she would slip up and call them male. Because that's what she assumed… And I was like, she thinks that this is the way it happened. And it like, it really changes the whole dynamic. When you assume that like, one person is male and one person is female.

This miscategorization of Robyn's relationship is an example of a heteronormative microaggression that undermined Robyn's trust in their counselor and caused them emotional distress (Berke et al., 2016; Nadal, 2013). Though they were able to access the student practitioner in a relatively timely matter and through a subsidized service, Robyn eventually discontinued their relationship with the student based on her lack of knowledgeability around SM-TGD identities and experiences.

Robyn also encountered a second student counsellor who was not able to move beyond heteronormative frameworks for understanding certain topics. Specifically, Robyn found that another of their student counsellors did not understand the importance of friends as chosen or found family for many SM-TGD individuals who have strained relationships with their biological family (Hull & Ortyl, 2019). This limited the counsellor's ability to help Robyn

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work through issues they were having with their friends because the counsellor did not attribute the same weight to those relationships as Robyn did. As Robyn put it, "[she] didn't understand. That these were my only family." As mentioned, Robyn eventually decided to forgo counseling altogether after having these experiences. This is a well-documented response to consistent experiences of non-affirming care (Dean et al., 2016; McCullough et al., 2017; Nadal et al., 2014) and clearly illustrates the negative impact of institutional heteronormativity on SM-TGD persons' emotional well-being.

Finally, the process of navigating forms, assessments, or questionnaires that did not include options for preferred names and pronouns posed an additional formal barrier for some participants in this study, and especially those who identified as TGD. Authors have pointed to the relevance of non-inclusive forms as manifestations institutionalized hetero- and gender normativity (Berke et al., 2016; Dean et al., 2016; Israel et al., 2008) and as key indicators SM-TGD persons assess in determining whether or not a service is likely to be affirming (Quinn et al., 2015). These were relevant considerations for some participants in this study who encountered forms that were tailored to cisgender people. For instance, in talking about filling out forms at one of their university mental health services, Damien stated:

> But, with those kinds of things it's always confusing because, I'm like, do I have to use my legal name, or, can I use my preferred name? … So, that's always confusing. And, it sucks. Because, sometimes like with those assessments specifically, there isn't anyone there, to ask…So yeah, that's frustrating. Because there isn't a space that's like, preferred name. It's just like, name. And I'm like, I don't know?

As Damien's experience illustrates, having to navigate institutionalized gender normativity

can be very frustrating for TGD individuals. Experiences such as this can further the emotional

distress that individuals seeking mental health supports are already facing and contribute to

feelings of discomfort and insecurity in healthcare settings (Quinn et al., 2015; Israel et al.,

2008).

The findings outlined so far point to a nuanced relationship between a marginalized

identity and the process of navigating structural or formal barriers to care. These findings also

demonstrate the relevance of micro-level interactions to the functioning of structural barriers in

the sense that SM-TGD individuals require care that is non-discriminatory *as well as* timely,

sufficiently long-term, and affordable. This adds an additional level of complexity to the process

of care-seeking and proved to be a stumbling block to accessing supports for a number of

participants. As will be discussed below, SM-TGD individuals also often experience

microaggressions or problematic interpersonal dynamics that materialize as constitutive elements

of barriers to care.

Interpersonal Barriers to Care

In addition to the structural barriers described above, SM-TGD individuals also

frequently experience microaggressions or problematic interpersonal interactions with healthcare

practitioners or staff members (Dean et al. 2016; Nadal et al., 2010; Shelton & Delgado-Romero,

2011; Nadal, 2013). Participants in this study experienced, or were concerned that they might

experience, a variety of different forms of discrimination in their engagements with service

providers. These experiences encompassed instances of blatant homophobic or transphobic

discrimination as well various microaggressions. These experiences often impacted participants'

decision-making around whether or not to disclose their sexual or gender identities and

sometimes led to them forgo care altogether. In this sense, these seemingly trivial or discrete experiences significantly undermined access to high quality care.

Discrimination

The literature indicates that in the present day, SM-TGD persons are more likely to experience microaggressions than explicit discrimination both in healthcare settings and in their daily lives (Nadal, 2013; Nadal et al., 2014). However, this is not to say that instances of blatant homo- or transphobic discrimination do not still occur. When it occurs in therapeutic contexts, discrimination tends to be very damaging and may impact SM-TGD individuals' willingness to access mental health support in the long term (McCullough et al., 2017; Quinn et al., 2015). Two participants in this study had such experiences of discrimination. Firstly, the most extreme instance of homophobia experienced by a participant in this study took place during a counselling session at a community mental health service. As mentioned earlier in this chapter, Carlos discontinued his sessions with a trusting and affirming counsellor when he could no longer afford her fees and instead sought subsidized therapy in the community. When he disclosed his gay identity during a meeting with a counsellor at the new service, the counsellor was blatantly homophobic:

> Well I got one guy and he was, he wanted to, to talk to me about, about Jesus Christ. I know, do you know Jesus Christ? It was, it was horrible [laughter]… Save my soul! That was Jesus Christ! Do you know? Have you heard of Jesus Christ – I have – so do you know he, he, he has got a plan for you? Scary [laughter]… not right after, but in, in the same session, [after] I say, I'm queer…Then I was scared.

Carlos was able to access a different, more affirming counsellor at the same service and laughs about the interaction now, but he has been wary of meeting new counsellors since this

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experience. This understandable mistrust and fear deterred Carlos from accessing mental health

services when he moved to a new city:

> Yea, I – think it's this um, ah, this, reject – not rejection – this fear … that guy [from the
>
> previous service], you know, that left me with, you know, I don't wanna see somebody
>
> that I don't know who he is. Or she is, or they are, I dunno. I don't wanna do that, so
>
> I'm afraid who is gonna be there...You know, so, so if I feel, I feel insecure.

At the time of the interview, Carlos had not yet accessed any local counselling services despite

his ongoing challenges with anxiety, which demonstrates the potentially longstanding negative

impacts of homophobic interactions with healthcare practitioners (McCullough et al., 2017;

Quinn et al., 2015).

Jesse was the second participant in this study who experienced marked, though much

subtler, discrimination. Specifically, Jesse encountered transphobia in his relationship with a

child psychiatrist. Though the psychiatrist did not make any overtly transphobic comments to

Jesse or his parents, she recommended a transphobic resource when Jesse brought up his gender

identity:

> So the later years of high school. I was, bringing forward to, the psychiatrist, like, hey.
>
> I've got these gender problems and I'd really like to parse them out. And, she, had
>
> seemed to want to refer me somewhere in Toronto, and my mom was investigating it.
>
> And she was like well, that's a conversion therapy thing. And I'm like oh. I don't think I
>
> trust this [laughs] psychiatrist anymore.

Similar to Carlos, this non-affirming experience fundamentally undermined Jesse's trust in his

psychiatrist (Dean et al., 2016), which impacted his willingness to continue to access mental

health supports. Jesse stopped seeing the child psychiatrist and did not access mental health

supports again for two years, even though he continued to experience challenges with low mood during his final high school years.

Microaggressions

In addition to the instances of discrimination outlined above, the vast majority of participants in this study experienced microaggressions in their interactions with mental health practitioners. Practitioners' incorrect use of names and pronouns was a particularly common experience among TGD participants, and one that often generated anxiety and mistrust (Nadal et al., 2010; Nadal et al., 2014). The incorrect use of names or pronouns serves to subtly invalidate TGD individuals' gender identities and also represents a refusal to respect a TGD person's identity in a much broader sense. Métis, trans, and queer social worker Kyle Shaughnessy (2016) very clearly articulates the broader implications of practitioners using SM-TGD people's preferred names in particular. He writes that healthcare practitioners using his correct name "feels like a signifier of respect…Although it seems very simple, having someone treat me as who I say I am…tells me that I will be safe enough accessing their services as support" (Shaughnessy, 2016, p.25). In this sense, being addressed by the correct name equates to being seen in one's entirety (ibid.), and this was certainly the case for some TGD participants in this study.

Unsurprisingly, misgendering or the use of an individual's legal as opposed to preferred name can further compound the emotional distress already experienced by individuals who are seeking support for mental health (Nadal et al., 2010; Nadal et al., 2014; Sheldon & Delgado-Romero, 2011). Consider, for example, Damien's experience. Damien experienced significant frustration about being greeted with confusion and blank looks when trying to use their preferred name to check in at their regular clinic, even after consistently informing staff that they do not go

by their legal name. They expressed frustration that staff were not listening to them and explained that this intensified the distress they were already experiencing:

> And, it's really frustrating when I go to university mental health services, to get help
>
> because I feel shitty, and then just having that extra like kind of like cherry on top.

Though staff at the counselling service Damien accesses were eventually able to address Damien using their preferred name, Damien has given up on advocating for the use of that name at the pharmacy where they regularly pick up their medication:

> So over there, I just use my dead name because I'm just like it's just easier. There's no
>
> point honestly. So, that's always a shitty experience.

Damien ultimately decided that being referred to by their dead name (a colloquial term for legal name) was preferable to continually having to navigate confusion and resistance on the part of pharmacy staff, despite the negative emotional impact associated with this choice. Such feelings of hopeless, exhaustion, and a desire to "pick one's battles" have been documented as a common emotional response among TGD persons who frequently encounter microaggressions (Nadal et al., 2014).

Aaron also described the moment of "oh no" that he experiences if he is misgendered while accessing a mental health service. For him, part of the anxiety around being misgendered is grounded in not knowing how to respond:

> I'm not strictly the best at correcting people. Cause of anxiety, like I just, I think it
>
> extends back to the whole feeling of not allowed, back in the first time I came out in my
>
> household, um, and just feeling like you're not allowed to be this, this is such a burden on
>
> other people, still carries with me, and if someone misjudges me it takes so much to
>
> actually be like, um, 'Actually..', cause I feel like such an, imposing on them.

TGD people who frequently encounter microaggressions often experience feelings of distress, anxiety, and being misunderstood such as Aaron has described, and want to appease others and avoid conflict in the face of microaggressions is also common (Nadal et al., 2014).

Damien and Aaron's experiences both illustrate the critical importance of healthcare practitioners and counselors using the correct names and pronouns when engaging with TGD individuals. However, and perhaps more importantly, these examples also demonstrate that in some cases, TGD individuals find accepting the invalidation of their gender identity more manageable than dealing with the emotional repercussions of pushing back against institutionalized gender normativity.

As mentioned briefly in chapter two, an additional microaggression that SM-TGD individuals may encounter when accessing mental health services is an unwanted focus on their sexual or gender identity, or practitioners who assume that those identities are the cause of emotional distress (O'Shaughnessy & Speir, 2018, McCullough et al., 2017). Though homosexuality and transgender identities are no longer institutionally pathologized via their inclusion in the DSM (Meyer, 2013; Zucker et al., 2013), societal hetero- and gender normativity continue to position heterosexuality and cisgender identities as the default against which SM-TGD identities are compared and deemed abnormal (Fisher, 2013; McCullough et al., 2017). Even healthcare practitioners who do not consciously consider SM-TNGC identities to be pathological may still assume that these identities are necessarily a source of distress and make that the focus of therapeutic interactions (Israel et al., 2008; Shelton & Delgado-Romero, 2011).

Though participants in this study did not encounter practitioners who pathologized or focused disproportionally on their identities (save Carlos and Jesse), many were either concerned that this could happen or expressed gratitude for practitioners they had worked with who did not

treat their identities as problematic and necessitating extensive discussion. Two TGD participants were particularly concerned about how their identities would be received by practitioners, which made them hesitant to disclose their identities in order to avoid an unwanted focus on their transness. This contrasted with SM participants, who were more likely to have disclosed their sexual identities and discussed their appreciation of practitioners who handled their disclosure in a casual and matter-of-fact manner.

For example, Quinn spoke the most extensively about their fears around disclosing their gender and sexual identity to therapists or counsellors. Quinn expressed several different concerns, the first being that practitioners would focus on their gender identity when Quinn wanted their experiences of trauma and anxiety to be the focus of the therapeutic relationship. They described themselves as articulate and very aware of what they want to achieve in therapy, and they were willing to hide significant parts of their identity and life from practitioners to ensure they would be able to work through the issues they wanted to focus on:

> Like for the purpose of this interaction I don't really need a gender. And, I can suspend that for like, so that I can try and, get the care that I need… Yeah, and I'm like it's better, if we can just breeze past this, and over it. And I'm just going to tell you, what you have to know, for us to talk about the situation, but I don't want to go to the place where it's like, "Tell me about your gender identity". Like *no*. Like that's not why I'm here.

A reluctance to disclose SM-TGD identity based on concerns about discrimination or to avoid an unwanted focus on identity has been well documented among SM-TGD people (Krehely, 2009; Quinn et al., 2015). Shaughnessy (2016) describes this as "leaving parts of who we are at the door" (p.25) and notes that having to doing so often has negative emotional repercussions and limits SM-TGD persons' ability to fully engage in therapeutic settings.

In addition to their concern that disclosing their trans identity would result in an unwanted focus on that identity in the context of therapy, Quinn also worried that they might need to defend their identity and relationships to practitioners if they were to disclose. This concern points to a fear that practitioners might pathologize Quinn's identity and assume that their emotional struggles could be attributed to that identity:

> [It] seems like a complicated thing that I would have to explain and, like. That I feel like I would have to defend, and. Then, and I the last thing that I want, is, for someone to, like, in a therapy environment…I don't want someone to be like, let's talk about your, identities. As if those are actually the problem. Like. I'm not going to be able to trust that person, if that's like the line of inquiry that they try and take.

Ultimately, Quinn stated that they were willing to be "whatever version of myself, that I have to [be]" in order to access care that would allow them to focus on their primary issues of anxiety and trauma and maintain a trusting relationship with their counsellor. Given that disclosure of sexual or gender identity is related to increased satisfaction with care and better physical and mental health outcomes (Baldwin et al., 2017; Dean et al., 2016), Quinn's decision to conceal parts of themselves in order to protect themselves from microaggressions or discrimination has important implications. Specifically, this is an example of how interpersonally enacted institutionalized hetero- and gender normativity (or fears thereof) manifests as an important barrier to mental health for TGD persons.

Quinn was not the only transgender participant who expressed these fears. Aaron also expressed worries about what would happen if he tried to seek counselling for mental health considerations that are not related to his trans identity:

I'm not sure like, what my experience, especially being trans would be, like I kind of, I'm always suspicious, of having to go in and be like, hi, uh, I'm trans, but that's not what I'm here for, let's focus on this.

Interestingly, neither Quinn nor Aaron described having previous experiences where practitioners had tried to focus on or pathologized their trans identities. Instead, it was an awareness of institutionalized gender normativity and the associated potential for discrimination that made them hesitant to disclose their trans identities. This illustrates how SM-TGD persons' own protective self-regulatory practices may materialize as a barrier to them receiving holistic care.

Of the participants who did disclose their sexual or gender identities to therapists or counsellors, the vast majority expressed an appreciation or preference for practitioners who did not have a strong reaction to their disclosure or try to shift the focus of therapy to the participant's identity. This is consistent with previous research that suggests SM-TGD individuals often prefer that healthcare practitioners respond to any disclosures in a neutral manner (Baldwin et al., 2017). For instance, Blythe was grateful that she and her therapist "didn't skip a beat" when Blythe disclosed her queer identity to the therapist. Aaron appreciated that his therapist "just totally got it" when Aaron told them that he wanted to discuss his mental health and not his transness, and Katie appreciated that her therapist treated Katie's breakup with her female partner just like any other break up and "didn't say anything stupid".

Katie also made a comment that illustrated the extent to which she did not take it as a guarantee that practitioners would react appropriately if she disclosed her identity by mentioning that that she was in a queer relationship:

I feel like, I'm still twenty-three, you've been out for a hundred years, and still I'm

floored when someone doesn't go like, "Oh, so you're gay! Like so you're seeing - " you

know, like they're just like "Okay, so you're gay", and we carry on.

Other participants expressed similar sentiments of surprise when they encountered practitioners

who did not reinforce the marginalization or difference of SM-TGD identities by attaching an

unwanted amount of significance to those identities or to participants' non-normative

relationships. These feelings of surprise and the expectation of discrimination which underlie

them illustrate the extent to which heteronormativity remains a significant problem in healthcare

settings.

A final microaggression that SM-TGD individuals often encounter in therapeutic contexts

and which impacted participants in this study is a lack of access to practitioners who are

experienced and knowledgeable in working with SM-TGD populations (McCullough et al.,

2017; O'Shaughnessy & Speir, 2018). This was relevant to many participants in this study,

though there was a great deal of nuance in how they individually experienced and navigated

around the issue. For some, practitioners' limited knowledgeability was a concrete issue that they

encountered, while for others, it was something they were concerned they might encounter and

tried to circumvent. The types of practitioner knowledgeability that individual participants

valued or desired also varied.

Firstly, some participants worried that the practitioners they engaged with would not have

an in-depth understanding of SM-TGD identities and lived experiences. Mirroring trends

documented in the literature, participants did not want to have to teach practitioners about the

specifics of minority identities, offer additional explanations about their personal identities, or

"coach" practitioners about "what it's like" to be a SM-TGD person or in a non-heterosexual

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relationship (McCullough et al., 2017). However, participants' concerns about practitioners' knowledgablilty were not necessarily grounded in their interactions with an individual practitioner but instead reflected a more general mistrust. For example, in talking about their therapist and why they chose not to disclose their trans identity, Quinn stated:

> Like she's never said anything like outright homophobic or transphobic. And I respect her, very much. And have been able to do great work in collaboration with her. But, I, just don't want to, have to, like, teach her, about, what anything means... I don't know, it was one of those like, not quite enough evidence to feel like I could just, fully lean into talking about, all of the different identities that I have.

This once again suggests that Quinn is very much aware of the broader institutional dynamics in which their interactions with individual practitioners are embedded, and that a lack of knowledgeability is one way that gender normativity may manifest in healthcare contexts (McCullough et al., 2017; Quinn et al., 2015).

Damien also chose not to discuss their gender identity with their therapist because they did not think the therapist had a very well-developed understanding of trans identities. Instead, as a means of protecting themselves from encountering microaggressions based in a lack of practitioner knowledgeability, Damien indicated that if they wanted to focus on their TGD identity they would seek out a specialized therapist:

> I heard about like, therapists that specialize in gender therapy. So, part of me is like, I need *that* if I want to talk about my gender identity. Not that the therapist I'm with isn't good. But he does not have those experiences, and he has not, studied that kind of stuff…So I haven't actually, felt comfortable, or thought it was like appropriate to like talk about, my gender identity, in depth with my therapist here.

Like Quinn, Damien spoke highly of their therapist and noted that he has been very helpful in other capacities. This suggests that a good and otherwise trusting relationship with a practitioner does not necessarily override SM-TGD persons' concerns about that practitioner's ability to provide affirming care.

Morgan employed a similar strategy to circumvent potential issues around practitioner knowledgeability and ensure that she received the type of therapy that was most helpful to her. Instead of choosing not to disclose or focus on certain aspects of her identity with practitioners based on concerns about their knowledgeability (or potential lack thereof), Morgan aimed to ensure that she would only be engaging with practitioners who have the appropriate expertise:

> And so I, when I learned more about, like consuming therapy, I had to, like ask very specifically I need narrative therapy, I need trauma-informed therapy, I need a family of origin therapist… LGBTQ friendly, like da da da da da… Because I know what to ask for, I feel like, I've weeded out some harmful people but I know that they exist.

Additionally, Morgan discontinued her sessions with one therapist very early on after feeling like "there was something off." This aligns with findings from other studies where authors have found that SM-TGD people may "read" practitioners and look for clues in behaviour or physical office space to determine whether or not a practitioner is likely to be affirming (eg. Baldwin et al., 2017). They may then "weed out" certain practitioners if indicators such as verbal cues, body language, or use of heteronormative language suggest that a practitioner is not necessarily accepting of or equipped to work with SM-TGD individuals (McCullough et al., 2017).

Discussion

Though this chapter has presented the structural and interpersonal barriers SM-TGD individuals often encounter in healthcare settings in two distinct sections, it has also aimed to

demonstrate the mutually constitutive relationship between these two dimensions. Formal barriers such as wait times or high costs may at first appear to be identity non-specific, but findings from this chapter illustrate that SM-TGD persons' need for care that is timely and affordable is complicated by the fact that that care must also be affirming. Further, microaggressions can undermine trust between SM-TGD persons and counselors (Berke et al., 2016; Dean et al., 2016), cause psychological and emotional harm (Nadal 2013; Nadal et al., 2014) and even contribute to individuals' decision to forgo seeking care altogether (McCullough et al., 2017). In this sense, microaggressions materialize as barriers to care which are just as impactful as formal barriers. Ultimately, conceptualizing the structural and interpersonal aspects of care as separate obscures the relationship between these elements and also makes it more difficult to see the ways that SM-TGD identity is relevant even in cases where barriers to care appear to be entirely identity non-specific.

Chapter 6: Discussion and Conclusion

Based on data from 12 unstructured interviews and grounded in a constructivist epistemology, this study explores the ways that SM-TGD individuals in southern Ontario understand their experiences of mental illness or emotional distress relative to biomedical discourse, and the relationship between those experiences and subjectivity. This study also discusses some of the barriers that SM-TGD people often encounter as they seek support for mental illness and aims to illustrate the mutually constitutive nature of formal and informal barriers in this context. This chapter begins by providing a summary of the study's findings in reference to the three research questions presented in the introduction, and then turns to a discussion of the broader insights these findings offer.

Summary of findings

This study aims to address the following three research questions:

1. *How do SM-TGD persons in southern Ontario relate to biomedicalized framings of mental illness in making sense of their experiences of distress and themselves?*

2. *How does SM-TGD identity feature in these processes?*

3. *What barriers do SM-TGD participants encounter when seeking affirming mental health care in their communities, and how do they perceive and navigate such barriers?*

Chapter four of this thesis addresses the first two research questions. Specifically, it describes how participants make sense of their experiences of distress in ways that integrate elements of dominant discourse as well subjective and contextualized understandings. This chapter illustrates that the majority of participants in this study understood mental illness to be a primarily

biomedical phenomenon. Even those participants who emphasized the role of social factors in contributing to mental illness did so in a way that linked the two via biological processes, and biomedical language featured prominently in most participants' accounts. These findings illustrate the degree to which biomedical discourse is hegemonic, even among SM-TGD individuals whose identities have historically been pathologized by psychiatry.

Chapter four also discusses the ways that participants' SM-TGD identities feature in processes of sense- and meaning-making as related to mental illness. In doing so, chapter four points to some of the contradictions embedded in participants' discussions of the relationship between their marginalized identities and experiences of distress. Specifically, many participants clearly articulated their belief that mental illness is a pressing concern in SM-TGD communities but considered their own sexual or gender identity and experiences of distress to be generally unrelated. However, many of those same participants also discussed the negative impact of homophobia, transphobia, microaggressions, or lack of familial acceptance and support on their mental health. This suggests that SM-TGD identity is perhaps more relevant to participants' experiences of mental illness than was explicitly acknowledged.

Finally, chapter four discusses the complex, fractured, and at times dilemmic nature of subjectivity as it relates to experiences of mental illness or emotional distress. This was particularly evident in the meaning and epistemic weight many participants assigned to psychiatric medications and diagnoses. Many participants who were prescribed medication or received an official diagnosis interpreted those events as a) objectively validating the severity of their distress, and b) reifying that distress as an illness. The defining authority that many participants granted medication and diagnosis often overshadowed participants' subjective understandings of their experiences but did not eclipse those understandings entirely.

In response to the third research question, chapter five then identifies multiple barriers to affirming care that were relevant to participants in this study. The majority of participants encountered formal or institutional barriers to care such as long wait times or issues around service affordability. Many participants also experienced microaggressions or discriminatory interpersonal interactions with service providers that, though informal, materialized as barriers to care that were just as impactful as (and further compounded) issues such as wait times. This illustrates the inseparability of the institutional and interpersonal dimensions of care and, as will be discussed below, provides insight into the ways that hetero- and gender normativity manifest in institutional contexts where inclusivity and non-discrimination are topics of increasing focus (DeBord et al., 2017).

Chapter five also discusses some of the ways that participants navigate these formal and informal barriers to affirming care. Findings from this study suggest that SM-TGD individuals are acutely aware of institutionalized hetero- and gender normativity and may engage in pre-emptive strategies to reduce the likelihood of experiencing microaggressions. In some cases, even participants who had never experienced discrimination in healthcare contexts were mistrustful of practitioners and tried to limit instances of potential discrimination. This often took the form of participants concealing their sexual or gender identities from practitioners or only discussing issues related to their SM-TGD identities with carefully selected practitioners. Given that concealing SM-TGD identity limits practitioners' ability to provide holistic and fully-informed care, findings from this study illustrate that individuals' self-protective strategies are themselves constitutive elements of barriers to quality care.

Together, these two analytical chapters offer an in-depth exploration of some of the ways that SM-TGD persons understand and experience mental illness and navigate local mental health

services. The remainder of this chapter discusses some of the broader implications of this study's findings, focusing on biomedical discourse as a hegemonic ideology and the ways that hetero- and gender normativity are institutionalized in the contemporary healthcare system. This chapter then concludes by characterizing SM-TGD individuals' experiences accessing mental health supports as a double bind.

Biomedical Discourse as Hegemonic

One of the things this study clearly illustrates is the degree to which biomedical discourse around mental illness is hegemonic. Coined in 1957 by Antonio Gramsci, the term *hegemony* refers to "the mainstream deployment and acceptance of ideologies that justify the inequities inherent in modern society" (Cook, 2008, p.384). Ways of living, thinking, and understanding that maintain and perpetuate existing social structures and benefit powerful groups come to be dominant and allow those in power to retain their dominant position through ideological means as opposed to force (Cook, 2008; Filc, 2004). Specifically, oppressed groups do not struggle against their oppression or challenge the current system because prevailing ideologies make it difficult or impossible to imagine a different social reality (Cook, 2008). Hegemonic ideologies operate though social systems and everyday communicative practices and pervade various levels of social reality, including institutions, culture, private life, and value systems (Cook, 2008; Filc, 2004).

Biomedicine currently exists as a hegemonic ideology that serves to individualize, desocialize, and depoliticize disease (Filc, 2004; Lupton, 1997; Zola, 1972). Specifically, biomedical discourse renders invisible the socially constructed nature of scientific data and research practices (statistical analyses, epidemiology, etiology, etc.) and instead presents the "facts" derived through medical science as objective, asocial, atheoretical, and morally neutral

(ibid.). Signs and symptoms of disease are similarly reified as objectively existing, which obscures the social processes inherent to the ways that diseases are studied, categorized, and treated (Filc, 2004). These processes of reification and objectification also "deflect questions of social inequality into the realm of illness and disease" (Lupton, 1997, p. 96) and present individualized medical interventions as the appropriate treatment for illnesses that may be based in or exacerbated by marginalization (Lupton, 1997; Zola, 1972).

Findings from this study illustrate the hegemonic and incredibly pervasive nature of biomedical discourse in the context of SM-TGD persons' understandings of mental illness. Biomedical language and concepts infused the vast majority of participants' accounts of their experiences, and of particular interest is that even participants' practices of discursive negotiation or resistance to biomedical categorizations typically evidenced some degree of acceptance of biomedical knowledge. This finding is perhaps especially striking given the population this study focuses on. As mentioned in chapter four, I had anticipated that SM-TGD persons would be particularly critical of biomedical approaches to mental illness based on the historical pathologization of SM-TGD individuals by psychiatry and my understanding of queerness as a politicized identity. The extent to which biomedical discourse permeated participants' accounts, even as those accounts evidenced considerable agency and resistance, clearly illustrates biomedicine's status as a hegemonic set of knowledges.

Hegemonic understandings of mental illness as a biological and asocial phenomenon that should be dealt with through the institution of psychiatry also has implications in terms of social control. Medical sociologists have long pointed to medicine's function as an institution of social control that has "[nudged] aside, if not [incorporated], the more traditional institutions of religion and law" (Zola, 1972, p.487). This is accomplished in part through medicalization, or a

sociocultural process that involves "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it" (Conrad, 1992, p.211). The process of medicalization facilitates social control in that it grants medicine the authority to define, surveil, and act upon certain behaviours and individuals (Conrad, 1992).

Mental illness is one example of a set of experiences that have been medicalized, which in turn grants the professions of psychiatry and psychology an incredible amount of typically invisibilized power (Turner, 1997; Zola, 1972). The DSM and the diagnostic categories it institutionalizes become "a tool through which a hegemonic worldview is imposed" (Burstow, 2005, p.435), and medical professionals retain the power to define what is normal or abnormal, healthy or disordered (LaFrance & McKenzie-Mohr, 2013). Specifically, scientific and professional knowledges "[establish] normative standards for bodily performance and presentation" (Henderson, 2015, p.325) against which individuals can be compared, judged, and measured. Those who fail to meet normative standards can then be managed and disciplined (ibid.). However, this is done in the name of optimizing health as a moral good, which makes it difficult to see the way that the mental health professions function as a potent form of social control (LaFrance & McKenzie-Mohr, 2013).

While these considerations are certainly relevant to this study, perhaps especially given that sexual and gender differences have also been subject to normalization via medicalization (Turner, 1997; Zola, 1972), I instead chose to focus on "the ways the hegemonic medical discourses are variously taken up, negotiated, or transformed" (Lupton, 1997, p.95) at the individual level. Authors such as Deborah Lupton (1997) have criticized analyses of social control via medicalization as insufficiently attentive to agency and resistance, and Lupton also

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notes that medicine can also have positive impacts on individuals' lives by reducing pain and suffering. Participants in this study did not discuss feelings of coercion or constraint in the context of their engagements with the mental health system, and many emphasized that psychiatric medications and mental health professionals have at times played a positive role in their lives. In instances when this was not the case, participants took action to seek out more affirming care or withdrew from the mental health supports entirely. Participants' agency was not "crushed beneath the might of the medical profession" (Lupton, 1997, p.97), and participants engaged with biomedical discourse in ways were at times critical and left room for subjective as well as hegemonic understandings of experiences. For these reasons, I chose not to focus on the regulatory implications of this study's findings.

Compulsory vs Normative Heterosexuality

Findings from this study also provide important insight into the nature of contemporary institutional hetero- and gender normative dynamics in the context of mental health services. Specifically, findings from this study support the notion that the social order Adrienne Rich (1980) described as *compulsory heterosexuality* has been replaced by increasingly "nuanced patterns of institutionalized sexual-gender social hierarchy" (Seidman, 2009, p.26). Rich's original concept was extremely influential and framed heterosexuality as "an institution, or socially formed structural order of patterned sexual-gender divisions and hierarchies" (Seidman, 2009, p.18). Rich argued that compulsory heterosexuality was embedded in all levels of social life from the everyday to the ideological, and was enforced through social institutions, laws, and informal regulatory practices such as harassment or violence (Rich, 1980; Seidman, 2009).

While sexual and gender inequalities certainly still exist in contemporary institutional settings, these inequities have begun to take on different contours. Specifically, some authors

(eg. Fisher, 2013; Seidman, 2009) have argued that there has been a decline in compulsory heterosexuality since the 1990s and suggest that institutions are now characterized by *normative heterosexuality.* Normative heterosexuality is still a regulatory order or "structural element that positions bodies and selves into particular sexual hierarchies" (Fisher, 2013, p.502), but unlike compulsory heterosexuality, it can coexist with manifest institutional recognition and integration of SM-TGD people (Seidman, 2009). Heterosexuality remains the dominant and privileged sexual category against which other sexual identities are judged and deemed subordinate, but this occurs against the backdrop of fewer state-maintained systemic discriminatory or homophobic practices and increased cultural normalization of non-heterosexual identities (Fisher, 2013; Seidman, 2009).

The proliferation of research related to affirming physical and mental health care for SM-TGD persons (see O'Shaughnessy & Speir, 2018) and publication of various policy documents intended to improve the quality of care available to this population (see DeBord et al., 2017) are examples of the manifest inclusion of SM-TGD persons in the contemporary healthcare system. However, as this study illustrates, these (albeit important) efforts have not yet translated into the consistent provision of affirming care for SM-TGD individuals or the elimination of sexual and gender-based inequities in the context of healthcare. Participants in this study often encountered discrimination or received a lower standard of care based on their SM-TGD identities despite increasing institutional recognition of their unique needs, which arguably exemplifies a shift from compulsory to normative heterosexuality.

The Double Bind

Finally, I argue that findings from this study illustrate that mental health supports as they are currently structured often leave SM-TGD people in what feminist scholar Marilyn Frye

(1983) has described as a *double bind*. Frye (1983) argues that one of the most "characteristic and ubiquitous" (p.2) features of the world as it is experienced by oppressed or marginalized people is the double bind, or a situation where one's options are reduced to a very limited number, all of which "expose one to penalty, censure, or deprivation" (p.2). Specifically, Frye (1983) points to the interconnected nature of barriers that may at first appear distinct and relatively innocuous, but that are in fact part of a network of forces that is extremely confining. She writes that:

> the experience of oppressed people is that the living of one's life is confined and shaped by forces and barriers which are not accidental or occasional and hence avoidable, but are systematically related to each other in such a way as to catch one between them and restrict or penalize motion in any direction. (Frye, 1983, p.4)

The concept of the double bind is a useful way of framing some of the primary issues identified in this study. Dean et al. (2016) and Hutchinson, Thompson, and Cederbaum (2006) have both employed the concept of the double bind to discuss the position in which SM-TGD persons often find themselves when they have difficulty accessing affirming care. These authors discuss the double bind specifically in the context of disclosure, wherein SM-TGD people may feel forced to decide between a) disclosing their sexual or gender identities and risking discrimination, microaggressions, or awkward or uninformed reactions on the part of healthcare practitioners, or b) concealing their SM-TGD identity, which limits practitioners' abilities to understand and validate client's experiences and provide fully-informed and holistic care (Dean et al., 2016; Hutchinson et al., 2006; navidson, 2016). Findings from this study similarly suggest that decisions around disclosure can be characterized as a double bind situation, but also illustrate that this bind in many cases extends beyond questions of disclosure.

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Specifically, this study found that formal and informal barriers to affirming care place participants in a double bind where they must make decisions about the following key concerns: whether or not to disclose their sexual or gender identities; whether to continue to access non-affirming or low quality services, go back on a waiting list and try to gain access to potentially improved services, or pay out of pocket for an affirming service; and sometimes, whether forgoing treatment altogether is ultimately less damaging than continuing to access non-affirming or low-quality care. These tensions clearly illustrate extent to which formal and informal barriers to care are "systematically related" (Frye, 1983) or mutually constitutive (Ewick & Silbey, 1998; Mezey, 2006), and interact in a way that left many participants in this study with extremely limited options.

This study aims to offer an in-depth exploration of how SM-TGD participants understand and experience mental illness. It also highlights access to affirming care as a key issue of social justice for this population and identifies some of the barriers that currently stand in the way of improved access to care. I have aimed to center participants' voices in this thesis and to that end, I wish to conclude with a very articulate quotation from Morgan which encapsulates some of this study's main intentions and findings. In Morgan's words:

> Yeah, I want to believe that, anything that's produced, and maybe published, that has, *queer*, [laughs] *LTBGQ*, adds a Google search. Adds, you know, a bulky thing to a shelf somewhere. It basically means like we exist. We have needs. They are specific, they are not specific. Right? Decency, humanity, authenticity, it's not specific. Do your research, don't expect us to educate you. You know, be professional. Be thorough…anything, to, strengthen the research that's out there is worth my time, and I'm glad it's worth your time.

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Project Title: At the Intersection of Queer Identity and Mental Illness

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Hi there! You are invited to participate in a research study being conducted by Bridget Livingstone, a queer Master's student in the Department of Sociology and Legal Studies at the University of Waterloo. The objective of the study is to better understand how queer people who have experienced mental illness or challenges related to mental health understand their experiences and pursue treatment or support. The study's results will be used to develop translatable knowledge about queer individuals' mental health experiences and needs that may be used to improve local mental health services available to queer folks.

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If anything in the letter is unclear, please ask for clarification before consenting to participate. You will be provided with a copy of this information and consent form if you choose to participate in the study. Thank you for your time!

What is the study about?

It is well documented that queer-identified individuals in Canada experience disproportionately high rates of mental illness. Research also indicates that mental health services are rarely tailored to queer folks, which can lead to subtle forms discrimination as individuals navigate treatment for mental illness. However, little research has explored queer individuals' perceptions about mental illness, the issues they face in accessing adequate mental health services and supports, and the ways these considerations impact individuals' sense of self.

Therefore, the purpose of this research is to explore how queer Ontarians who identify as having experienced mental illness or challenges related to mental heath understand those experiences and pursue treatment or support. The researcher is particularly interested in the language queer individuals use to describe their experiences with mental illness or mental health challenges. The study will help generate knowledge about queer folks' unique mental health experiences and needs that is currently lacking.

If you decide to participate in the study, you will be asked to meet with the researcher for an interview. The data the researcher collects will form the basis of her Master's thesis, a summary to be provided to policy makers and healthcare organizations, and future academic publications. You are also welcome to receive a copy of the completed thesis if you would like.

Your responsibilities as a participant

Participation in the study is entirely voluntary. If you choose to participate in the study, you will be asked to meet with the researcher for an in-person interview at a quiet location of your choosing. The interview will likely last between 1 and 1.5 hours. You may decline to answer any of the questions the researcher asks, and you will be welcome to guide the interview conversation in the direction that feels best for you.

The researcher also identifies as queer and has a mental illness, and she aims to be an empathetic and non-judgemental listener. You may stop the interview or withdraw from the study by informing the researcher at any time, with no negative consequences. With your permission, the interview will be audio-recorded and later transcribed to facilitate data analysis. If you agree, the researcher would also appreciate your feedback as a part of data analysis. You would be provided with the researcher's developing findings and invited to point out any inaccuracies, request clarification, and make suggestions. You may decline to participate in this extra step if you wish.

Who may participate in the study?

You may participate in the study if you identify as queer and as having experienced mental illness or challenges, problems, or concerns related to mental health - whatever language you use to describe your experiences, you're welcome to participate. You do not need to have a formal diagnosis to participate, and you do not need to disclose your diagnosis if you do have one.

Will I receive anything for participating in the study?

You will receive a $50 gift card of your choosing (including Visa gift cards, which are basically the same as cash), as well as reimbursement for any transportation costs ($10 to cover bus fares or gas and parking costs, if applicable). The researcher wishes to thank you for your participation and recognize the time you dedicated to speaking with her. You will receive the gift card immediately after the interview, regardless of whether or not you complete the interview or agree to contribute to data analysis. Please note that the amount received is taxable, and it is your responsibility to report this among for income tax purposes.

What are the possible benefits of participation?

There are possible benefits to participating in this study. Firstly, participating in the interview gives you the opportunity to discuss your experiences with an attentive and non-judgemental listener who likely shares some of your experiences. This can be fulfilling or positive for some folks, as sometimes it can be difficult to share or process these experiences with others who do not share in them. Secondly, you will have the opportunity to contribute to the development of important knowledge that is relevant to your community. It can sometimes be difficult to find platforms where your voice and opinions are taken into consideration.

What are the risks associated with participation?

There are also emotional risks associated with participation in this study. The researcher understands that talking about difficult experiences can be distressing or triggering. Please note that the researcher is not a clinician or mental health worker and is not able to offer treatment or counselling for mental health concerns. However, she has undergone training that will help her to respond calmly and empathetically should you experience distress, and she will also provide you with a list of community mental health supports that you may access if you require support.

Will my information be kept confidential?

The researcher is committed to ensuring your anonymity and confidentiality to the best of her ability. Your identity will be kept confidential. The only exception to confidentiality is if the researcher suspects child abuse/neglect or that you or others are in imminent danger of harm. Your name will not be mentioned in the thesis, and any information that might identify you will be removed. You may consent to the inclusion of anonymous quotations in the thesis if you wish. Additionally, all audio files, transcripts, and consent forms will be kept in a secure location. Only the researcher will have access to this information, and it will be kept for a minimum of 7 years.

For all other questions or to discuss any concerns, please feel free to contact the researcher by email at blivings@uwaterloo.ca. You may also contact her supervisor, Dr. Kate Henne, at khenne@uwaterloo.ca. This study is funded by the Social Sciences and Humanities Research Council of Canada (SSHRC) and has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #23216). If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

I would like to thank you for considering participating in this study!

Sincerely,

bridget Livingstone

Informed Consent to Participate in this Study

Title of study: At the Intersection of Queer identity and Mental Illness

Signing this form does not waive your legal rights or release the researcher or involved institutions from their legal and professional responsibilities.

I have read the information presented in the information letter about a study conducted by Bridget Livingstone, under the supervision of Dr. Kate Henne, from Department of Sociology and Legal Studies, University of Waterloo. I have had the opportunity to ask questions related to the study and have received satisfactory answers to my questions and any additional details.

I was informed that participation in the study is voluntary and that I can withdraw this consent by informing the researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# 99999). If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or oreceo@uwaterloo.ca.

For all other questions contact Bridget Livingstone at blivings@uwaterloo.ca.

	Consent and Privacy Options	**Yes**	**No**
1	I understand that I am voluntarily participating in this research, and that I can withdraw at any time.		
2	I agree to have my interview audio-recorded.		
3	I agree to the use of anonymous quotations in the thesis and any publications that come of this research.		
4	I would like to contribute my feedback as a part of data analysis.		
5	I would like to receive a copy of the summary of findings and thesis when they are completed.		

Participant's name _____

Date _____

Participant's signature _____

Researcher's signature _____   Date _____

Do you identify as queer? Do you also identify as having experienced a mental illness or a mental health problem, challenge, or concern?

Whatever language you use to describe your experiences, I would love to speak with you!

You are invited to participate in a study that aims to better understand the ways queer folks who have experienced challenges related to mental health understand those experiences and seek support. The study is being conducted by myself, Bridget Livingstone, a queer master's student at the University of Waterloo.

Participation would involve an in-person interview lasting between 1.5 and 2 hours, and you do not need to have a formal diagnosis to participate. Participants will receive $50 in appreciation of their time.

For more information about this study, please contact:

Bridget Livingstone
Department of Sociology and Legal Studies
University of waterloo
Email: blivings@uwaterloo.ca

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee.