STORIES FROM THE RAINBOW ROAD: 2SLGBTQIA+ Identified Youth and Service Provider Experiences of Mental Health Service Delivery in the Province of Newfoundland and Labrador

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STORIES FROM THE RAINBOW ROAD: 2SLGBTQIA+ Identified Youth and Service Provider Experiences of Mental Health Service Delivery in the Province of Newfoundland and Labrador

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DISSERTATION
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Kathleen M. de Jong © 2020
ABSTRACT

Stories from the Rainbow Road: 2SLGBTQIA+ Identified Youth and Service Provider Experiences of Mental Health Service Delivery in the Province of Newfoundland and Labrador

The purpose of this research project was to understand how publicly funded mental health service provision to 2SLGBTQIA+ identified youth in the Province of Newfoundland and Labrador (NL) is influenced by cis and heteronormativity. In a review of the associated literature, there is a notable focus on the barriers to mental health services experienced by queer and trans youth in general; however, there is very little information about the actual service delivery experiences of those youths who manage to access mental health supports and an even greater paucity of information that is specific to the province of NL.

This research project sought to “step into” these identified gaps to give 2SLGBTQIA+ identified youth in the province of NL the opportunity to share their stories of mental health service delivery concerning cis and heteronormativity. Similarly, to provide context for these experiences, mental health service providers were also included and asked to share their experiences of the mental health service delivery system concerning their work with queer and trans youth.

A total of ten 2SLGBTQIA+ identified youths and five service providers were recruited for this project. A triangulated research design was employed as follows: 1) fifteen narrative-based interviews were conducted with study participants regarding their respective service delivery experiences with regard to cis and heteronormativity; 2) four youths and two service providers participated in the development and production of a personal digital story which highlighted their mental health service delivery experience as a recipient and/or provider of the same; and 3) four youths took part in a storytelling circle where they shared their personal digital story with other storytelling circle participants.

The outcomes of this study are significant for several reasons. They are Newfoundland and Labrador specific. Their timing aligns with the provincial mandate to overhaul its addiction and mental health service delivery systems and they represent the actual voices of the queer and trans youth consumer and the voices of those who provide services. As such, this project seeks to make a local contribution and it provides timely and salient recommendations for the improvement of future mental health service delivery making it safe, inclusive and responsive to the needs of 2SLGBTQIA+ youth service users in the province of NL.

Key Words:

Heteronormativity; Cisnormativity; 2SLGBTQIA+ Identified Youth; Mental Health Service Providers; Mental Health Service Provision Experiences; Qualitative Research; Digital Storytelling; Newfoundland and Labrador.
ACKNOWLEDGEMENTS

It is impossible for me to find the words to express the depth of gratitude I feel for all of those who have supported me over the course of this Ph.D. journey. During this time, so many life changes have occurred. The constants through it all have been my family—including my chosen family and, to each of you, I owe a debt beyond compare. To Henry and Scott, you have held my feet to the ground (both literally and figuratively) and without each of you, I would have been unable to complete this journey. To Scott, I am so very proud of you and want you to know that this accomplishment pales by comparison—I will never accomplish anything greater than gifting you to this very fortunate world. To Nancy, Katie, Kurtis and Jenny (yes Jen, you made it into this acknowledgement), my life would be empty without each of you. Blood is not thicker than water—we are family in every sense of the word. I love you all more than words can convey.

To my chosen family Louise, Brent, Jen, Anna and Margarita, we’ve had each other’s backs for so long. You have grounded me, comforted me, and pushed me to continue. The quality of your clinical work and the commitment to the youths that you serve has inspired me—I am proud to have been your colleague and partner in crime and I love each of you very much. To Tetyana, you were there when I necessarily became undone, ugly, and threadbare. Piece by piece, you helped to sew me back together and I will always be grateful for your care, your comfort, and your craftsmanship.

Along the road of this academic journey, I have found friends, supporters and confidants. Beth Taylor, I simply would not be here without your invaluable support. You unselfishly gave me your time, your impeccable editing skills, and your feedback. You have become a friend, a colleague, and a sister; I love you very much. Heather, your support and push to get this done was so appreciated and very much needed. Thank you for being there when I needed you most! To Ona, my mentor and friend, you have enriched the heart and life of this settler in ways undeserved—I thank you for your companionship and guidance as I stumble forward on my reconciliation journey. Finally, to AmyAnne—your support of and interest in this project went far beyond your editing for APA compliance. I am grateful for your suggestions and encouragement and I look forward to the possibility of a collaboration in Labrador in the future.

To my committee members: Andrea, Eliana, and Kathy and to my chair, Shoshana—this has been a long road and you have been patient during its many twists and turns. I thank you for your support, your guidance, and your feedback. You are a group of strong, generous, and wise women and I will always be grateful for the role modelling and “womentorship” provided. It is my sincere hope to pay your generosity forward as I travel through the academy.

Finally, to those whom I have lost along the way. It is so very hard to close this chapter of my life because you were here with me when it began. While I trust that you are all in better places, I selfishly would like to have had you with me at the end. I miss and love each one of you very much and carry your presence with me in my heart.

“Real isn’t how you are made... it is something that happens to you. You become…” (Williams, 2003) And so, I am grateful that over the course of this project I have yet again been made all the more real, supported and enriched by each of you along the way.
DEDICATION

This dissertation paper is dedicated to those who participated in this research project. You unselfishly gave me your time and your trust, and you shared with me your wisdom. I thank each of you for all that you have offered, and I hope that I have honoured these contributions through the writing of this paper. The end of each journey represents the beginning of another. I look forward to working with you all to ensure that your experiences, perspectives and recommendations do not fall “on deaf ears”.

LAND ACKNOWLEDGMENT

I respectfully acknowledge the territory on which I completed this research project as the Ancestral Homelands of the Beothuk, and the island of Newfoundland, as the Ancestral Homelands of the Mi’kmaq and Beothuk. I also recognize the Inuit of Nunatsiavut and NunatuKavut and the Innu of Nitassinan, and their Ancestors, as the original peoples of Labrador. As a settler and a guest on these lands, I recognize my full complicity in the historical and ongoing legacy of colonization. Accordingly, I am committed to taking personal and collective responsibility by walking my own reconciliation path. As a resident of this province, a scholar and a settler educator at Memorial University I acknowledge that there is much to be done to address the injury that has and continues to impart violence upon the Indigenous peoples in Newfoundland and Labrador and across Canada. For my part, I am committed to allyship, to a process of learning and unlearning and to the decolonizing of my teaching, coursework and classroom space. I am similarly committed to supporting the Indigenization of Memorial University and to supporting all Indigenous-led efforts toward resurgence and self-determination.
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CHAPTER ONE

Stories from the Rainbow Road: 2SLGBTQIA+ Identified Youth and Service Provider Experiences of Mental Health Service Delivery in Newfoundland and Labrador

The Organization of this Dissertation

I have organized this dissertation paper into seven chapters including this one, which introduces the study and describes the background to this research project. This chapter explains how it evolved and it identifies the central research question. My social location and positionality are explicated in order to situate myself within this inquiry. Additionally, the rationale for undertaking this project and its pertinence to the Province of Newfoundland and Labrador (NL) is outlined. To maintain clarity and consistency throughout the paper, a section on terminology and a note on the use of pronouns have been included. In sum, this chapter serves to provide a platform from which the dissertation paper evolves.

In Chapter Two, an overview of the key theoretical and conceptual frameworks is presented, and the research project is placed within the relevant literature. The intent is to clarify the usefulness of the chosen theoretical lenses for analysis and to provide an introduction of the topic area to the reader. Additionally, this chapter will ground the research in what is already known about 2SLGBTQIA+ youth mental health service delivery and the respective experiences of youth service users and those who provide mental health services to these youths. Salient gaps in the literature are identified and additional literature review has been undertaken that is relevant to the specifics of this project. Accordingly, a section on the impact of settler colonialism in the province of NL has been included as a part of the theoretical and conceptual framework section. This is important as it serves to contextualize the related experiences of those participants who identified as Indigenous in the context of this study. Additionally, given the geography and demographics of NL (there are very few large urban centers), literature that elucidates the impact
of rurality on the experiences of queer persons has also been included as a pertinent conceptual framework. Finally, given the high proportion of trans youth participants, literature reflecting Transgender theory that explicates the unique experiences of trans folk has similarly been included in the conceptual and theoretical framework section in this chapter.

Chapter Three outlines the rationale for the methodological choices made and the research design employed. The chapter chronicles the various stages of the research process including the relocation of this study from Ontario to NL; the ethics review processes; the recruitment of participants; their respective demographics; the details of the interview processes; how interviews were transcribed; and the data analysis processes. Additionally, the production of digital stories and their use in the project is discussed, as well as how the story circle and its outcomes have been integrated into the data analysis process.

Chapter Four marks a space for a retrospective analysis of the research experience. In this chapter, I place my own experiences as a situated researcher in the context of the research process. I summarize relevant excerpts from my field journal, reflecting on the impact of each participant and the lessons personally learned from sitting with them and hearing their story. I also speak to the power of their collective digital stories and a link has been inserted into individual stories where appropriate so that the reader can hear and personally experience the digital stories produced. Finally, as applicable, I speak to the ethical dilemmas encountered while engaging in the research process.

In Chapter Five, the findings are presented. This chapter details the insights gained from listening to the stories of the youth and the service providers who were involved in this research project. The analyzed themes emerging from all aspects of the data analysis process (individual interviews, story circles) are presented and excerpts from the digital stories are incorporated to help support the findings. The integration of digital story sound bites makes possible the
inclusion of the lived experiences of the youth and providers in an unedited format that honours their stories and centers their wisdom. This was an important ethical imperative that was foundational to the research design.

A discussion of the research findings is undertaken in Chapter Six. To this end, pertinent outcomes are connected to the central research question guiding this dissertation. In doing so, an overview of the main themes that emerged from the findings chapter is presented and placed within the related literature. Following this overview, the findings are discussed as they relate to their implications for social work practice and pedagogy. I then bring forward recommendations based on these implications. Finally, I consider the limitations of this study and suggest areas for further research and potential social justice initiatives that may also be undertaken post-study.

In Chapter Seven, I highlight the project’s contribution to the potential betterment of the NL service delivery system and to the practice of social work with 2SLGBTQIA+ youth. I also address its contributions to the body of social work knowledge building on the existing literature. At the end of this chapter, this project is drawn to a close with concluding remarks and reflections.

**The Origins of this Project**

This research project evolved from the writing of my comprehensive paper (de Jong, 2014b). It was borne of an initial desire to uncover the impact that heteronormativity\(^1\) had on mental health service delivery to 2SLGBTQIA+\(^2\) youth and those who provide mental health services. As such, it was a move away from the highly theoretical application of post-structural theory to the process of recognition through Diagnostic and Statistical Manual (DSM) diagnosis (that was presented in my comprehensive paper), and a move toward grounding and centring my

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\(^1\) Please see terminology section at the end of this chapter for clarification of meaning and word use
\(^2\) Please see terminology section at the end of this chapter for clarification of meaning and word use.
research in the wisdom of participant lived experience. To this end, the focus of my work became hearing the service delivery stories of youth (n=10) who identified as 2SLGBTQIA+, and who were currently or had previously been recipients of mental health services in NL. This occurred in a three-fold process: youth participated in individual narrative-based interviews; were invited to participate in a digital storytelling workshop where they created their own story; and these stories were then shared in a storytelling circle. Additionally, to provide context for these experiences, a small sample of service providers (n=5) were also interviewed, with some creating digital stories about their own experiences of service delivery.

**The Research Journey**

This research journey began with great fury. In 2012, I was introduced to the work of Judith Butler (1993, 2004), and was immediately captivated. In an individual reading course, I sought to make a beginning application of a Butlerian lens to the process of mental health recognition through DSM diagnosis (de Jong, 2013). Intrigued by the outcomes and the possibilities that emerged from this paper, I ventured deeper into this topic area. In my comprehensive paper (de Jong, 2014b), I expanded my exploration beyond Butler to include those whose work had potential application: Giorgio Agamben (1995), Sarah Ahmed (2014), Eugene Levinas (1979) and Linda McDowell (1999). As a consequence of this examination, additional intersections were identified and drawn from key concepts presented by each selected thinker and their respective theoretical suppositions. In a further effort to broaden the scope of my exploration and to search for accompanying connections, the foundational tenants of queer theory, critical feminist geography, post-structural theory and the madness literature were similarly examined. There were indeed great synergies between all selected materials and what emerged was an integration of the literature that yielded a cogent web of connections. Hence, the key theoretical concepts identified, and the associations drawn from the theories examined were
succinctly mapped onto the various aspects of the process of mental health recognition through DSM diagnosis (de Jong, 2014b). In sum, my comprehensive paper was a broad examination focused on generic mental health without specific reference to 2SLGBTQIA+ folk. Accordingly, it became the place where this current study took root and an apt theoretical framework from which this study proceeds.

**The Research Question**

This study was guided by the question: “How does heteronormativity influence mental health service delivery and what is its impact on the experiences of 2SLGBTQIA+ youth and those who provide mental health services?” (de Jong, 2017). All study guides and prompts were developed, and interviews proceeded loosely based upon this question. While it certainly was the central driver of inquiry, it is important to note that as a function of time, the process of continuous learning and the operationalization of the research question through the interviews and digital story development processes the influence of other associated hegemonic discourses such as psychiatrization, settler colonialism, cis-normativity and rurality became central to the inquiry as well.

**Placing Myself in the Research Process: Socially Locating**

My place in this research space was fluid as I moved across multiple subject positions while participating in this project. I entered onto the land where my project was situated as a guest, a settler, and an ally. Specifically, I acknowledge Newfoundland and Labrador as the homelands and ancestral territories of the Beothuk, the Mi’kmaw, the Inuit, and the Innu. By virtue of my colonial heritage and as a settler educator in a western institution, I recognize my complicity in the historical and ongoing assimilation and eradication of Indigenous peoples and

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3 Please see Chapter Two for a detailed definition of settler colonialism
4 Please see terminology section at the end of this chapter for clarification of meaning and word use
5 Please see terminology section at the end of this chapter for clarification of meaning and word use
their ways of knowing and being across Canada. As a result, I have endeavoured to not replicate this same violence within this research project. To this end, I have abided by all relevant research protocols and sought to honour Indigenous wisdom and scholarship through its inclusion in this dissertation paper. Due to the recency of my relocation to the province of NL, I occupied an ekstatic space (Butler, 2004). Many assumptions were made by research participants (and providers) about the service delivery systems and concurrent user experiences in other parts of Canada. There was an overall sense that, somehow, things in NL were different due to the political and economic climate and the distance from the mainland. As a result, I was ironically positioned on the outside of my shared lived experiences as a service recipient due to my status as “CFA” (Come from Away) and having received mental health services elsewhere. As a Ph.D. candidate, a newly appointed faculty member at Memorial University, and a researcher, I came to this process with all of the attendant power and privilege(s) afforded me by these positions. Finally, I entered into this research as personally situated on various levels: as a queer-identified individual far from being dispassionate by multiple personal battles with hetero and cisnormative expectations; as one who brought a personal history of mental health service use and related experiences of the conflation of gender and sexual identity with mental health struggles; and as a former service provider and manager complicit in the invisibilizing, the pathologizing, the lack of safety and inclusion, and the oppression experienced by 2SLGBTQIA+ youth service users. To this end, I socially locate as a white settler ally of English/Irish descent. I am a queer-identified individual who is cis and hetero presenting/passing. I have used mental health services and have been epistemically violated, medicalized, and psychiatrized; but I do not identify as mad. I am well-educated, of upper middle income, and have stable employment and housing. I have

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6 I make this distinction to let the reader know that despite my personal experiences as a mental health service user, I do not participate or hold membership in the mad community/movement.
previously been employed in the mental health field for 22 years and recognize my complicity in the very things that I write about. In sum, I hold a high degree of undeserved power and privilege and seek to be reflexively self-aware of this as I navigate life, scholarship, and relationships.

The Study Rationale and It’s Importance for the Province of Newfoundland and Labrador

My personal and professional rationales for undertaking this research project have been articulated in part through my stated social location and positionality in this study. Practically, this study contributes to foregrounding the experiences of 2SLGBTQIA+ youth service users and mental health service providers in the research literature. As such, it offers a conduit to inform change for the future service experiences of 2SLGBTQIA+ youth in the province of NL. The completion of this inquiry opens the way for the inclusion of queer youth in community-based events and conferences, allowing them to share their stories of service delivery, making suggestions, and advocating for a system that works for all youth. The use of digital storytelling as an additional medium to impart participant wisdom and experiences further expands the possibility for social action, as these stories can be shared on multiple levels and with various parts of the service delivery system, including policymakers and funders.

From a scholarly perspective, research of this nature is scant, especially related to youth. In particular, the heteronormativity lens is unique. Additionally, there is a paucity of research regarding the social work practitioners’ own experience of heteronormativity and its discursive impact on their practice (please see Chapter Two for a more fulsome discussion of these points). This study contributes to social work knowledge in all of these areas. There is also a concomitant need for a shift in social work pedagogy and practice, which was confirmed through this research - a timely finding given the state of the mental health and addictions service delivery system in

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7 Please see terminology section at the end of this chapter for clarification of meaning and word use.
the province of NL, and the current government priority to fix what was effectively “broken” (poor accessibility, long wait times, gaps in service delivery etc.).

To this end, in 2015, the province of Newfoundland and Labrador established the all-party committee as the result of a private member’s motion that was passed unanimously in the House of Assembly. As a consequence, consultation regarding the state of the mental health and addictions service delivery system occurred across the province with service users, their families, service providers, and key stakeholders. Consultation also occurred through the invitation of expert presentations (All-Party Committee on Mental Health and Addictions, 2017).

Accordingly, a mental health and addictions strategy was launched in May of 2017 entitled “Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador”. The report outlines a five-year plan that makes fifty-four specific recommendations for a system overhaul. It is a comprehensive effort that addresses: promotion, prevention, and early intervention; access to services; quality of care; policy and programming; as well as community supports (p. 3). In relation to this study, three relevant recommendations have been made and fall under the purview of the government-appointed inclusion committee. It is important to note the specific inclusion of the LGBTQ2S acronym in the report, inferring recognition of the need to include the Indigenous and Two Spirit members of this community in the recommendations made. Accordingly, recommendation 40 identifies the need to “develop standards, policies and programs specifically to address mental health and addictions gender-based needs” (p. 9).

Recommendation 41 seeks to “provide general education to community leaders and policymakers, with a specific focus on LGBTQ2S youth, [to] increase understanding of sexual orientation, gender identity and mental health concerns” (p. 9). Recommendation 42 similarly mandates that the province “provide specialized training for people who work one on one with
LGBTQ2S individuals. This must include physicians, nurses, community and school-based psychologists, teachers, counsellors and social workers” (All-Party Committee on Mental Health and Addictions, 2017, p. 9).

This study will help to inform the fulfillment of these recommendations through the distribution of its findings and recommendations to the inclusion committee and their respective “leads”. Of importance to note is that, at the time of writing, a collaboration has been undertaken with government representatives and key community stakeholders to write a SSHRC community connections grant application for funding to begin the recommended educational processes.

There was one specific recommendation made regarding supporting Indigenous-led mental health initiatives that also connected to this study. Under the policy and programs section of the report, the third recommendation was “to support Indigenous people to achieve their mental wellness goals by providing resources to assist with sustained land base programming” (All-Party Committee on Mental Health and Addictions, 2017, p. 46). While not specific to Indigenous LGBTQIA+ or Two Spirit folk, and while not within the scope of this project to provide guidance on this recommendation, there is nevertheless support and endorsement of it through the literature review chapter of this paper.

Also relevant to this study is a report that was released in May of 2019 by the Provincial office of The Child and Youth advocate on the needs of trans youth in the province of NL (Office of the Child and Youth Advocate Special Report on Trans Youth in Newfoundland and Labrador; May, 2019). Among the recommendations put forward by the advocate’s office was recommendation 4, which entrusts various government departments and authorities with the responsibility to offer mandatory professional development and in-service training opportunities on gender diversity for professionals who work with children and youth (Office of the Child and Youth Advocate, 2019, p. 17).
There is a timeliness to this study and its findings. This research is undeniably pertinent and will help to inform these necessary systemic changes. Most importantly, though, is the fact that the recommendations made through the findings of this project represent the voices of queer and trans service users and those who have provided clinical mental health services to 2SLGBTQIA+ youth. These recommendations are highly valuable as they are specific to service delivery experiences in the province of NL and represent the views of urban and rural, Eastern, Central and Western 2SLGBTQIA+ NL youth service users and the providers interviewed for this study.

**Terminology, Word Use and a Note on Pronouns**

Three central concepts that are integral to this project will be defined. Firstly, for this research project, heteronormativity has been operationalized as the belief that: people fall into two genders (male and female), with naturally assigned gender roles; that being “straight” is the only “normal” sexual orientation; and that sexual relationships should happen between people of opposite sexes (de Jong, 2017). Secondly, cisnormativity is recognized as: “a cultural and societal bias, often unconscious, that privileges cisgender identities and gender norms, and ignores or underrepresents trans identities and/or gender non-conformity by assuming that all people are cisgender and will express their gender in a way that aligns with perceived gender norms” (EGALE, 2017, p. 12). Finally, rurality refers to living in an “other than” urban space and the concurrent influence that this can have upon an individual.

Also, of note is that the umbrella term 2SLGBTQIA+ (Two Spirit, lesbian, gay, bisexual, transgender, queer and questioning, intersex and asexual and all other sexual/gender identifications and expressions) has been used interchangeably with the term queer. Queer has been conventionally defined as:
a term used by some in LGBTQIA+ communities, particularly youth, as a symbol of pride and affirmation of diversity. This term makes space for the expression of a variety of identities outside of rigid categories associated with sex, gender or attraction. It can be used by a community to encompass a broad spectrum of identities related to sex, gender or attraction, or by an individual to reflect the interrelatedness of these aspects of their identity. Queer was historically a derogatory term for difference, used in particular to insult homosexuality and LGBTQIA+ people. Although sometimes still used as a slur, the term has been reclaimed by some members of LGBTQIA+ communities. (EGALE, 2017, p. 11)

Mulé (2015) challenges this conventional definition of queer by taking exception to its essentializing function - reducing the queer identity to standardized categories of sexuality, gender and gender expression. Instead, as a self-identified “politicized queer” (p.18) he reminds the reader that many who identify as queer do so for political reasons seeking to reclaim a term that was once considered derogatory, committed to queer activism and expressing their sense of marginalization within the conventional 2SLGBTQIA+ community. He states “queers are one such marginalized group. Although not fully agreed upon within queer communities queer is defined… as inclusive of non-normative sexual orientation and gender identities and expressions” (p.18). While not stated directly by any of the participants in this study, it is my sense that many of the youths would ascribe to this definition of queer. They were a young, progressive and politically motivated group who definitely felt “left of center” but remained hopeful that they could play a key part in moving the margins into the center.
The exception to the interchangeable use of these terms occurs when referring to an individual who has identified as having a particular sexual or gender identification or expression. In this case, their stated sexual or gender identification/expression will be used.

It is important to note that for this dissertation paper and in respect of inclusive language, all participants were asked to share pronouns and their stated pronouns have been used. In the case where gender identity and pronouns are unknown, gender-neutral language will be used and “they/them” pronouns employed. Given that the literature cited in this paper has largely been authored by individuals whose pronouns are unknown, the same principles have been applied when presenting their works.
CHAPTER TWO: LITERATURE REVIEW

The Theoretical and Conceptual Foundations of this Study

The following section will provide a succinct overview of each of the theoretical and conceptual frameworks associated with this study to highlight their respective relevance and usefulness in understanding and analyzing the research outcomes.

Queer Theory

Foundational to this examination, queer theory takes up the challenge of exposing the taken for granted lodged in hegemonic discourse. Greene (1996) describes the process of queering as shifting the lens through which we view, conceptualize and participate in the world. It implicates the heteronormativity embedded in most social theory and creates a space to critique the dominant ideas regarding subjectivity, power, and meaning. Watson (2005) notes that “most prominent queer theorists work to challenge and undercut any attempt to render identity singular, fixed or normal” (p. 74); hence, fundamental to queering is a disruption of binarized and essentialized thinking. Sedgwick (1990 as cited in Semp, 2011) highlights the “minoritizing view” of such thinking, pointing out its relevance to only a small portion of the population. In contrast to this narrowness, queer theory seeks to capture the experiences of all of those caught in the delimiting regime of heteronormativity and subsumed by the heterosexual matrix (Butler, 1990). As a result, a broader picture of the pervasive function of these categorizing processes emerges.

All youths who seek the support of mental health services, but especially queer youth, experience the impact of heteronormativity. The same can be said for mental health service providers. Many youths have been categorized numerous times over, epistemically violated they become recognized by only the labels that remain. Providers can become complicit in such processes without consciously being aware of their contribution. The roots of heteronormativity
sink deep into the bio-medical soil from which services emerge. This is evidenced by the hidden and taken for granted nature of this paradigm moving beyond theory to envelop the very foundation upon which services are structured and received in the day to day.

The intersection of queer theory with mental health service provision and the associated literature necessarily shapes the direction of this inquiry. At the heart of the criticisms launched in this area is much of what Judith Butler (1990, 1993, 2004) has exposed concerning the heteronormative regime associated with gender. Related scholars concern themselves with issues of: in/visibility; stigma (read discrimination) and heteronormative structures and processes. As established in my comprehensive paper there are direct theoretical applications of these issues to mental health service delivery. What emerges from this study is an examination of the very real-life consequences of this association and the related impacts on queer and trans service users and those who provide these services—thus confirming the utility of a queer analysis as the primary framework for this research project.

**Transgender Theory**

Emerging as a field of study in response to the perceived limitations of queer theory, transgender theory encompasses the unique experiences of trans folk (Nagoshi & Brzuzy, 2010). Judith Butler (1990, 1993, 2004) whose work is largely associated with post-structural and queer theory posits that gender is a social construction that exists only by virtue of performance. As such, Butler finds hope in the possibility of performing gender differently and in doing so, disrupting the narrowness of the socially constructed gender binary. Critics of Butler take exception to their and other post-structural feminists’ disregard for the materiality of such a performance. In other words, they believe that there are consequences attached to such performances in the “real” world. Transgender theory “picks up” these criticisms and exposes the oppressive reality of being trans in a cis dominated world. It highlights the hegemony of cis-
normativity, the intentionality of transphobia and the subsequent denial, invisibilizing and violence that is inflicted upon trans bodies (Pyne, 2015).

Defined earlier as “a cultural and societal bias, often unconscious, that privileges cisgender identities and gender norms, and ignores or underrepresents trans identities and/or gender diversity …” (EGALE, 2017, p. 12) cis-normativity, like heteronormativity, is a discourse and as such goes largely unchallenged in daily life. Reminiscent of Ahmed (2014)—when the world is set up to be a comfortable garment that fits only a select few bodies (read cis), those that it doesn’t fit become the “other” (p. 147). As a consequence, trans and gender non-conforming folk must navigate a world that defines them as “unnatural” and that renders them unintelligible, failing to recognize or to endorse the essence of their very being (Butler, 1990). The supremacy of the cis-normative discourse manifests itself in the materiality of transphobia. Transphobia is defined as “fear and/or hatred of any transgression of perceived gender norms, often exhibited by name-calling, bullying, exclusion, prejudice, discrimination or acts of violence” (EGALE, 2017, p. 12). The pervasive reality of transphobia is that it creates violence in virtually all aspects of the world. Even the most mundane of tasks such as using a washroom or being addressed with the proper name or pronouns creates opportunities for violence and denial. Also relative to the experiences of participants in this study, professional mental health spaces that are purported to be safe and helpful are similarly infiltrated by cisnormative ideology and transphobic acts. Sadly, these experiences make transgender theory a pertinent and relevant theoretical framework for this study.

**Psychiatrization**

“Psychiatrization is a process of diagnosing, and labelling [as] ‘mentally ill’, those people who are seen to have thoughts, feelings or behaviours that are outside of what is understood socially and culturally to be the norm” (Lefrançois, 2020). Central to the theoretical framework
of psychiatrization is the concept of sanism. Effectively, sanism is a mechanism that serves to “subjugate people who have received mental health diagnosis or treatment” (Rheume, Lefrançois & Menzies, 2013; p. 339). Mad Studies is an emerging field of scholarship (lead in Canada), that was born from the mad movement and that interrogates psychiatrization and sanism. The Mad movement represents myriad individuals and its scholarship is encompassed by those who identify as “mad”, psychiatric survivors, activists, academics, and allies. Many themes that are pertinent and relevant to this study emerge from the literature associated with psychiatrization: the sovereignty of the psychiatric regime; epistemic violence; the power of the DSM (2013) to “name and frame”; the racist and colonial roots of sanism and issues related to in/visibility (Burstow, 2013; Daley, 2013; Lefrançois, 2013; Lefrançois and Diamond, 2013; Meerai, Abdillahi, & Poole, 2016).

In a similar vein, the literature associated with mad studies discusses the relationship between psychiatrization and neoliberalism. This relationship is evidenced in discursive practices such as mental health literacy that does little more than reinforce the responsibility of the individual to “understand” mental health (as constructed through a bio-medical lens) and to seek out the necessary supports to ensure that they “measure up” to what is held up as “normal” (White and Pike, 2013). In placing the burden for ensuring “wellness “onto the individual, the associated responsibility for rectifying the societal factors creating mental distress is thereby removed from the state.

As a colonial structure, psychiatry has a historically violent relationship with 2SLGBTQIA+ communities. It has long served as a tool that regulates sexual and gender identity/expression via pathologizing and medicalizing queer and trans bodies. Over time, psychiatry has continued to garner critique from scholars who challenge its systemically racist,
sexist and homo and transphobic origins (Daley & Mulé, 2014; Meerai et al., 2016; Allan and Smylie, 2015).

The pre-eminence of the DSM manual, which seems to include and exclude queer people at will is the primary conflating mechanism for the psychiatrization of queerness (Mizok & Flemming, 2012). As a testament to the oppressive power of the psychiatric regime, at the time of writing trans folks still need to have psychiatrist approval to begin the process to transition and to have gender-confirming surgeries. All of the youth interviewed for this study identified these processes as life-saving. In stark contrast to this is the availability to the average Canadian of the same life-saving surgeries (mastectomy, hysterectomy etc.) and to hormones when medically warranted. In the province of NL, approval for health care providers to assess for gender-confirming surgery was just granted in November 2019. Before this, residents of the province would have to pay “out of pocket” to travel to Toronto for an assessment at The Centre for Addiction and Mental Health (CAMH). Beyond this expense were issues of extensive wait times, creating a backlog that was years long (Grant, 2017, April 17).

**Intersectionality**

At the heart of this study was a desire to hear the unique experiences of queer youth service participants and those who provide mental health services in the province of NL. The research design intentionally centred their respective voices through the use of digital storytelling, thus allowing for actual uncensored stories to be heard. The participants recruited for this study represented a multitude of intersecting subjectivities. Because intersectionality honours this reality, it was an overarching framework guiding this project. Taking a non-essentializing gaze, intersectionality finds its roots in the work of Black and Women of Color Feminist theory and is expounded in the foundational works of such scholars as Kimberlé Crenshaw (1991), Patricia Hill Collins (1986, 1989) and the Combahee River Collective (1979).
Together, this group of women influenced feminist scholarship and theory by critiquing white feminism for being only concerned with white, straight, middle-class issues. According to Crenshaw (1989), “the intersectional experience is greater than the sum of racism and sexism” (p. 140). Hence, intersectionality must be considered in order to understand the uniqueness’ of how vectors of power (Butler, 2004) intersect to create experiences of oppression.

Specific to social work research, Rossiter and Morrow (2011), challenge scholars to “take up” an intersectional lens. They identify a paucity of this type of research and practice particularly within the field of mental health. As a consequence, they purport that social work inquiry in this area is often limited to essentializing research that treats categories such as race and sexuality as static variables and represents individuals by broad group membership (Rossiter & Morrow, 2011, p. 316). An earnest effort to heed this call was made in the design of this study. Specifically, Rossiter and Morrow (2011) identify two outcomes of this paucity of research which were addressed in this research project: first, the emphasis on the bio-medical paradigm that decontextualizes persons from the context of their experiences was explicitly avoided (p. 311); and second, the lived experiences of the participants were not viewed as patterns and trajectories to be analyzed (p. 312). In sum, intersectionality was a key overarching framework for this research project ensuring that the uniqueness of participant stories was contextualized within the many and varied converging oppressions experienced by the participants who participated.

**Settler Colonialism**

Canada is a settler nation characterized by a settler state that continues in its legacy of assimilation and genocide of Indigenous people’s traditions and ways of knowing and being. The settler colonial lens is central to this study as it reflects the stark realities of all Indigenous participants interviewed. Battell, Lowman, and Barker (2015) examine settler colonialism and
argue that all forms of oppression rely on the violent, racialized and myth-based functions of settler colonialism. In their book “Settler Identity and Colonialism in 21st Century Canada”, they distinguish settler colonialism from other forms of the same. Grounding their position in the work of Lorenzo Veracini, they purport that “settler colonialism, along with large profits at the expense of human life, also generates an entirely new people—a settler society” (p. 14). The authors further argue that Canadian colonialism is particularly unlike other forms of “classical colonialism and the founding of overseas colonies because it is directed internally against an Indigenous population essentially captive within the borders of the state” (p. 14).

Battell et al. (2015) identify three key pillars that are inherent to settler colonialism, the first being that “invasion is a structure and not an event” (p. 14). As such, an invasion is not a once and for all occurrence but instead creates a pervasive and ongoing process holding those invaded subjects to its ongoing colonizing functions and structures (p. 15). Pillar two is represented by the reality that in Canada, “settlers come to stay”. In turn, settler claims-making activities occur in an attempt to create an unquestionable justification for occupancy, for ownership of the land and the right to sovereignty. In effect this process of erasure functions to eradicate Indigenous histories and to re-story the narrative, to begin with, the colonial conquests of Canada (p. 15). Similar to pillar two, pillar three purports that the “end goal of settler colonialism [is to] transcend colonialism” thereby eliminating Indigenous peoples and establishing the illusion of the settler society as “naturalized, normalized, unquestioned and unchallenged” (p. 16). Hence, “as Indigenous peoples are physically and conceptually displaced; settler society grows into the (perceived) open space created by their (perceived) absence” (p. 17). What also becomes hidden in this process is the legacy of theft, violence, subjugation, and elimination all of which get “whitewashed” and sanitized by notions of settler benevolence and charity (p. 16).
**Impact on Two Spirit Peoples.** Settler colonialism has had a particularly violent impact on Two Spirit people. It has effectively functioned to assimilate and erase Two Spirit identities through the introduction and enforcement of the western gender binary within Indigenous communities (Dakin, 2012). This occurred through the imposition of Christianity via residential schools, which served to condemn sexual and gender identities that were perceived as deviating from western, patriarchal, cis and heteronormative standards. Hence, Two-Spirit identity became conflated with sin and something that was deviant and undesirable (Cameron, 2005).

Historically, Two Spirit individuals held places of honour within their communities. They possessed the spirits of both male and female and were often healers, Elders and Knowledge Keepers. Overtime and as a function of colonization, Two Spirit individuals became less and less valued and were often driven out of community by the cis and heteronormative values and beliefs that overtook the traditional teachings and understandings of Indigenous peoples (Dakin, 2012). Also, as a function of colonization, Elders no longer passed down teachings about being Two Spirit with generations of individuals having no understanding or awareness of the history and/or existence of Two Spirit identity (Cameron, 2005).

Mi’kmaw Two Spirit Scholar, Margaret Robinson (2020) a member of the Lennox Island First Nation expands upon this discussion when they discuss the erasure of the unique Nation-specific gender identities represented within the umbrella term Two-Spirit. They assert that this erasure has largely been accomplished through the concomitant eradication of Indigenous languages via colonial mechanisms such as residential schools and the sixties scoop. They purport that in turn, these mechanisms have served to indoctrinate and assimilate Indigenous peoples into western heteronormative and homophobic categories for sexual and gender diversity by robbing them of language to know and describe themselves:
Speaking an Indigenous language supports Indigenous people in describing [their] gender in terms [that] Indigenous nations can recognize and accept. Having [their] languages eradicated undermines [this] ability... [And it prevents them from being able] to describe who [they] are to [them]selves and others, outside of colonial ways of knowing and doing (p. 1676).

Vowel (2016), agrees arguing that the use of the generic term Two Spirit “homogenizes distinct genders across Nations, and may overwrite terms such as agokwe⁸, undermining Indigenous language survival” (Robinson, 2020, p. 1678). Despite this drawback Robinson (2020) supports the use of the term Two Spirit and endorses its potential for decolonization and resurgence amongst Indigenous peoples. A recent example of such resurgence and the reclamation of the Indigenous language to define Two Spirit identity is found in the scholarship of John Sylliboy (2019). They are a Mi’kmaq Two Spirit scholar from the Eskasoni First Nation who conceptualized Two Spiritedness using a L’Nuwey⁹ worldview:

Two Spiritedness is an interrelatedness of its multi-forms of expressions, such as sexuality, gender, and spirituality in an individual’s identity within the four realms of physical, mental, emotional and spiritual, similar to how people are interrelated with other people and entities or spirits in a space or territory within an ecosystem... (p.103).

In a similar vein, the campaign and website “WE MATTER” was launched in an effort to increase the profile of Two Spirit youth across Canada (retrieved from: https://wemattercampaign.org/). The founders of “WE MATTER” provide Indigenous-led role modeling and resources including a number of digital stories/diaries and a tool kit that promotes the message that “I am amazing; you are amazing; we are amazing”. The intent of this campaign

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⁸ An Ojibway term meaning feminine male (Robinson 2020, p. 1676)
⁹ A Mi’kmaw (one who is part of the Mi’kmaq First Nation) worldview
and its website is to offer hope to Two Spirit youth and to help to decrease the colonization related disproportionate rates of suicidality and homelessness amongst Indigenous youth across Canada (retrieved from: https://wemattercampaign.org/).

**Settler Colonialism in the Province of Newfoundland and Labrador**

While it is clear that settler colonialism is a pervasive reality across the country of Canada, it is important to acknowledge that its impacts upon Indigenous peoples are distinct and reflect the unique culture and heritage of each Nation and group of Original People. To this end, and for the purposes of this paper, this section will provide context for the experiences of many Indigenous people across the province of NL.

Beginning with the contested eradication of the Beothuk (Robinson, 2014), settler colonialism has a long and dark legacy within the province of Newfoundland and Labrador. Presently, there are 7,200 Labrador Inuit (2,500 on land claim area; 4,700 off) that reside in the communities of Nain, Hopedale, Postville, Makkovik, and Rigolet. There is an additional 6,000 Nunatukavut Inuit that reside in the communities of Happy Valley-Goose Bay, Mud Lake, North West River, Cartwright, Paradise River, Black Tickle, Norman Bay, Charlottetown, Pinsent’s Arm, Williams Harbor, Port Hope, Simpson, St. Lewis, Mary Harbour, and Lodge Bay. Both of these groups speak Inuktutitut as their first language. 2,520 Innu First Nation Members, (2,300 on reserve; 220 off-reserve) reside in two Labrador communities: Mushuau Innu First Nation (in Natuashish), and Shetshatshiu Innu First Nation (in Shetshatshiu). Both Nations speak Innu-Aimun as their first language. On the Island of Newfoundland, 27,000 Mi’Kmaw First Nations members (850 on reserve, 26,150 off-reserve) reside in geographically distinct areas of the province. In the Western and Central regions members of the Qalipu First Nation reside in Benoit’s Cove, Corner Brook, Exploits, Flat Bay, Gander Bay, Glenwood, Port au Port, Stephenville, and St. Georges. In the East, members of the Miawpukek First Nation reside in
Conne River. Both Nations speak Mi’kmaq as their first language (The First Light Native Friendship Center of St. John’s, 2019).

The province of NL is relatively new to the country of Canada joining in 1949 by a slight margin of 52.3% agreement in a provincial referendum (Newfoundland and Labrador Heritage Web Site, 2020). Before confederation, the Indigenous peoples of the province were not subject to the Canadian Indian Act and upon joining Canada, the decision to extend its jurisdiction to the province of Newfoundland and Labrador was left unsettled. While for many this legislation was recognized as a tool of assimilation and control, there was nevertheless a sense of inequity with the rest of the Indigenous peoples across Canada (Mackenzie, 2010, p. 167).

The struggle for Indigenous recognition has been a long and arduous one. To date, “The Conne River Band [has been] recognized under the Indian Act in 1984; in 1997, an agreement was reached with the Innu and a federal order-in-council authorized the treatment of the Innu as if they were registered under the Indian Act. A broader land claims agreement-in-principle was signed in 2001. Work also continues on the land claim of the Labrador Métis”10 (Mackenzie, 2010, p. 166-167).

Perhaps there is no greater example of the continued colonial conquest in NL, than the ongoing plight of the Qalipu First Nation. In 2007, “after many years of negotiation and legal action, the federal government and the Federation of Newfoundland Indians negotiated an agreement for formal Indian status in a ‘landless’ claim that gives recognition and services to the majority of Newfoundland’s Mi’kmaq people” (Mackenzie, 2010, p. 167). The agreement-in-principle was ratified in 2008 by both parties. In September 2011, the Qalipu First Nations band was formed. As a landless band, “federal agencies [retained] the right to determine social and

10 The Labrador Métis are now known as the Southern Inuit of NunatuKavut. As of September 2019, they entered into a Memorandum of Understanding with the Canadian Government entitled Moving Forward on Self-Determination: MOU between Canada and the NunatuKavut Community Council
political orders and all rights to the lands and resources [were] forfeited” (Robinson, 2014, p. 383). “Adding insult to injury” was the flawed process for acquiring Qalipu status. Employing a points system to determine the worthiness of individuals residing outside of 13 designated areas, many Mi’kmaw community members were denied status (both those residing on the Island and those who live abroad) and claims continue to be processed and re-processed using this same faulty system (CBC, 2018). According to the same article “Applicants once included on a list of more than 23,000 affirmed, “founding members” of Newfoundland’s Mi’kmaw have been rejected for membership in Qalipu First Nation for failing to prove their connection to their culture through tangible documentation, among other reasons” (Meloney, 2018). The resultant outcome of this debauchery finds families divided, confused, and further eradicated from their birthrights and ancestral heritage.

Concerning this research project, settler colonialism emerged as a powerful variable in understanding the experiences of Indigenous participants (the specific of which will be expanded upon in chapters four, five, and six of this paper). While these experiences were many and varied, there was a common thread of colonial assimilation, removing all participants from their ancestral heritage and many from their right to status.

**Rurality**

In 2019, the population of the province of NL was 523,790 with the vast majority of people living on the most easterly point of the Island also known as the Avalon peninsula (World Population Review, 2020). Found on this peninsula, St. John’s is the capital city of NL and 202,000 people reside in its metropolitan area (World Population Review, 2020). Moving west across the Island, the major centers are found along the Trans-Canada Highway. Cumulatively, Clarenville (6,291), Gander (11,688), Grand Falls-Windsor (14,171) and Corner Brook (31,917) comprise an additional 64,067 people. Labrador, which is part of the mainland and lies just
northwest of the Island, has an estimated population of just under 30,000 people (Statistics Canada, 2016). Accordingly, approximately 227,723 people live in rural towns and remote outport communities scattered over and around the rest of the Island. These communities are varied reflecting the broad cultural heritage of the Island. They range in size with many of the smallest having undergone the process of resettlement (Power, 2019, April 19).

Literature reflecting the intersection of 2SLGBTQIA+ mental health service delivery experiences with rurality is scant (Brown, Rice, Rickwood, & Parker, 2016). There is literature that speaks to social work practice in rural settings which focuses on issues of confidentiality and dual roles (Brownlee, Halverson, & Chassie, 2012) as well as articles that explicate ethical dilemmas and practice issues for rural practitioners (Daley & Hickman, 2011; Waltman, & Waltman, 2011). Some literature even reflects the experiences of youth in rural areas of NL (Grills, 2015; Norman, Moss, & Power, 2015; Pearce, 2018) but is not specific to mental health service delivery. While the majority of the literature cited is written with a focus on the practitioner’s experience of working in a rural context (the exceptions being the NL specific literature), it is not difficult to extrapolate its findings to the client experience. Hence, just as practitioners need to contend with issues of dual relationships, confidentiality and proximity, clients must also deal with the same, creating a therapeutic environment rife with vulnerability. Pearce (2018), in their graduate thesis, explores the experience of being “Gay by the Bay”. “The Bay” is a NL reference for rurality and refers to anyone who does not live in an urban setting (known as a “Townie”). In their study, Pearce interviewed six youth residing on the west coast of the Island. Of relevance to this study is their finding that these youth had “difficult—often painful and traumatic—experiences” of growing up in rural Newfoundland (Pearce, 2018, p.ii). When considering the already precarious nature of seeking mental health services as a queer youth, this vulnerability becomes all the more heightened in rural communities that are hostile,
dangerous and that lack resources to support the 2SLGBTQIA+ community. The same is true for queer providers of services in rural spaces when a practitioner makes the choice not to be “out” in their community. Effectively, when working with a queer or trans youth, the service provider must assess the risk to self, versus the therapeutic benefit to the client of choosing to “out themselves” during service delivery. While this experience is not unique to rural spaces, I would suggest that the attendant negative consequences of making such a decision could be far greater for the rural practitioner.

Hulko (2015) identifies a gap in the literature noting that queer research has indeed expanded beyond urban settings to include the rural; however, the scholarship still lacks qualitative studies reflecting the experiences of queer youth (p. 194). Placing themselves squarely within this gap, Hulko (2015) proceeds to study the experiences of younger (16-24-year-old) lesbian and bisexual women and transgender youth in a small city and rural contexts. While this research project was situated in Western Canada it, nevertheless, has relevance to this inquiry. Through their research, Hulko (2015) identifies the experiences associated with being a queer youth in a smaller context. To this end, participants spoke of issues with safety and acceptance, places of support and resources and the importance of social media. Suggestions are made for future social work practice and policy-based upon the recommendations of participating youth. Specifically, there was an identified need for the creation of inclusive and safe educational settings through the organization of Gay Straight Alliances and a concomitant need for these groups and other related campus organizations to have the support of positive and affirming staff. In a similar vein, the youth interviewed also spoke to the need for role models and informed helping networks.

Clearly, rurality has a very real and meaningful impact on queer youth (especially those seeking mental health services) and also on the social workers who provide these services. Given
the demographics and the physical topography of the province of NL, more than 50% of the population occupies rural and remote places and given the demographics of my sample, rurality is an apt lens through which queer youth participant experiences come into focus.

Section Summary

In sum, the theoretical and conceptual foundations of this study emerged from my comprehensive paper (de Jong, 2014b), as well as from the interview and digital story making processes. To reiterate, queer theory has been chosen as the main theoretical framework given its relationship to my comprehensive work and the research question guiding this inquiry. Transgender theory also serves as a fitting backdrop for this research study. Given that 60% of the youth participating in this study identified as trans and gender non-conforming, its use provides an apt lens to understand the unique experiences of trans and gender non-conforming participants related to cisnormativity and its discursive foe, transphobia. A psychiatrization lens (emerging from my comprehensive paper) provides context for the situated experiences of those participants who have been “psychiatrized” due to their embodiment of non-conforming expressions of gender and sexual identity. Settler colonialism is a key framework for understanding the associated historical legacy in Canada that provides momentum for ongoing colonial violence (Battel et al., 2015). This ongoing assimilation, eradication and erasure of Indigenous people’s history, language, traditions and ways of knowing have distinct impacts on the lives of the Indigenous peoples across this country and similarly surfaced during this research process. An intersectional analysis of participant experiences is foundational to this study. The interlocking nature of the multiple oppressions experienced by the participants became apparent in this inquiry. Additionally, the impact of how these oppressions combined to influence, inform and impact individual youth and service providers became equally clear. As such, this lens respects the unique stories and experiences of research participants. Finally, rurality had a
definitive and decidedly meaningful impact on many of those interviewed for this study. This lens highlights the isolating function of this factor when taken together with the already precarious nature of occupying a queer or trans identity. Thus, rurality is a relevant and necessary framework for this analysis.

**Placing this Research Study within the Existing Literature**

The overall intent of this section of the literature review is to provide an appropriate context for my research project. Section one highlights the grim statistical relationship between growing up as a 2SLGBTQIA+ youth in a colonial “container” marked by cis and heteronormative standards, and the likelihood of experiencing mental health difficulties. This is important information as it is as much a message about the value of these young lives to society as it is about their ability to navigate an inhospitable world. It speaks to the distinctly colonial strategy of avoiding complicity or responsibility by medicalizing queer sexuality and trans identity and expressions and constructing each as a biological deficit within the youth that requires treatment. In effect, this serves to ignore, deny and invisibilize homophobic and transphobic structures that have created the issue and remove all burden of responsibility from the state.

The research literature associated with queer and trans youth often locates them within a problem/deficit framework. While the following information is important, it is also acknowledged that this is not the whole story as it lacks reference to the resilience, the strength and the ingenuity that queer and trans youth exhibit. Similarly, it erases the intersectional experiences of the multiple oppressions that they endure.

**2SLGBTQIA+ Youth and Mental Health**

Historically, queer sexuality and trans identities(expressions have been conflated with mental health experiences. Due to the efforts of gay liberation activists, the American Psychiatric
Association removed homosexuality as a mental disorder from the DSM in 1973 and the World Health Organization did likewise in 1990. Since then however, some skepticism has been present within the 2SLGBTQIA+ community about the actual meaninglessness of this removal. While hailed as a pivotal victory by some, others viewed this move more cynically disavowing the power of the psychiatric profession to have pathologized and categorized homosexuality in the first place (Lewis, 2016). It was argued that the psychiatric profession merely reasserted its power through the declassifying of homosexuality and in doing so re-established its authority to continue to determine what is normal versus aberrant sexuality and gender (Lewis, 2016). To date, gender dysphoria remains in the latest iteration of the DSM (2013) and significant discrimination toward gender and sexually non-conforming folk continues (Rainbow Health Ontario, 2015, p.1).

Through my comprehensive examination and the studies leading up to it (de Jong, 2013, 2014a, 2014b) the heteronormative categorizing function of the DSM was explicated. I noted how it was akin to Butler’s (1990) “heterosexual matrix” in so much as it served to place individuals into narrow, fixed, and stable categories of psychiatric recognition. Fundamental to these categories is the assumption of a “relationship of coherence between sex, gender, and sexuality… largely reflective of the norms and values associated with dominant groups” (Daley & Mulé, 2014, p. 1292). Given these assumptions, Daley and Mulé posit that there is a high risk for “damage done to individuals who are more fluid and non-traditional in their gender and sexual expressions” (p. 1292). Further, they contend that this causes these individuals to become stigmatized as the system labels and pathologizes them rather than offering understanding and support (Daley & Mulé, 2014, p. 1307). As a result of this reality, queer and trans youth are subject to dire consequences.
According to CAMH, “LGBTQ youth face approximately 14 times the risk of suicide and substance abuse [as compared to their] heterosexual peers” (Canadian Mental Health Association, n.d.). What is more, LGBTQIA+ youth are at higher risk for homelessness (Saewyc et. al, 2017), poverty (Ross et. al, 2018), school-based bullying (Marx & Kettrey, 2016) and poorer academic and health outcomes (Elliot et. al., 2014; Hoffman, Freeman & Swan, 2009; Marx & Kettrey, 2016) than their heterosexual and cisgender counterparts.

There is an extensive body of literature that addresses 2SLGBTQIA+ youth homelessness (Abramovich, 2012; Dunne, Prendergast, & Telford, 2002; Durso & Gates, 2012; Ray 2006 as cited in Abramovich, 2016). In their article entitled: “Preventing, Reducing and Ending LGBTQ2S Youth Homelessness: The Need for Targeted Strategies”, Alex Abramovich (2016) discusses the connection between coming out as a member of the 2SLGBTQIA+ communities and the likelihood of homelessness. They posit that “family rejection, inadequate social services, and discrimination in housing, employment, and education, [are the primary issues that] result in situations where LGBTQ2S youth are unable to secure safe and affirming places to live” (Abramovich, 2016, p. 87). Grant et al. (2011) add that “transgender youth, especially young transgender women of colour, are amongst the most discriminated against groups of people in housing programs and shelters” (p. 8).

With specific reference to transgender youth, the incidence of poor mental health becomes even graver. For instance, 77% of transgender respondents in an Ontario-based survey had seriously considered suicide and 45% had attempted suicide (Canadian Mental Health Association, n.d.). An online Canada-wide survey conducted with 923 trans youths between the ages of 14-25 revealed similar results and showed that “the mental health disparities [associated with the trans youth participants] were considerable [and] more extreme than the disparities faced by lesbian, gay, and bisexual youth in Canada” (Veale et al., 2016, p. 46).
Within the context of this study, a recent NL study conducted by Trans Support NL (2018) found that among youth participants, nine in ten reported suffering from depression and/or anxiety” (Temple-Newhook, Benson, Bridger, Crowther, & Sinnott, 2018, p. 23). Other studies substantiate these realities (Fergusson, Horwood, & Beautrai, 1999; Hadland, Baligh, & Harvey, 2016; Lucassen, Stasiak, Samra, Frampton, & Merry, 2017; Russel & Fish, 2016). King et al. (2008) (as cited in Craig, Austin & Alessi, 2012) report that, statistically, queer youth are “at higher risk for mood, anxiety, and substance abuse disorders than youth who identify as heterosexual” (p. 258). A quick reference of the Rainbow Health Network fact sheets on LGBTQ+ mental health (2015, 2016) confirms evidence of the same.

The rates regarding the prevalence of mental health disorders and suicide amongst queer and trans youth are astounding. They are a horrifying testament to how much distress the colonial regimes of hetero and cisnormativity wreak on the lives of those who are more fluid in their sexual and gender expressions and identities. In an attempt to contextual these statistics, Dr. Albina Veltman (2011) a Canadian psychiatrist provides a cogent synthesis of the daily realities facing Canadian 2SLGBTQIA+ youth. Veltman (2011) reports that: 70% of all high school students hear homophobic remarks every day in school with almost 10% of LGBTQIA+ students having heard homophobic comments from their teachers daily or weekly; more than 40% of queer students have experienced sexual harassment in school; three-quarters of LGBTQIA+ students and 95% of trans students feel unsafe at school (compared to 20% of heterosexual students), while approximately 28% of queer youth drop out of high school because of discomfort or fear in the school environment. Finally, 22-35% of homeless youth identify as 2SLGBTQIA+ with many of these youth having been kicked out of their home and/or not feeling safe at home. Given the daily level of hostility experienced by youth (as represented by these statistics), it is no wonder that the mental health of queer youths can be so very precarious.
With specific reference to Indigenous LGBTQIA+ and Two Spirit youth mental health, the realities are similarly bleak. Indigenous people have endured centuries of government violence to manage what was deemed by Duncan Campbell Scott as “the Indian problem” (Facing History and Ourselves, 2015). The resultant erasure and assimilation and the fall out of the attendant damage created by the Canadian government and inflicted upon Indigenous citizens were denied and blame was shifted back on to those who suffered the consequences. In contrast to this denial, a clear connection between the impacts of government-induced intergenerational colonial trauma and poor mental health is strongly made within the literature written by critical Indigenous scholars (Spear, 2014; Reeves and Stewart, 2014; Reeves and Stewart, 2017; Varley, 2016; Duran and Firehammer, 2017; Blackstock, 2019; Methot, 2019; Esquimaux, 2020). Most recently, Bombay, McQaid, Young et al. (2020) conducted a study which demonstrated that:

Adults with a parent who attended Indian Residential Schools were more likely to have spent time in foster care or in a group home during the Sixties Scoop era. They were also more likely to have grown up in a household in which someone used alcohol or other drugs, had a mental illness or a previous suicide attempt, had spent time in prison, had lower mean levels of general household stability, and tended to have lower household economic stability (p.62).

Attempts have been made by the Canadian government to repair damages done by centuries of colonial violence. For instance, the Royal Commission on Aboriginal peoples (RCAP), was established in 1991 shortly after the end of a standoff at Oka, Quebec. This standoff, also known as the Oka Crisis occurred between the Mohawk community of Kanesatake, the Sûreté du Québec, and the Canadian army (Spear, 2014). The intent of the RCAP was “to help restore justice to the relationship between Aboriginal and non-Aboriginal people in Canada, and to propose practical solutions to stubborn problems” (retrieved from:
https://www.cbc.ca/news/indigenous/20-year-anniversary-of-rcap-report-1.3469759). The commission’s final report consisted of five-volumes and it made numerous recommendations for: transforming relationships based on the principles of reconciliation, for addressing pressing social issues facing Aboriginal nations, for giving voice to the diverse perspectives across Aboriginal nations, and for the achievement of reconciliation (Institute on Governance [IOG], 2014). Also emerging from the recommendations of this report was the Truth and Reconciliation Commission (TRC). According to the IOG, the TRC:

was created with the mandate of informing all Canadians of the experience of the victims and survivors of Indian residential schools. Through a series of public events, including seven national dialogues, the Commission created a historical record of the policies and operations of the schools… used to create a public report documenting this important historical event, and to provide recommendations regarding reconciliation (p.7).

Despite the establishment of this commission in 2008 and their subsequent calls to action in 2015, little has been done to address the injury and the continued impact of historical and intergenerational trauma looms large for all Indigenous peoples across Canada (Duran and Firehammer, 2017; Mitchell, 2017; Reeves and Stewart, 2017).

Also, in response to the RCAP, the Aboriginal Healing Foundation (AHF) was established in 1998. According to the IOG (2014), AHF had a ten-year mandate to disburse government allocated funds to “victims affected by the legacy of physical, sexual, mental, cultural, and spiritual abuses in Indian residential schools” (p.25). They were also charged with the responsibility to “address unresolved trauma, achieve reconciliation in relationships, and enhance the capacity [of Aboriginal nations] to form meaningful, self-sustaining futures” (p.25). Accordingly, the foundation supplied funds that supported initiatives that supported these efforts.
In true fashion and as an example of the ongoing legacy of the colonial agenda, the Canadian government ended funding to the AHF in 2010 resulting in its closure in 2014. In doing so, the Canadian government effectively denied “that healing is an ongoing process and [that] shuttering the AHF… set a false end date on the healing process” (IOG, 2014; p.25).

The repercussions of the many injustices experienced, manifest themselves in myriad ways. The literature that specifically focuses on Indigenous LGBTQ IA+ and Two Spirit youth mental health is scant, and information tends to be a function of youth being a part of a larger study on queer youth with Indigenous LGTQIA+ and Two Spirit youth representing a small part of the sample (Logie & Lys, 2015). Nevertheless, issues discussed reflect concerns regarding an overall sense of invisibility in schools and healthcare, a need for flexibility in the ways that services are delivered, and the need to enhance the visibility of diverse people to combat feelings of isolation. Additionally, there is a caveat that stakeholders needed to better understand the unique needs of LGBTQIA+ Indigenous and Two Spirit youth.

On a broader level, the impact of settler colonialism on Indigenous youth and people, in general, is painfully apparent and is represented by statistics that indicate:

First Nations young people in Canada are more likely to become involved in gangs, to have higher rates of suicide than non-Indigenous youth, to be unemployed or underemployed, and to come into contact with the western justice system. They are less likely to complete high school or form long-term, healthy, intimate relationships. High rates of physical and sexual abuse against Indigenous women and children, high rates of unemployment, low rates of education, and disproportionate rates of conflict with the law are some of the common community dysfunctions which are inter-generational. (NAHO, November 2009, p. 62)
Continuing with the colonial agenda of assimilation, families are being torn apart with a disproportionate number of Indigenous children being brought into care and placed into non-Indigenous homes (Blackstock, 2006) and this despite government promises of Indigenous self-governance of child welfare systems (retrieved from: https://www.sacisc.gc.ca/eng/1507122976766/1533315997269 ). Statistically, there are disproportionate rates of homelessness and mental health and addictions issues and prisons continue to be occupied by disproportionate numbers of Indigenous inmates with relatively few wholistic healing centers available for rehabilitation (Waldram, 2008; Menzies, 2008).

Two-Spirit folk have been acutely affected by the colonial discourses surrounding sexuality and gender inflicting violence upon their lives, creating stigma and discrimination that results in rejection and dislocation from their traditional place of status and honour within their communities (Savage, 2020, January 8). Literature that discusses Two Spirit youth experiences in other contexts such as school classrooms confirms this reality (The Society for Safe and Caring Schools & Communities, 2011, p. 9). Further, it exposes the western propensity toward homophobia, biphobia and transphobia that is endemic to colonialism and how Indigenous 2SLGBTQIA+ youth suffer its effects resulting in a lack of safety and a concomitant increase in mental distress.

Overall and in relation to this study, settler colonialism has inflicted an injurious legacy upon Indigenous 2SLGBTQIA+ youth that continues to take its toll on their lives and their mental well-being. A more detailed examination of the impact of settler colonialism on the construction of Indigenous mental health and service provision to this population follows later in this chapter.

In sum, it is clear that generically, the distress experienced by 2SLGBTQIA+ youth is disproportionate to that experienced by their heterosexual counterparts. It is equally clear that
without culturally appropriate supportive and therapeutic services that are equipped to meet the needs of queer and trans youth, the outcomes are devastating. While it seems that there has been recent recognition by the province of NL (Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador. All Parties Committee Report; The Government of Newfoundland and Labrador, 2017) of the need to address these mental health disparities and educate service providers it, nevertheless, leaves the issue of embedded colonialism and associated hetero and cisnormativity experienced daily by queer and trans youth largely unaddressed. This study seeks to expose the impacts of these taken-for-granted discourses recognizing that, as long as queerness and gender non-conformity continue to be conflated with mental illness, the systemic and structural factors causing it will not change. It is hoped that surfacing these realities will help to prevent neoliberal downloading of responsibility for mental wellness back onto the youth. Ultimately, the broader intent is to avoid a catch-22 whereby 2SLGBTQIA+ youth are deemed truly “queer”, unable to fit into a service system that is predicated on the very thing causing their distress.

**Resilience and 2SLGBTQIA+ Youth**

The absence of studies reflecting the resiliency of queer and trans youth and the strategies that they employ to navigate a hostile world has been noted by Asakura (2016, 2019). While acknowledging an increase in interest in this area, they observe that much of the current scholarship focuses predominantly on LGB youth ignoring the trans and gender non-conforming population (the exception being Singh, Meng, & Hansen, 2014). With no mention of Indigenous LGBTQIA+ or Two-Spirit youth resiliency, Asakura infers the total erasure of this population from research conducted in this area. Within the studies that have been undertaken, there is consensus that there is an overemphasis on the risks associated with being young and queer and not enough attention paid to the contextual factors creating these risks. Park and Crath (2018)
concur, observing that these structural sights of oppression often get “relegated to the margins of the manuscript elided in favour of individualized analysis and intervention” (p. 1). Hence, the resiliency literature tends to privilege the capacity of an individual to accommodate to oppression rather than issues of social justice (p. 1). There is an additional concern that the concept of resilience itself and how it has been operationalized in most quantitative research conducted with queer youth has been normed using cisgender and heterosexual populations (Asakura, 2019, p. 271).

Asakura (2016) undertook a grounded theory study with 16 service providers and 19 LGBTQ youth to develop a substantive theory of resilience processes among queer youth. One core category emerged: paving pathways through the pain. Accordingly, Asakura posited that LGBTQ youth build on emotional pain inflicted by external adversities to carve out pathways to resilience. Five resilience processes emerged from the data (2016, p. 521).

Process one involved navigating safety across contexts. Essentially, this process involved a careful assessment of the specific context (setting/relationship) that the youth was in combined with a calculated assessment of their safety to “come out” as LGBTQ. As such, youth made choices regarding if and when they would disclose their sexual and/or gender identity/expression as well as the degree to which they could be honest (fully or partially).

A second resiliency process identified by youth in this category was accessing “safer space” such as Gay Straight Alliances (GSA) even temporarily to offset the stress of less safe space (p. 527). Resilience process two was asserting personal agency via privileging their own needs, limitations, and future directions as well as taking ownership of their decision-making processes. While expressed as a strategy by many participants, Asakura (2016) references the developmental component to this process with older youth and young adults indicating more capacity and opportunity for employing this tactic (p. 528).
Resiliency process three was identified more by the service providers than the youth themselves, perhaps indicating their broader view of the youth and their respective support systems (Asakura, 2016, p. 528). Hence, providers noted that LGBTQ youth sought out and cultivated meaningful relationships with “LGBTQ adults and peers who reflected their LGBTQ-specific experiences and [with] others, regardless of their sexual orientation or gender identity, who provided youth with physical or emotional resources” (p. 528).

Resilience process four involved a process of un-silencing marginalized identities, and process five involved a similar strategy of engaging in collective healing and action. To this end, the youth sought out resources to build up and support their knowledge of their respective identities and enhance their identity development (Asakura, 2016, p. 530), as well as to ground their understanding of their lived adversity in the structural realities causing it. These processes occurred while engaging in action to make things better for themselves and others suffering the same or similar consequences (p. 531).

In a follow-up article entitled “Extraordinary Acts to ‘Show Up’: Conceptualizing Resilience of LGBTQ Youth”, Asakura (2019) revisits their data from the 2016 research project discussed above. Applying an ecological framework to resilience and a grounded theory methodology, two broad categories emerged from their analysis (p. 268). Category one, “facing adversities across contexts” revealed that, across time and context, LGBTQ youth experience both normal youth adversity as well as adversity that is specific to being LGBTQ in a cis and heteronormative context (p. 274). Examples of LGBTQ specific adversity included homophobia and transphobia within the family, school, employment, and community contexts, as well as societal marginalization (p. 276). Category two was “doing well” while still in pain. Within this category, participants referenced their enduring struggle and pain as it co-existed with their ability to be functional and do well in the day to day. Of relevance to this research project is the
reference made by Asakura (2019) to the structural realities of hetero and cisnormativity as the source of the continued and enduring pain experienced by LGBTQ youth. Hence, every victory, be it large or small, represented the ability to “show up” in the day to day demonstrating their inherent resilience (p. 280).

Several important outcomes emerged from Asakura’s (2019) research project. First was the endorsement by the youth of a different form of positive adaptation to adversity (one of the conventional measures of resilience). Accordingly, the youth did not necessarily measure their resilience by the absence of psychopathologies or other standard benchmarks such as school success. Instead, as indicated by the second category discussed above, youth spoke to the ability to “push through” ongoing diverse contexts as an alternate measure of conventional resilience (p. 278).

On a related note, Asakura (2019) discussed the need to measure the concept of “doing well” as a contextually bound phenomenon that varies depending upon levels of cis and heteronormativity experienced by 2SLGBTQIA+ youth. For my study, this is especially relevant to understanding youth experience of growing up in rural NL versus those experiences of having grown up in more urban settings. Finally, Asakura (2019) also advocates for 2SLGBTQIA+ youth and their service providers to be incorporated into research as “knowledge keepers” in the area of resilience.

In an earlier study, Singh et al. (2014) interviewed 19 trans-identified youth about their resilience strategies for navigating stressors in their lives. Five supports to resilience were identified by the youth and six threats were similarly reported. Accordingly, youth identified the associated risks to their resilience as adultism or being constructed as not having the capacity to make their own choices; health care access challenges; emotional and social isolation; limited access to financial resources; as well as the act of gender policing (p. 208). Given the focus of
this particular section of the dissertation paper, it is important to acknowledge that these negative processes have significant impacts on youth capacity for resilience.

Continuing with an emphasis on LGBTQIA+ resilience, Singh et al. (2014) identified the following five factors as specifically supportive to the resilience of the trans youth interviewed for their study: the ability to self-define and theorize one’s gender; proactive agency and access to supportive educational systems; connection to a trans-affirming community; reframing of mental health challenges; and navigation of relationships with family and friends (p. 208). While none of these factors seem to be surprising, they nevertheless endorse a theme of affirmation. Relatedly, current statistics regarding suicidality amongst trans youth speak to the significance of affirmative spaces and people (especially family) as mitigating factors that substantially reduce the associated risk (Veale et al., 2015).

As indicated at the beginning of this section, scholarship regarding Indigenous LGBTQIA+ and Two Spirit youth resiliency is virtually nonexistent. A search of the literature using the terms Indigenous LGBTQ youth and resilience and a concurrent search using the terms Two Spirit youth and resilience revealed very few articles. Those found related to increased risk for homelessness (Saewyc et al., 2017) and substance misuse (Whitesell & Kaufman, 2017). Other gray literature, such as government publications and guides, offered suggestions for working with Indigenous 2SLGBTQIA+ youths in respectful, reciprocal, and culturally safe ways. There was also one dissertation that discussed the challenges and successes of Two Spirit youth in the workplace (Ayoub, 2019). The lack of information in this area is abhorrent and speaks to the broader and ongoing processes of assimilation and erasure of Indigenous peoples, their wisdom, their experience, and their knowledge. It also reflects the particularly devastating effect that colonization has had on the lives of Indigenous LGBTQIA+ and Two Spirit folk. The inherent cis and heteronormativity associated with the colonial regime has created a historic
disjuncture amongst Indigenous communities and their queer and Two Spirit members. The results of this violence are myriad and reflected in the statistics on homelessness, gang involvement, and poor mental health outcomes presented in the section previous to this one. Despite a lack of scholarship within the scope of this research project, there are related articles that reflect the resilience of Indigenous youth in general (Hackett et al., 2016; Rohani & Hatala, 2016). To this end, it is not hard to extrapolate these findings to the LGBTQIA+ and Two Spirit community bearing in mind the additional impacts of homophobia, biphobia and transphobia.

Rohani and Hatala (2016) undertook a “systematic review of health literature that considered processes of resilience among Indigenous youth in Canadian contexts” (p. 45). The authors examined seventeen mixed-methods studies and identified the health disparities that exist among this population. Rohani and Hatala (2016) also examined how resilience processes can inform strength-based approaches designed to improve the health and well-being of Indigenous youth in Canada (p. 45). Three central themes emerged as a result of their review.

Theme one identified the importance of cultural continuity in promoting resilience amongst Indigenous youth. The articles reviewed all highlighted the need for youth to re-establish expressions of their Indigenous identity through connections with the land or environment, language, and spiritual or cultural practices (Rohani & Hatala, 2016, p. 48). Given the diverse nature of Indigenous peoples across Canada, youth necessarily go about this process in different ways, both formal and informal. To this end, learning about the collection and preparation of traditional foods and increasing the consumption of the same; participating in ceremony; learning from Elders; and having a connection to/identifying with their Indigenous heritage have all been shown to increase resiliency for youth (p. 49). Formal programs such as the “Going Off, Growing Strong” program, offered to Inuit youth struggling with mental health and suicidality in Nunatsiavut have likewise demonstrated that connection to the land and the
learning of traditional Inuit skills promotes resiliency, increases mental well-being and decreases the incidence of suicidality amongst participants (Hackett et al., 2016, p. 82).

Theme two described the necessity for community and family ties as a means to increase resiliency for Indigenous youth. Within this theme, Rohani and Hatala (2016) explicated research findings that demonstrated the need to center therapeutic intervention within families and community; the importance of older adult mentorship, especially parent and grandparent; as well as, the emergence of communities of interest and support for youth that are accessed via social networking (p. 50).

The final theme emerging from Rowhani and Hatala’s (2016) systematic review was the positive relationship between the youths’ ability to access empowering programs and the likelihood of increased resilience. As with theme one, the diversity of Indigenous peoples and their cultures determines the types of programs that best serve the youth in their community. Nevertheless, a final recommendation made by the authors after examination of all relevant articles was that “staff should become allies united with the youth they work” (p. 52). This recommendation was based on Bird-Naytowhow et. al (2017) finding that “several of the collaborative research projects indicated increased awareness of resilience among youth as they were able to express and delve deeper into a certain community’s own culture, customs, and solutions to social problems” (Rowhani & Hatala, 2016, p. 52).

In sum, it is apparent that, despite multiple risk factors and disproportionate rates of mental health distress, addictions and homelessness, 2SLGBTQIA+ youth are resilient. Further, this resilience is resultant from purposeful strategies employed by youth while they navigate a hostile environment. Of greatest importance and most relevant to this research project is the acknowledgement that the colonial legacies of cis and heteronormativity are the greatest sources of the ongoing adversity and consequent mental health distress experienced by queer and trans
youth. The next section examines the seepage of these destructive discourses into the space of mental health service provision. Sadly, what should be a haven for 2SLGBTQIA+ youth becomes yet another battleground for safety, affirmation and recognition.

Settler Colonialism, Cis and Heteronormativity and Mental Health Service Provision

Settler colonialism is a pervasive force that brings with it a continued regime of assimilation, erasure, and eradication. Embedded within its structure are cis and heteronormative beliefs and values regarding gender and sexuality predicated on western binarized thinking. The infiltration of its influence extends far beyond the discursive impacts of whiteness, racism and cis and heteronormativity. It espouses a continued history of structural processes and procedures which have disembodied not only the Indigenous individual from their traditional beliefs and values but also the Indigenous nations from their land and their rights to Indigenous sovereignty over all aspects of the lives of their people (Allan & Smylie, 2015; Czyzewski, 2011; Dakin, 2012;).

Billie Allan (2015) is an Anishinaabe-kwe Social Worker and Scholar from Sharbot Lake, Ontario who, in conjunction with Dr. Janet Smylie and the Counsel of Indigenous Grandparents of Well Living House, undertook a review of the role of racism in the health and well-being of Indigenous peoples in Canada. At the heart of this review is the belief that “the relationship between racism and colonialism are inextricably intertwined” (p. 5). While this review was not exclusive to youth or mental health and well-being, it was nevertheless extensive and included the narratives shared by the counsel of Indigenous grandparents, an examination of Canadian colonial policies and practices and their impacts on Indigenous health and well-being and a systematic literature review (p. 2).

Allan and Smylie (2015) began by establishing the racist roots of colonialism and by identifying the destructive influence of Canadian policies and procedures that are grounded in
imperialist and colonial ideologies (p. 1). In particular, they focus on racism as it relates to the social determinants of health. They explicate its wide impact and its capacity to cut across a broad swath of systems and factors drastically impacting the health and well-being of Indigenous peoples resulting in Indigenous peoples experiencing the worst health outcomes of any population in Canada (p. 1).

In their section entitled “Telling our own stories”, Allan and Smylie (2015) discuss how the colonial construction of Indigenous mental health has been influenced by racism and how it results in non-Indigenous peoples “author[ing] not only stories of who [Indigenous peoples] are but also [of] how they are” (p. 2). To this end, Indigenous peoples have historically been constructed as “mentally inferior, childlike, unpredictable, untrustworthy and violent” (p. 3). These constructions, in combination with disparaging stereotypes, have become the justification for the violent Canadian history of exclusion, assimilation, and erasure, as well as, the continued privileging of western bio-medical knowledge and the concomitant “marginalization of Indigenous ways of knowing and practicing in the Canadian health care system” (p. 4).

Nelson and Wilson (2017) undertook a scoping review of the research relating to Indigenous people’s mental health. To this end, they queried the question of: “What published literature exists on the topic of mental health relating to Indigenous peoples in Canada, and what gaps in terms of geography, population, or research theme can be identified” (p. 94). Through this process, Nelson and Wilson were able to identify several themes that emerged from the literature with an emphasis on the role of colonialism and its impact on Indigenous mental health. There were numerous issues raised by this investigation that have pertinence to this study.

To begin, significant gaps in the literature concerning specific Indigenous populations were identified by the authors:
... both demographically and geographically, research on the mental health of Indigenous peoples in Canada shows some significant gaps. As a result of historical identity politics and jurisdictional issues with respect to the provision of health services, both health services and health data on Indigenous peoples in Canada do not adequately address the specific mental health determinants or issues faced by different Indigenous populations in different geographical spaces (for example, on-reserve and off-reserve). In particular, Métis peoples and urban or off-reserve Indigenous peoples are dramatically underrepresented; this is a significant gap that needs to be addressed. (Nelson & Wilson, 2017, p. 103)

Further, Nelson and Wilson (2017) identify a troubling trend within the literature whereby there is an over-emphasis on certain mental illnesses over others, in research about Indigenous peoples’ mental health. They caution that:

[this] can have implications for access to health care. Prevalent themes in research can lead to perceptions on the part of health care providers that an Indigenous person is most likely to be suffering from substance use problems or having suicidal thoughts. Scholars have documented the fact that such perceptions often lead to inaccurate diagnosis, inappropriate delays of treatment, and in some cases the complete denial of health care for Indigenous peoples. (p. 101)

Finally, the need for a more critical use of the terms colonialism and historical trauma is advocated for by the authors. Specifically, they warn of the confluence of colonialism as a mechanism that only impacts Indigenous peoples individually thereby erasing its systemic roots they state:

It is important, moving forward, for research on the mental health of Indigenous peoples to consider the concept of colonialism carefully, in order to ensure that the societal and
structural Indigenous level problems of a colonial society are not obscured by attention to the immediate mental health needs of individuals. (Nelson & Wilson, 2017, p. 100)

In reference to the historical and intergenerational trauma literature, they offer a similar caution insisting that “colonialism… at its heart [is] a collective and structural force, requiring collective and structural change” (p. 102).

Czyzewski (2011) discusses settler colonialism as a distal determinant of Indigenous health and, as such, exposes how it has been complicit in the intergenerational trauma and real-life health effects of the social, political and economic processes of marginalization experienced by the Indigenous populations in Canada (p. 1). Distal effects are those “that are not within the control of the individual or community and are the “causes of causes” for unjust life situations for certain groups or people over others” (p. 4). When applied to mental health, this lens contextualizes the disparity in rates of increased suicide, substance misuse and depression for Indigenous youth (p. 4).

In sum, there is a clear connection (albeit largely denied by settler society) between colonialism, settler colonialism, psychiatry, pathology and Indigenous people. The historical neglect of this relationship and the impacts of colonial trauma have led to disproportionate rates of poor mental health, homelessness and suicide amongst Indigenous youth (Spear, 2014; Reeves and Stewart, 2014; Reeves and Stewart, 2017; Varley, 2016; Duran and Firehammer, 2017; Mitchell, 2017; Blackstock, 2019; Methot, 2019; Esquimaux, 2020). What is more, there has been a concurrent psychiatrization and pathologization of Indigenous peoples’ colonial trauma. As a result, the construction of Indigenous peoples as inferior to settlers in all aspects of life has been perpetuated (Allan and Smylie, 2015) and the ongoing subjection of Indigenous peoples to the institutions of settler colonization (child welfare systems (Blackstock, 2019), non-wholistic mental health treatments (Waldram, 2008) etc.) continues to be legitimized.
As discursive by-products of the Settler colonial regime, cis and heteronormativity perpetuate the imperialist values and beliefs foundational to the oppression, violence and subjugation enacted through its respective discourse. Allen (2015) endorses the discursive nature of heteronormativity as they posit that it constitutes the ‘social air that we breathe (p.158). Semp (2011) describes heteronormativity as an “emphasizing of the ‘normalcy’ and ‘superiority’ of heterosexuality” referencing its organizing function stating that heteronormativity “sexualize[s]—heterosexualize [s] or homosexualize [s]—bodies, desires, acts, identities, social relations, knowledges, culture, and social institutions’ (p. 70). Cisnormativity is an equally pervasive discourse that works “hand in hand” with heteronormativity. Together, they form the foundational basis upon which western mental health services have been predicated and through which queerness and transgender identities have been pathologized.

As referenced earlier in this paper, the DSM is the primary conflating mechanism of psychiatrization with queerness (Daley & Mulé, 2014; Mizok & Flemming, 2012). This manual is the “matrix” through which the bio-medical constructions of mental health and the construction of psychiatric identity categories are substantiated, and its legitimizing function reflects its inherent omnipotence:

Not only does it serve to determine who is ill and who is not, it also serves as the primary determinant of insurance eligibility, disability payments, and who receives special educational services. It figures in legal decisions regarding child custody disputes and criminal responsibility. It shapes the direction of research, the allocation of research funds, and the approval of new drugs. Furthermore, it informs the structure and content of courses and textbooks on abnormal psychology in the various mental health professions. (Marecek & Gavey, 2013, p. 4)
Recent literature (Daley & Mulé, 2014; Drescher, 2014; Kilicaslan & Petrakis, 2019; Russel & Fish, 2016) chronicles the pathologizing of queerness and trans identities and the cis and heteronormative agenda associated with the DSM. In particular, Daley and Mulé (2014) present a cogent and deliberate critique.

At the outset of their response, Daley and Mulé acknowledge the diversity within the 2SLGBTQIA+ communities (p. 1288) and recognize that “a range of diagnoses including those seemingly unrelated to gender and sexuality” may affect members (p. 1289). Equally important is their exposition of the “gatekeeping function” and inherent systemic abuse of power that is predicated on the requirement of formal diagnosis to access health insurance when medical intervention is sought (p. 1292).

Daley and Mulé (2014) draw focus to two specific diagnoses: Gender Dysphoria and Paraphilias. They critique their inclusion in the DSM based on “three primary thematic concerns” (p. 1293). These concerns are summarized for the reader in the form of tables (p. 1296-1302) but essentially represent issues with diagnostic criteria, reliability, and validity of diagnoses and the inclusion of the criteria of clinically significant distress/impairment as a part of a diagnosis. While all concerns are of great individual importance, collectively they represent the interrogation of stable, narrow, and fixed categories of recognition that are heteronormative, [cisnormative], racialized, classed, and sexualized and that pathologize and codify behaviours that fall outside of their hegemonized and idealized descriptors (p. 1296). Further, the reliability and validity of the DSM are challenged based on the socially constructed nature of the diagnostic criteria and the inherent reductionism of complex human behaviour into restrictive categories of recognition that results in oppression, discrimination and stigma (p. 1299). Finally, the authors problematize the inclusion of the criteria of clinically significant distress/impairment as a basis for diagnosis. To this end, they trouble the cis and heteronormatively repressive undertones, as
well as, the lack of focus on the social and cultural mechanisms that not only “disorder” alternative expressions of sexuality and gender, but also subject individuals to poignant discrimination, enacting distress, and impairment of functioning, which becomes subsumed into the disorder (p. 1302).

Daley and Mulé (2014) end their response by reiterating the pre-eminence of the DSM in mental health hegemony and by acknowledging its increasing regime of power. They expose its continuing collusive nature and challenge the idea that the current iteration of the DSM does anything more than reify traditional and normative expressions of gender and sexuality, they conclude:

… The DSM-5 and its finalized version continues, in the tradition of earlier iterations of the DSM, to serve a conventional, restrictive, and constrictive normative agenda within which to contain sexual and gender expression that abides by middle-class, White, heteronormative, and cisgenderist notions of acceptability… (Daley & Mulé, 2014, p. 1307)

Mizok and Fleming (2012) provide specific evidence of the potentiality of the cis and heteronormative agenda associated with the DSM in their article entitled: “Transgender and Gender Variant Populations with Mental Illness: Implications for Clinical Care”. In particular, they highlight the necessity of distinguishing between the clinical presentations of transgender patients due to psychosis as compared to conflating transgender identity with psychosis. Reminiscent of Daley and Mulé’s (2014) concern regarding non-gender related behaviours being subsumed into the pathologizing of non-conforming gender performances, the authors offer a stern warning against “attributing gender variance among populations with mental illness solely to a psychotic process” (p. 208).
Throughout the remainder of their article, Mizok and Fleming (2012) aptly illustrate the unique nuances of navigating mental health services as a trans and/or gender variant consumer. To this end, they reference the lack of familial support, the difficulty of health insurance issues, and cis and heteronormative assumptions that make “identifying” as trans or gender variant safe or even possible.

In a similar vein, and of particular relevance to this research project, is the impact of cisnormativity on the lives of gender creative children and youth and their respective families. Drescher (2014) notes the controversies surrounding the treatment of children and young adolescents “which raises many complex issues that are not entirely the same as those involving the treatment of older adolescents and adults” (p. 144). On one side of the divide are those, who believe that childhood gender identity diagnoses are assigned as a means to justify treatments aimed at getting young people to reject their expressed gender identity and to accept the sex (and gender) they were assigned at birth—reminiscent of archaic treatment attempts to convert youth from homosexuality (Pickstone-Taylor, 2003). On the opposite side of the debate are proponents of assigning a gender-related diagnosis to youth and young adults. Underlying this argument is the pragmatic reality of medical diagnostic requirements for treatments such as hormones and the same requirement for gender-confirming surgeries. Additionally, advocates of this position would argue that maintaining gender-related diagnosis within the DSM provides legal grounds to prevent the denial of rights to trans and gender non-conforming individuals. According to Drescher (2014), there is a fine line between the stigma attached to diagnosis and the necessary access to medical care (p. 144).

Access to safe and affirming care be it medical or mental health is an issue that finds prominence in the literature regarding the impact of cis and heteronormativity on service provision. Daley (2012; 2011; 2010; 2003) has co-authored multiple publications that discuss...
the persistent inequity experienced by the queer community when it comes to the delivery and accessibility of mental health services. She and her co-authors call for the education of all health professionals in this area and propose models of service that are less cis and heteronormative and thereby less oppressive and impinging on the experiences of queer folk. Perhaps most pertinent to this research project, Daley (2013) examines “negotiated spaces” for lesbian-identified women who have been involved with the mental health system. In her work, she identifies the cis and heteronormative nature of the various intersectionality of space that queer women navigate while a part of the mental health system and how these spaces impinge upon the women and both allow and delimit their performances of the identity category “queer”.

Akin to Butler (2004), Daley (2013) uses the concept of in/visibility to capture the delimiting and obscuring of queer identity within mental health spaces. To this end, she proposes a conceptual framework that identifies three types of intersecting space through which identity must be negotiated: “body”, “intersubjective” and “real” (p. 301). Body space captures the multiple subjectivities of an individual and involves such elements as self-disclosure and previous life experiences that impact the negotiation of identity. Intersubjective space represents the interaction between the women in the mental health system and service providers and includes the attitudes and beliefs of the providers as well as their practice skills and abilities. Finally, real space is the organizational space and institutional philosophies and practices that house the services provided to queer women. Taken together, queer women must navigate across all of these cis and heteronormative spaces and in turn, their queerness is made more or less visible as they do.

Semp (2011), takes up a similar agenda to Daley (2013) by querying the embedded heteronormativity in public mental health service delivery and related research. Focusing on services for men who have sex with men (MSM), Semp presents a provocative argument
regarding the pre-dominantly positivistic methodology that informs the majority of research in this area. The essentializing function of such a framework is noted opening up the possibility for the development of mental health services that do not meet the needs of those that it is intended to serve. Specifically, Semp troubles the binary of hetero and homo that “minoritizes” homosexuality resulting in service strategies that do not meet the needs of all same-sex attracted clients.

Similar to Semp (2011), Lefrançois (2013) uses a queer lens to uncover the heteronormativity buried in the treatment experiences of children and youth navigating the psychiatric system in a child and youth inpatient unit in the United Kingdom (UK). Through her ethnographic study, Lefrançois exposes the heteronormative practices and assumptions that shape the view and treatment of the youth on the inpatient unit. Using an example of two young straight-identified women who were labelled as lesbians due to their caretaking of one another, the author illustrates the power of the heteronormative discourse to “name and frame” individuals and in doing so to uphold social norms as the standard by which other patients should perform.

Finally, recent research reports (Elliot et al., 2014; Ellis, Bailey & McNeil, 2015; Kilicaslan & Petrakis, 2019; Russel & Fish, 2016) including a Canadian publication by Ross et al. (2018), document how the embedded cis and heteronormative standards in health care systems impede queer and trans peoples’ access to services resulting in poorer mental health outcomes. While not all specific to the youth population, these studies speak to issues of implicit bias, cis and heteronormative practitioner assumptions, intake forms that fail to recognize sexual and gender non-conforming people, a lack of training for service staff, insufficient knowledge of 2SLGBTQIA+ issues, a lack of policies and procedures that support inclusive and affirmative service delivery, and issues with accessibility. Hadland et al. (2016) with, specific reference to
LGBTQ+ youth, echo the findings of these studies and maintain that “examining these components and the messages they send to 2SLGBTQIA+ youths is not simply good care but should be the baseline standard health care organizations apply” (p. 1).

In sum, it is apparent that settler colonialism and cis and heteronormativity all have major impacts on mental health service provision to 2SLGBTQIA+ youth. Fundamental to these impacts is a service system that remains ensnared by western bio-medical ideology, continued deference to the psychiatrizing of queerness and trans identities, and health care that is designed to meet the needs of those embodying normative constructions of gender and sexuality. Staff are self-admittedly lacking knowledge and skills. Training, when available, is generally in the form of generic diversity or cultural competency training, which offers solutions based on essentialized notions of the mental health needs of queer and trans youth. There is also a concomitant lack of administrative and policy support for safe, affirmative and inclusive service delivery processes. Despite a recent spike in interest regarding the mental health needs of 2SLGBTQIA+ youth, few studies are specific to the experiences of trans and gender non-conforming youth and even fewer explore the experiences of those who are Indigenous and/or Two Spirit. What is more, the scholarship in this area rarely reflects the personal perspectives of the youths themselves leaving their voices largely absent from the literature and their input into solutions stifled.

2SLGBTQIA+ Youth and Their Experiences of Mental Health Service Provision

Little has been written from a scholarly perspective in this area. Studies that reflect the voices and experiences of 2SLGBTQIA+ youth service users are rare and, apart from a recent study referenced earlier in this paper (Temple-Newhook et al., 2018), none are specific to the province of NL. Wilson and Cariola (2019) endorse this gap in scholarship and assert that “having the voice of young LGBTQIA+ people available through qualitative research is
imperative if we are to address the ecological, social, and pedagogical issues and ultimately the 
human rights of this marginalized group” (p. 4).

Temple-Newhook et al. (2018) conducted a mixed-methods research project in the Province of NL. Their total youth sample (n=24) was comprised of participants aged 12-17 who identified as trans or gender non-conforming. The scope of the inquiry was broader than just mental health service delivery and their objectives were “…to describe the healthcare and support needs of transgender and gender-questioning children and youth in NL, as understood by youth and by parents; as well as, to examine the main concerns and hopes of transgender and gender-questioning youth and parents in NL” (p. 15). Irrespective of the broadness of their scope, the findings of this study are relevant to this research project.

Youth completed surveys as well as open-ended qualitative interviews regarding their healthcare needs (Temple-Newhook et al., 2018). Parents of youth (n=21) also completed surveys on the healthcare needs of their children and a second survey on their own healthcare and support needs. Parents were similarly interviewed about these topics. In relation to this study, the youth responses are most pertinent, although parental concerns reflect the issues underlying the current system transformation. Hence parents spoke to extensive wait times at urgent care and for longer-term services, a lack of guidance and information about services and a need for their children to be de-pathologized by service providers (p. 20). Youth responses reflected four themes: lack of parental support; feelings of dysphoria; a desire to be fully accepted by peers; and family and safety and transphobia. Concerning service delivery experiences, youth shared parental concerns regarding wait times for surgeries and accessibility to services (p. 21). Both youth and parents also spoke to the need for providers to be more educated regarding trans healthcare and the needs of their trans patients (p. 22).
Overall, a series of six recommendations emerged from this study, with three having a direct connection to this research project. To this end, the authors endorse: prioritizing access to care for trans youth; improving training and continuing professional development on gender diversity and identity for all healthcare professionals, including general practitioners and community mental healthcare providers; and centring the voices of trans youth and their families in developing solutions (Temple-Newhook et al., 2018, p. 24-25).

Wagaman (2014) introduces their research project acknowledging the gap in scholarship regarding queer youth service experiences stating that:

due to a paucity of research on the experiences of LGBTQ young people with community-based organizations and services, this study qualitatively explored the barriers faced by LGBTQ young people, [they continue] … even more striking is the almost non-existent voices of LGBTQ youths themselves in defining and discussing what their needs are and how they can best be served in ways that enhance their optimal growth and development in a sometimes-hostile environment. (p. 112-113)

In proceeding with their mandate to work within this gap, Wagaman (2014) interviewed fifteen LGBTQ youth regarding their service delivery experiences. Central to the investigation was an intersectional lens which was imperative to understanding “LGBTQ young people’s perceptions of service experiences and needs providing insight into effective approaches for serving a population that cuts across multiple identity groups” (p. 115). To this end, Wagaman explored the types of services that LGBTQ youth accessed, their experiences of these services and the barriers associated with accessing the same. From this exploration, several suggestions emerged for service providers to consider in order to make services more effective and inclusive of LGBTQ youth perspectives.
Study participants accessed three different types of services: basic needs services, school-based services, and LGBTQ specific services (Wagaman, 2014, p. 119). Within each of these service types, the youth had both positive, as well as, negative service experiences. In the basic-needs services, youth mostly cited negative experience with shelter involvement being viewed as highly unhelpful and at times re-traumatizing (p. 121). Within school-based services, youth reported instances of staff being encouraging, as well as school-based support groups as positive and helpful to their academic success (p. 120). Negative experiences within the school setting included inadequate recognition of their needs and inadequate responses to the same (p. 122). Finally, within LGBTQ specific services, participants reported varied experiences including isolation; feeling like family; stability; social support; finding role models; having common experiences; and a greater need to learn about LGBTQ-specific services (p. 125).

Multiple barriers to service within each of the service types emerged. Overall, youth identified these barriers as a lack of knowledge about existing services (Wagaman, 2014, p. 133); non-existent shelter and housing services (p. 133); limited access to health and mental health care (p. 135); and difficulty with meeting documentation requirements (p. 137). Within LGBTQ specific services, other themes emerged that reflected: exclusion when unwilling to identify ones’ specific gender or sexual identity category (p. 137) and assumptions made by LGBTQ specific service providers regarding client needs and experiences.

Wagaman (2014) concludes their article with a section on lessons learned from the research and how these insights can inform service delivery to LGBTQ youth. Four areas are identified for consideration: understanding and addressing the nature of the risk being experienced by LGBTQ youth (p. 140); promoting resiliency and reciprocity within service delivery to LGBTQ youth (p. 140); building service systems that are safe, inclusive and affirming (p. 141); and finally, using an intersectional approach to service provision (p. 141).
Sheriff, Hamilton, Wigmore and Gambrone (2011) interviewed LGBTQ youth with the intent of exploring the experiences of young people including bullying, “coming out,” social service and educational needs” (p. 939). The authors also sought to investigate how practitioners viewed the needs of LGBTQ young people (p. 940). While not addressing the specific service experiences of the eleven LGBTQ youth participants interviewed for this study, responses to questions did reveal that youth sought out support for life experiences related to homophobia, biphobia, and transphobia. Youth participants also indicated that when sought out, service providers were ill-equipped to provide support to them in these areas and lacked skills and needed training:

The majority of youth felt that there was a need for practitioners working with all young people (not just LGBTQ young people) to be better trained around LGBTQ issues, including how to deal with homophobic bullying… young people felt that basic skills such as not being presumptuous, listening, showing respect, and being open and sympathetic were important qualities particularly in practitioners working in mainstream services with youth on a regular basis. (p. 950)

Responses from the eighteen service providers interviewed were not that dissimilar to those of the youth and included an emphasis on the development of “tangible skills and knowledge” as well as, education that was based on the real-life scenarios of LGBTQ youth (Sheriff et al., 2011, p. 951). The need for understanding how to help LGBTQ youth “come out” seemed a priority for most. Additionally, service providers felt that reading manuals as a source of “diversity training” was insufficient to meet their needs indicating that youth should be involved in both the development and delivery of the training (p. 952).

Maria Liegghio (2016), while not specifically focusing on 2SLGBTQIA+ youth, examined the real-life and situated experiences of seven youth who were involved with mental
health services and who were diagnosed with some type of serious mental health issue. This article is written from an intersectional perspective and examines the binaries through which these youth have been constructed and have received services and how they interlock to become constitutive in the process of ongoing psychiatrization. Of particular interest to the youth themselves was the binary of normal/abnormal as represented by the question “what is normal mental health in children and youth?” (p. 118). Employing a participatory action research (PAR) framework and using Photovoice, this question was explored by the seven participants. Accordingly:

… three main interrelated themes emerged from the photovoice project: The first theme consisted of concepts about ‘normal’ as an ideal against which young people are compared and judged. The second theme is that the standard is a matter of perspective that depended on who was observing and making interpretations… consequently, ‘normal’ was experienced as ambiguous and shifting. The third theme was resistance to disabling encounters with normal, whereby the youths offered a counter-narrative in which normal mental health was inclusive of emotional distress. (p. 119)

In relation to this research project, Leigghio’s (2016) article advocates for the inclusion of youth voice in their mental health treatment. Additionally, it exposes the mechanisms by which this becomes virtually impossible. As such, it provides a strong caution regarding the interlocking oppressions of adultism, sanism, and ableism and demonstrates how when taken together, they render youth incapable of making treatment decisions for themselves and obscure their lived experiences and ultimately their presence from the mental health treatment system.

Wilson and Cariola (2019) take up this theme and use it as the starting point for their inquiry. To this end, the authors undertook a systematic review of qualitative literature that
sought to provide a youth voice concerning mental health challenges and experiences for LGBTQIA+ people (p. 4). They reference the myriad quantitative studies in this area that provide rich data and “a picture of clear trends based on statistical indications of sexual and gender minority youth who experience adverse outcomes in a heteronormative society” (p. 4). In general, quantitative literature “focuses on the impact of isolation, marginalization and discrimination against sexual and gender minority youth in relation to mental health outcomes and the identification of risk and protective factors” (p. 3). In contrast, qualitative research provides the thoughts and feelings of the participants and through reflexive analysis can provide insight and understanding into their lived experiences (p. 3).

In total, thirty-four articles made it through the eligibility and quality analysis processes. As anticipated, only one of these articles referenced social service provision (Sheriff et al., 2011), and has been included in this paper and was cited earlier in my dissertation proposal (2017). Of note, this article, like almost all relevant to this paper, focused broadly on what youth saw to be their social service needs (Sheriff et al., 2011). Similarly, the interviews conducted with providers examined their perceived sense of competency when working with 2SLGBTQIA+ youth and what was needed to increase this competency. Hence, the specific service delivery experiences of the youth or the provider and the themes emerging did not reflect their individual experiences or actual voices. While nevertheless valuable, the benefit to my research project is that it provides a retrospective analysis of service provision to queer youth from the lived experiences of both the youth and the service provider. Consequently, the themes that have emerged reflect conversations that go beyond the perceived and generic into the bound and contextual realities of the NL service system. As such, the findings of this study are nuanced beyond the overarching elements making service provision safe and affirmative.
The remainder of the articles examined by Wilson and Cariola (2019) reflected themes that related more broadly to the mental health challenges of queer youth—once again valuable to provide context for mental health service providers. Accordingly, youth spoke to experiences of isolation, rejection, phobia, and a need for support; marginalization, depression, self-harm, and suicidality; policy; and environment and connectedness (p. 17). Future research directions were also proposed. Of importance to this study is an endorsement of qualitative inquiry centred on the voices of the youth themselves as well as the inclusion of these voices in policy development.

Apart from the studies described above that reference the voice of the queer service user, the bulk of the scholarship in this area focuses on quantitative or mixed methods studies that reflect the distress experienced by 2SLGBTQIA+ youth and how service provision must shift to meet their needs. (Craig et al., 2013; Dysart-Gale, 2010; Scherrer, 2013; Wells et al., 2013; Wilson & Cariola, 2019). Similarly, there are myriad articles that discuss issues relating to accessing mental health services (Brown et al., 2016) and that focus on finding a model that will best meet the mental health needs of 2SLGBTQIA+ youth (Citations?). To this end, these articles reflect the ongoing debates regarding the types of services that are best for serving 2SLGBTQIA+ youth: universal services that are queer affirmative; culturally appropriate serves that are targeted to specific 2SLGBTQIA+ groups; and/ or queer specific services that are offered by queer professionals (Wells et al., 2013). There is also a focus on the need for practitioner training (Gandy, Carter & Portwood, 2013; Kilicaslan & Petrakis, 2019) and the adaptation of best practice models such as CBT to 2SLGBTQIA+ youth (Craig et al., 2013). Unfortunately, in the case of the latter, despite the well-intentioned motivation for undertaking such adaptations, 2SLGBTQIA+ youth nevertheless become essentialized and their unique intersectional subjectivities blurred. The resultant outcome is a neoliberal, evidence-based approach to a “one-size fits all” service delivery model.
Overall, there is a trend within the literature whereby the mental health distress of 2SLGBTQIA+ youth is constructed as evidence of “minority stress” (Hadland et al., 2016; Meyers, 2003; Russel & Fish, 2016). Although cis and heteronormativity are identified as the source of this distress, there is an inherent construction of 2SLGBTQIA+ youth as the “other”. In troubling this trend, I do not question the effectiveness of these studies in exposing the stark realities of the lived experiences of 2SLGBTQIA+ youth and the overwhelming need to better address their mental distress (Russel & Fish, 2016). Similarly, I do not question that increased accessibility to safe and affirming mental health services is a critical issue facing queer youth and their support systems (Hadland et al., 2016). Rather, I posit that as we become more and more adept at understanding and explaining the consequences of minority stress and at developing models to treat it, the emphasis will inevitably shift. At its heart, this study begs the question as to why this should be so. It challenges the removal of responsibility from the discourses and structures perpetuating minority stress and the concomitant responsibility placed back on to the youth and the service provider to deal with the consequences of the same.

Of pertinence to Indigenous LGBTQIA+ and Two Spirit youth experiences of mental health service delivery is the discussion of the colonial construction of mental illness. Inherent to this process is an emphasis on bio-medical definitions of well-being which, in turn, contributes to statistics related to the incidence of suicide and distress such as those cited earlier in this paper. Indeed, the difference in how well-being is constructed and measured is an intrinsic part of how settler colonization has stripped Indigenous peoples of traditional values and beliefs that are more wholistic (Waldram, 2008; Wieman, n.d) and encompass broader components of spiritual, emotional and mental wellness. For instance, “the Cree concept of ‘being alive well’ or *miyupimaatisiun* is informed by historical, contemporary events and cultural practices. This
definition extends beyond the usual biomedical parameters of physiological well-being and highlights the importance that various relationships have on health” (Czyzewski, 2011, p. 5).

So, what exactly is the impact of settler colonialism on Indigenous LGBTQIA+ and Two Spirit youth seeking mental health services and in particular for those who have been and continue to be constrained by the colonial spectrum of sexual orientation and gender binaries? As was stated earlier in this paper, the scholarship in this area is scant and information tends to be a function of youth being a part of a larger study on queer youth with Indigenous LGBTQIA+ youth representing a small part of the sample (Logie & Lys, 2015). However, a search of the First Nations Child and Family Review (2017-2019) proved fruitful, with related literature discovered, albeit mostly centred on child welfare experiences and not specific to Indigenous LGBTQIA+ and Two Spirit youth. One article, in particular (Citation?), had bearing on clinical work with Indigenous peoples and the content is transferable to work with Indigenous queer and Two Spirit folk. While focused on directions for appropriate clinical social work for clinicians, the suggestions are inherently corrective. As such, the authors speak to how therapeutic spaces can be hostile environments for Indigenous 2SLGBTQIA+ people to navigate, re-enacting experiences of violence, traumatization and cultural assimilation.

Fast and Collins-Vezina (2019) review the literature focused on historical and intergenerational Trauma and Indigenous resilience. While the topic of Indigenous resilience has been addressed in the section previous to this, there is nevertheless relevant content. To this end, the authors suggest that:

Clinicians that work with Indigenous peoples around manifestations of trauma should also be aware of culturally appropriate treatment models. Duran and Duran (1995) argued for a shift in the counsellor’s worldview when working with Indigenous populations… as] most Indigenous peoples’ belief systems about mental health and healing are very
different from euro-centric viewpoints. For example, the concept of time is generally used by western mental health counsellors to set goals for treatment. For Indigenous peoples, it may not be a length of time that is required to heal, but rather the intensity in which they engage in the process. Dancing intensely during a traditional ceremony may provide as much cathartic relief as discussing problems over a longer period of time. (p. 175)

Jeffery McNeil-Seymour (2015), a Two Spirit Tk’emlupsemc and fourth-generation English settler concurs writing about Cross-Dancing as a culturally restorative process for Two Spirit peoples. In their article, they also make a number of recommendations for social work practice in general including a reminder that decolonizing perspectives and approaches while useful are still centred in settler discourses. Further, they purport that when using approaches like anti-oppressive, decolonizing social work models with Indigenous 2SLGBTQIA+ people there is a concurrent risk that western understandings of gender and sexuality are inferred and that Two Spirit peoples will be excluded. Ultimately, the author calls for “Indigenous-led, culturally restorative practices [with the inclusion of] strong allies for Two Spirits” (p. 101).

Extending this discussion, Sara Hunt (2016), a Kwagiulth Nation scholar, discusses the impact that cis and heteronormativity have on Two Spirit health, reiterating findings from a 2004 report by Rainbow Health Ontario. They state that “the structure, design and delivery of health care are deeply impacted by homophobia, transphobia, cisnormativity and heterosexism, creating barriers for Two Spirit people as they try to access health services” (p. 12). While not referencing LGBTIA+ Indigenous folk, it makes sense that they would experience similar barriers to service. With specific reference to youth, Hunt (2016) notes that Two Spirit youth are often perceived as being “at-risk”, a conceptualization that is rejected within the Two Spirit community itself. In response to this position, Hunt discusses the need to work with youth in a manner that is
supportive rather than stigmatizing. This would involve such things as meeting them where they are at, focusing on their strengths, and allowing them to self-determine identity and experience (p. 18).

In sum, that the scholarship representing the actual voices of Indigenous LGBTQIA+ and Two Spirit youth mental health service users is virtually non-existent comes as no surprise and goes far beyond barriers to access and safety. There must be a recognition that settler notions of benevolence and social work piety (Blackstock, 2019) play a large part in this erasure of Indigenous knowledge and the right to self-determine appropriate mental health services. Colonization has and continues to have a devastating impact on the well-being of Indigenous people. It is imperative that wholistic and culturally restorative mental health service provision be designed, delivered, and evaluated through Indigenous-led initiatives (Waldram, 2008; Weiman, N.D.; Reeves and Stewart, 2017; Mitchell, 2017). It is equally imperative that as this takes place the voices of youth service users be centred for all to hear.

**Service Providers Experiences of Cis and Heteronormativity in Mental Health Service Provision to Queer Youth**

While there is a paucity of articles regarding service providers’ reflections on their experiences of heteronormativity in their clinical practice, there are numerous articles that discuss the discursive effects of the same. To this end, when searching the literature, the preponderance of articles reflected studies that discussed the relationship between service providers’ negative affective responses (homophobia) toward 2SLGBTQIA+ clients and the factors that influence these attitudes (Snively, Kreuger, Stretch, Watt, & Chadha, 2004) and how these manifest themselves in practice beliefs and behaviours (Mullins, 2012, 2015). Some articles discussed how increased competency in understanding issues that affect 2SLGBTQIA+ clients could mitigate the effects of homophobia (Eubanks-Carter, Burckell, & Goldfreid, 2005).
Others traced the origins of homophobia, biphobia, and transphobia to social work pedagogy and how sexuality and gender are constructed in social work education (Jeyasingham, 2008).

Lev (2013) discusses the challenge of fully incorporating 2SLGBTQIA+ clinical knowledge into the mainstream of clinical social work. They argue for the need “to deconstruct heteronormative thinking, to queer the discourse… [to move] this discussion past ‘gay-affirmative’ therapy, and to imagine a ‘more’ queer psychotherapy, one that truly challenges the pathologizing of 2SLGBTQIA+ lives, and the heteronormativity of non-queer ones” (p. 289).

Daley (2013) would concur, arguing for service delivery that does not delimit gender or sexuality for queer and trans individuals and for a system that is not obstructive but instead accessible to all across the spectrum of genders and sexuality (2012, 2011, 2010, 2009, 2003).

Indeed, without acknowledging the larger systemic influence of cis and heteronormativity on the service providers’ own lives and on how they provide services and without challenging the construction of gender and sexuality in mainstream social work education, the crux of the issue becomes far too simplistic. If the literature is any indication, it appears as if the solutions lay within the control of the service provider themselves. As such, it becomes solely an issue of getting to know and accept 2SLGBTQIA+ family members, colleagues, and friends (social interaction), education and training, being mindful of moralistic perspectives associated with religiosiy, and being mindful of how geography contributes to exposure and ignorance regarding 2SLGBTQIA+ individuals and their clinical needs (Mullins, 2012). A recent study referenced earlier in this paper may be the exception to this position. Kilcaslan and Petrakis (2019) undertook a survey of health care staff regarding their need for training and a sense of competence when working with 2SLGBTQIA+ patients. Unique to this article, the authors specifically traced the cis and heteronormative origins of the models of care and made a direct connection between staff lack of knowledge and the need for training back to these models.
While not examining the unique elements of how cis and heteronormativity impacted individual practice, there was an overall recognition that there was indeed an impact on service provision due to institutionalized cis and heteronormativity and that there was a concurrent need for staff training to mitigate these effects.

In sum, in mental health service provision, cis and heteronormativity not only informs the conceptual understanding of diagnosis and therefore clinical knowledge (Daley & Mulé, 2014), but it also permeates the very system, impacting the day-to-day operation of services in every aspect of the work. This is evidenced in how clients are brought into service, how they are “treated” and the criteria for deciding whether the work has been successful, and the client can be discharged (de Jong, 2014b). It is also clear that, based upon the literature, personal lived experiences and the associated experiences of colleagues heteronormative thinking impinges upon the daily experiences of those who do the work—albeit often unwittingly and unbeknownst to the practitioner. Further, when a queer theory lens is applied to research with 2SLGBTQIA+ individuals, the cis and heteronormative underpinning of mental health service provision is exposed. Interestingly, recent literature has begun to take up the mantle of exposing this reality and the attendant consequences for 2SLGBTQIA+ clients. It is hoped that this research project will add to this growing body of literature, further shaking the silent and hegemonic hold that allows cis and heteronormativity to dominate mental health service provision and the research in this area.

**Chapter Summary**

The intent of this literature review was to provide context for this research project. To this end, it was broad and encompassing and opened space within the literature for the placement of my findings and the analysis and discussion of the same. I am a social work scholar who is foremost a practitioner “at heart”. I am committed to translating theory into meaningful and
useful practice wisdom in the real world. As such, I began this chapter by identifying the theoretical and conceptual foundations from which this research project emerged and evolved. Specifically, I attempted to draw out the salient applications of these theories and concepts to social work provision to 2SLGBTQIA+ youth and those who deliver these services. The multiplicity of lenses identified was important, as it highlighted how I understood, experienced, and celebrated the unique story of each participant. In the end, the intersectional nature of participant identities ultimately determined the selection of these guiding frameworks.

Having established a solid theoretical basis for this study, it made sense to explore and place it within the relevant literature. Accordingly, section one of this review examined the realities of growing up as a 2SLGBTQIA+ youth in a world dominated by colonial ideology and cis and heteronormativity. It explicated the statistical realities concerning mental health disparities and as such, provided the rationale for the importance of this inquiry. Further, it opened space for a more fulsome examination of these experiences setting the stage for section two.

In section two of this review, the resilience of 2SLGBTQIA+ youth was examined. This was important as it demonstrated that despite the hegemonic nature of settler coloniality and cis and heteronormativity, queer youth can prevail. It also identified the very sad reality of the uphill nature of this battle. Indeed, the distress experienced by these youth will not end until the systems and structures responsible for it change. This is a clear message that must be heard by all providers of mental health services and in section three the current practice context concerning the impact of settler colonialism and cis and heteronormativity was examined.

The outcomes of the literature examined in section three of this review were sadly not surprising. Very clear and damaging consequences emerged from the impacts of settler colonialism and cis and heteronormativity on mental health service provision. Fundamental to
these impacts was the reality that the current service systems remain ensnared by western, colonial bio-medical ideology, continued deference to the psychiatrizing of queerness and health care that is designed to meet the needs of those embodying conforming constructions of gender and sexuality. Clearly when a system is predicated on such priorities, navigating it safely becomes a near impossibility for 2SLGBTQIA+ youth.

Section four picked up on this theme and focused on the scholarship that reflected the realities of queer youth service experiences. The literature explored was varied, with few articles that referenced the lived and situated experiences of the youth as told in their own words. Other literature reflected the views of queer youth based upon their sense of what safe and affirming service delivery would look like and what they perceived to be their greatest needs. Much of the scholarship examined was based on quantitative and mixed methods using survey research to assess the mental health service needs of queer and trans youth. A trend was also identified regarding the use of the minority stress model (Myer, 2003) in understanding 2SLGBTQIA+ mental health disparities. There was a paucity of literature regarding Indigenous LGBTQIA+ and Two Spirit youth actual service delivery experiences. As a consequence, the scholarship that offered direction to service providers about safe and affirmative service delivery to this population was used as a proxy to infer the damaging impact of settler colonialism on the lives of the queer Indigenous and Two Spirit youth and on how service providers approached service delivery with them. It was also noted that this scarcity was as much a reflection of the lack of safety and accessibility in services for Indigenous youth as it was a function of an overall erasing of Indigenous knowledge, voice, and the right to self-determine Indigenous-led service delivery options.

Finally given the scope of this investigation and the inclusion of service providers, section five of this review examined the literature that explicates the providers’ experience of cis
and heteronormativity in mental health service provision to 2SLGBTQIA+ youth. To this end, there was an unfortunate lack of any literature that spoke directly to this issue; however, the cis and heteronormative foundations upon which service providers are trained and services delivered were identified along with articles that described the discursive impacts of the same. In sum, the consistent theme emerging in this exploration was an acknowledgement of the need for increased training to decrease the likelihood of queer youth having negative service delivery experiences.

After carefully reviewing this literature and establishing a firm foundation from which to proceed with this paper, I find that I am still left with a need to know more about the actual lived experiences of the 2SLGBTQIA+ youth service user and those who provide services to them. This is especially true with respect to the experiences of those in the province of Newfoundland and Labrador as these experiences are largely absent from the literature in this area. I am also left wanting to hear the stories of mental health service provision in the voices of the actual youth service users and the providers themselves. In my many years of social work practice I found that regardless of how well a clinical case note was written it could never capture the intensity and true essence of what transpired during the actual therapeutic exchange itself. While participants quotes may be powerful, they are never the less chosen by the researcher, decontextualized from their origins and placed strategically to support the researcher’s position. As such they are a proxy measure of the intensity and the reality of the actual participant experiences. The inclusion of digital stories in this project represents my attempt to address this absence within the literature.
CHAPTER THREE: METHODOLOGY

My Social Location as the Teller of the Stories Told

At various points in the following chapter, I have spent time speaking to my positionality in this study both personally and as a researcher. I have done so by sharing the ethical dilemmas associated with entering into and situating myself within this research project. I have done my best to be transparent about these circumstances and yet I have been reminded upon submission of this draft chapter that I may have inadvertently missed an important first step (thank you, Shoshana). To this end, I begin this chapter by reminding the reader of my social location in recognition of the fact that every aspect of this research project including the choices that I have made with respect to the telling of the stories told by participants have been influenced by who I am and how I have come to be.

Accordingly, I am a white settler ally of English and Irish descent and a guest on the ancestral homelands of the diverse Indigenous peoples of Newfoundland and Labrador (NL). I am a queer-identified individual who is cis and hetero presenting. I have been a recipient of mental health services and have formerly been psychiatrized and epistemically violated in the process of receiving these services, but I do not identify as mad. I am well educated, well employed, and well aware that I possess and exercise a high degree of unearned personal power and privilege which has ultimately brought me to and situated me in the place of being the teller of the stories told to me during this research project.

Background to the Choice of Research Design

The research design associated with this study was exploratory. I planned to invite participants (N=15) to engage in a research process that would facilitate an understanding of their mental health service delivery experiences concerning cis and heteronormativity. I wanted to center the participants lived and situated experiences so that their individual stories could be
heard. I was mindful that I would need to maintain an intersectional lens to open space for an understanding of the vectors of power that impacted upon participant lives, their fluidity across multiple subjectivities, and the rich texture of their individual experiences.

At the heart of this project was the desire to dispel the expert voice. Accordingly, this meant that I would need to position myself in such a way that I could achieve a balance between my specialized researcher knowledge (Rossiter, 2011) and the participant’s wisdom and experiences. To this end, I realized that the design of this project would become integral to the accomplishment of this priority. As such, I made a conscious choice to engage in processes of reflexivity and critical reflection as a supportive element of the research design. This decision was both a “blessing and a curse”, as it took a long time for this project to come to fruition and, at each juncture, reflexivity and critical reflection played a crucial role.

**Reflexivity and Critical Reflection: Establishing my Personal Positionality in the Project**

Reflexivity and critical reflection are terms that are often used interchangeably in the social work literature and they are processes that have become conflated in their application to clinical social work practice (Watts, 2019). Common to both processes is the use of a critical lens; however, to explain my use of them in this research project I will explicate how I differentiated between the two. Accordingly, when engaging in critical reflection during this project, I undertook a process of considering multiple frameworks when thinking through an issue. In doing so I attempted to ensure that I considered and integrated other perspectives before coming to a place of understanding and/or conclusion. Although similar, reflexivity was more of an iterative process for me in so much as I was not just applying multiple lenses when considering an issue; rather, I was also aware of my positionality and social location as well as, my relationship to the issue and how taken together, these things influenced me as I thought things through. In general, reflexivity and critical reflection were concurrent processes that I
employed together and that ultimately allowed me to enter wholly and ethically into this research project.

During the comprehensive examination, the processes of reflexivity and critical reflection hastened this study allowing me to integrate concepts and come to a theoretical understanding of my research project fairly quickly. As time went by and this project needed to take concrete form and find direction, reflexivity and critical reflection became a weight, slowing this project down to a halting pace. At issue was my personal positionality; I needed to find a way to fully and wholly situate myself within the study, which required a personal project of honesty and integration. This took time and many life transitions ensued, some of which were of my doing and others were not. In the end, it was my realization and acceptance of the entwined nature of my life and the meaningfulness of this research that allowed me to move forward with personal integrity and to continue with this inquiry. A similarly reflexive and critically reflective process occurred simultaneously about my positionality as a researcher in this project and this will be addressed in the section following this one.

Over the last year, reflexivity and critical reflection continued to play an instrumental role in the data collection, analysis and writing up of this inquiry - yet again proving their worth. I have kept a research journal where I have recorded my thoughts throughout this process. This
has been helpful and has provided a space for me to place my worries, my doubts, my fears and my observations and realizations. It has also been a repository for my reflections about my interactions with participants and the insights that I gained from these exchanges. This became an invaluable resource for me during the data analysis process as it functioned as a baseline for my earlier thoughts regarding participants and research processes and it provided space that allowed me to expand upon these thoughts, reflections and observations over time. In particular, these reflections served as a key element of the retrospective analysis of this research project undertaken in chapter four of this paper.

**Unsettled Social Work Research: Establishing Researcher Positionality in the Project**

The work of Amy Rossiter (2011) has been highly influential in my social work pedagogy, scholarship and practice. She endorses an “unsettled” position - one that I have experienced both intentionally, as well as, unintentionally at differing points throughout this research project. Her admonishment to allow for the emergence of knowledge rather than beginning from a place or position of knowing became a guiding ethical imperative for me. While her writing was concerned with ethical social work practice I nevertheless, found that it had direct application to ethical social work research and this project specifically.

Rossiter’s (2011) provocative and compelling argument towards “unsettled social work practice” embraces the very act of practice as ethics rather than, ethics being solely a set of guiding principles applied to clinical work. Hence, social work practice becomes “defined by a conscious and deliberate commitment to working in full view of the tensions and contradictions derived from social work’s professional status and knowledge claims” (p. 981). Referencing Eugene Levinas, Rossiter argues that to enter into social work practice from any other position is unethical and epistemically violating (p. 985); when one assumes that one “knows” an individual’s need-based upon specialized knowledge, an individual is
essentialized and the fullness of who they can become and what they need is delimited. Rossiter refers to this experience as being placed in a state of “ethical captivity” (p.984).

Certainly, within the research literature, the issues of researcher positionality and participant representation have been widely debated. Rossiter, while speaking specifically to ethical practice, nevertheless addresses the “very heart” of the ethical dilemma that I faced surrounding my researcher positionality and the representation of the participant experiences in this research project. At the crux of this dilemma was my need to reconcile how the fullness of the experiences of 2SLGBTQIA+ youth and the practitioners that service them could emerge against the backdrop of a research project stemming from my comprehensive paper. Practically I wondered if I would be able to divest of the specialized knowledge gained through my comprehensive process and balance my researcher privilege to open authentic space for the experiences of research participants to emerge? If so, how would I be able to join in this process as one who has been historically complicit in the practice of “knowing” apart from hearing the lived experiences of youth involved with the mental health system? Would I be able to sit in my own experience of being epistemically violated due to heteronormative expectations of gender and sexuality and would I likewise be able to allow stories of difference from mine to emerge? And ultimately, would I be able to let go of my research agenda and truly hear the stories that the youth and the providers wanted to tell? (Thomas, 2015). Taken together, these questions became the basis for finding an appropriate research design, one that would allow me to enter into the latter parts of this research project with a sense of ethical integrity.

**The Rationale for the Choice of Research Design**

As outlined above, centring the lived and situated experiences of the research participants and holding a space that would allow for these experiences to emerge were the driving
forces behind this inquiry. From the inception of this process, I was bound by the knowledge that I would be interviewing youth and potentially providers who may have experienced the violence associated with the colonial and cis and heteronormative impacts of the mental health service delivery system. This weighed heavily on me as I was determined to position myself within this project so as not to inflict further violence upon participant lives. The concept of ethical captivity ironically rendered me immobile as I found myself held hostage by the need to find a research design that not only allowed participant experiences to emerge, but also to remain intact. I was reluctant to “pull apart” stories and apply my specialized knowledge as a lens to interpret them. I was reticent to yet again categorize and essentialize participant experiences replicating the very processes [read violence] that were implicit to the mental health service delivery systems in question.

In the search for an appropriate research design, I stumbled upon digital storytelling as a potential medium for inquiry. I immediately knew that I had found an alternative to the exclusive option of data analysis via dissecting stories into snippets that represented broader themes. While not perfect, digital storytelling represented a compromise for me. It presented the opportunity for participant voices to be completely heard in an unedited manner. It was a way to augment the data analysis process—softening the expert voice and inviting the reader into the fullness of the rich and textured stories as told by the participants themselves. To this end, digital storytelling became one of the three design elements that grounded this research project.

**The Research Design**

The following sections describe each element of the triangulated research design associated with this project (with the supportive elements of reflexive journaling and critical reflection having been detailed earlier in this chapter). Accordingly, biographical narrative-
based individual interviewing, digital storytelling, and the storytelling circle process will be discussed.

According to Patton (1999), triangulation involves the application of multiple methods or data sources in qualitative research. The use of these sources aids in the development of a comprehensive understanding of what is being studied. Lincoln and Guba (1985), posit that the process of triangulation increases the trustworthiness of the data by increasing its credibility through the use of multiple sources of data; by increasing its dependability through the use of overlapping methods and by increasing its confirmability through the use of reflexive journaling (Table 1; p.330). To this end, all three aspects of trustworthiness are reflected in the research design associated with this project, including three different sources of data collection, the use of three different formats for collecting this information, and the inclusion of reflexive journaling and critical reflection throughout all stages of the research process.

**Phase One: Biographical Narrative Inquiry as the Basis for Participant Interviews**

The research processes associated with narrative inquiry are broad and varied and represents numerous genres. According to Kim (2016), these include biographical narrative inquiry; autobiographical narrative inquiry; and arts-based narrative inquiry (p. 121). Despite the emergence of these clearly defined genres, Kim acknowledges that not all projects fit neatly within a classification (p. 120). Such is the case for this study. Hence, a combination of biographical narrative inquiry (participant interviews) and arts-based narrative inquiry (digital storytelling) was used.

The objective of biographical narrative inquiry is to “understand how the participants construct and interpret their life experience, appreciating participants’ genuine accounts and interpretations which are largely absent from most qualitative approaches” (Kim, 2016, p. 126).
As such, biographical narrative inquiry embodies the preferred ethical imperatives from which this study emerged. Hence, the real-life stories of mental health service provision of 2SLGBTQIA+ youth and service providers became the texts from which themes emerged. Additionally, the process of narrative-based interviewing aligned with my preferred personal and researcher positionality, allowing the interviews to proceed in a dialogical manner. This was a fluid process between the participant and me, which often shifted throughout the interview itself. At times, it felt as if I was being led into places that had no bearing on the topic at hand and I struggled to contain my urges to redirect the conversation back to my research agenda. At other times I lost track of time and was swept up in a conversation that could not have been any more centred on the research topic if I had tried. There were moments of connection and learning when I was humbled as my adultist assumptions were corrected by the youth participants and still other moments when my adult presence provided hope that the lives of the youth participants mattered and that the stories being told were important and could make a difference.

Narrative-based interviewing was an apt choice as the first stage of this research design. It served as a foundation going forward and a gateway to my understanding of the stories that participants ultimately wanted to tell. It allowed me a glimpse into emergent themes and created momentum and anticipation for the second and third stages of the research process. The details of the exact unfolding of this first phase of the research project follow later under the data collection section of this chapter.

**Phase Two: Arts-Based Narrative Inquiry and the Use of Digital Story Telling**

The digital storytelling method refers to a three to five-minute visual narrative that synthesizes photo images, video, an audio recording of voice and music and text to create compelling accounts of lived experience” (Kim, 2016, p. 150). This process has been used
widely in the United States since the mid 1990’s and with the increase in access to and the
development of new digital technologies, it has been used for research, public advocacy, and
social justice initiatives (Story Centre, n.d.). In Canada, Dr. Carla Rice, a Professor at the
University of Guelph, provides digital storytelling education and services through her Re-Vision
Centre. Her projects include funded studies such as: “nishnabek de’bwe win telling our truths:
Aboriginal people and allies using technology, telling stories, and making change” (Re Vision,
n.d.) and “Through thick and thin: Investigating body image and body management among queer
women in Southern Ontario” (Rinaldi et al., 2016). In general, and for this research project, the
digital storytelling process occurs in a workshop format where participants get trained in all
aspects of digital storytelling and are supported to create and produce their own story. While
digital storytelling is a relevantly new medium for gathering information and for sharing the
lived and situated experiences of research study participants, the process of storytelling has
been a central element of Indigenous culture and research methodologies for some time
(Hart, 2002; Archibald, 2008; Wilson, 2008; Kovach, 2009; Kovach, 2010; Lavalee, 2009; Hart,
2010; Absolon, 2011).

Margaret Kovach (2009), an Indigenous scholar from the traditional territories of the
Plains Cree and Saulteaux Peoples of the Great Plains, shares:

> Stories remind us of who we are and of our belonging. Stories hold within them
knowledge while simultaneously signifying relationships. In oral tradition,
stories can never be decontextualized from the teller. They are active agents
within a relational world, pivotal in gaining insight into a phenomenon. (p. 94)

In a research project such as this, the risk of decontextualizing the story from the teller is
high. In fact, it is almost guaranteed if the sole objective is to record, code, and categorize
participant experiences across stories. There is much to be learned from the teachings of
Indigenous scholars (Hart, 2002; Archibald, 2008; Wilson, 2008; Kovach, 2009; Lavalee, 2009; Hart, 2010; Absolon, 2011). In this case, it is about the process of how stories are told and received and the relational nature through which content is understood and contextualized. Hence, without the inclusion of the (digital) storytelling process as part of this project’s research design, there would be an inherent loss of the richness and the history contained within individual participant stories.

Qwul’sih’yah’maht Robina Anne Thomas is a member of Lyackson First Nation and an academic who has used storytelling as methodology in her graduate work. In chapter seven of Research as Resistance, Thomas (2015), details the nuances of using storytelling methodology and discusses the various ethical dilemmas (spirit of ethics) that she experienced as a part of the process. Her experiences speak deeply to me, as she sought first and foremost to represent the storyteller and their words; she states that “Storytelling should always be teller-focused and share what the tellers deem important about their experience and should not be about studying what the researcher deems important” (Thomas, 2015, p. 187). Thomas advocates for the use of dialogue and conversation and she sits with the teller while they engage in the process of telling their stories over multiple occasions (p. 187). Herein lies yet another aspect of my attraction toward digital storytelling as a part of this research process.

The digital storytelling workshop portions of this study provided the opportunity to sit with participants and support their story development over time and through various iterations. For me, it created an intimate connection to the participants’ experiences and the respective impacts upon their lives that went far beyond the interviewing format. It invited others to share in these experiences. Together, we held space, shared food, and supported one another through the process. The process was a rhythmic dance of stepping in and
stepping out of each other’s lives and, as personal accounts took form and made their way to production, there was recognition of the teller-focused nature of the stories created and shared.

In sum, the digital storytelling workshop was a key component of the research design associated with this study. As with the other design elements supporting this project, the data collection section chronicles the details of the digital storytelling workshop process demonstrating the richness of this experience. A fuller analysis of the influence of this element of the research design on the findings of this project will occur later in this chapter.

**Phase Three: Talking Circles and the Final Storytelling Circle**

According to Shoshana Pollack (2016), “there are various formats and ways of working with talking circles, but most models have their origins (whether explicitly acknowledged or not) in Indigenous ways of sharing and learning” (p. 4). To this end, I acknowledge that the digital storytelling circle associated with this research design finds its origins in Indigenous traditions. Jean Graveline (1998) is a Métis feminist and anti-racist activist and scholar and presents a model for transforming Eurocentric consciousness in her book *Circle Works*. In the chapter entitled “Talking circle as pedagogy”, she illustrates the Indigenous roots of the talking circle process and how the principles of traditional beliefs can have an application to classroom and research contexts such as this project (p. 136).

Essential to the talking circle process are two key elements: heartfully speaking (p. 142), which represents voice, and respectfully listening (p. 145), which represents silence. According to Graveline (1998), one is equally as important as the other and participants learn through both positions. She notes that, while people often think of the circle process as a place to give/find voice, silence is also essential to learning and personal transformation (p. 145). In relation to this study, this is an important point. Sitting in silence is an awkward experience in any western
context (Palmer, 2004). As an educator and a researcher, I acknowledge my propensity to fill the dialogical void. In particular, sitting in silence becomes a particularly difficult task when sharing stories that reflect pain (as was the case with this research project). For Graveline (1998), the alternative to filling this silence is the recognition of “collective mindfulness” (p.148).

Collective mindfulness transpires when “communication is occurring without reliance on expressed words” (Graveline, 1998, p. 148). Graveline (1998) discusses how sharing from the heart and respectfully listening allows for a depth of relationship between participants that is contrary to that experienced in traditional, western learning contexts. I have personally experienced the power of this process as a participant in Indigenous teaching circle processes. To this end, there are no words to describe this privilege; instead, I am left with intense feelings of humility and gratitude. In a western research project such as mine, there was no hope of or any attempt made to replicate such an experience; rather, there was just a desire for a meaningful connectedness shared between participants. Graveline endorses this hope when she speaks to the desire to create space for lived and situated experience (p.144) and the invitation for participants to sit in the experience of the other (p. 138) as two of the main principles guiding the talking circle.

Michael Anthony Hart (2002), a Cree scholar, highlights the role of the conductor (the one who leads circle) as key to the Indigenous sharing circle. In his book: Seeking Mino-Pimatisiwin: An Aboriginal approach to helping, he shares that it is expected that the conductor demonstrates the values that are key to the circle process (p. 71). The conductor must also be a good listener, non-judgmental, caring, and be prepared to employ some basic counselling skills (p. 72). Conductors must take time to prepare themselves, which can happen in many different ways, including the use of a smudge and prayer and intentionally slowing themselves down; similarly, prayer and a smudge are often used to open the circle process (p.
72). Clear guidelines must be set for all participants and the conductor must ensure “the sanctity” and safety of the process by acting in such a way as to ensure everyone remains present and is a respectful participant (p. 74-75). It is equally important that each participant who wishes to speak be given an opportunity that is not restricted by a time limit (p. 76).

In acknowledging my settler status and colonial heritage, I am mindful of appropriation and very much aware of my inability to lead circle as a conductor. Notwithstanding, there is wisdom to be gained and principles to be honoured in the information shared above. As such, I sought to create a safe, respectful, and inclusive space. Clear ground rules were negotiated with participants and I held the space in the most therapeutic way possible; additionally, there was no time limit placed on participant presentation and/or feedback.

The Indigenous talking circle process holds valuable learning for a research project that includes any manner of circle work as a portion of the design. Given the western nature of this project, I am indebted to the Indigenous legacy of this process and as mentioned earlier I am personally grateful for its power and healing in my own life. The digital storytelling circles that evolved from this project were indeed meaningful to participants and were spaces of shared experience and understanding. A detailed description of the processes of these circles is presented in the data collection portion of this chapter and includes a reflection on my experiences of being in circle with participants and my sense of the impact that this had on all involved.

**Methodological Processes**

**Research Ethics Board Review Processes**

This project received ethics approval from the Wilfrid Laurier University (WLU) Research Ethics Board (REB) in July of 2017. Two pilot interviews were conducted in Ontario under the authority of this approval, both in January of 2018. Following my relocation to the
province of NL in July of the same year, I began to consider moving this research project to NL. My initial reasoning was primarily for logistics; however, as I settled into my new community and became familiar with the mental health service delivery system and the recency of the provincial mental health and addictions strategy, I saw a synergy between my research project and the “political climate” in the province. I also felt an ethical pull towards contributing to the knowledge base and potentially making a difference in my new home province. Even more compelling was the reality of recruitment in Ontario and my commitment to participants post-study. Early on in the formation of this project, Dr. Kathy Absolon gifted me with valuable insight (thank you, Kathy). While her guidance was specific to the recruitment of Indigenous participants, it nevertheless, became an ethical imperative that undergirded the entirety of this project. Kathy warned against entering into relationships with participants that were time-bound and for the purposes of the research project only (K. Absolon, personal communication, May 30, 2016). In effect, she spoke to the Indigenous research principle of reciprocity which, over time, spoke very clearly to my heart. As a consequence, collaborative social action possibilities with participants post-study became as important to me as the research project itself. In short, I would not be able to accomplish this commitment in Ontario while residing in NL. After consultation with my committee chair and agreement from my committee, I modified my original WLU REB application and was granted approval to move the project to NL. It was, however, suggested that I speak with REB at Memorial University (MUN) to ensure that I did not need local approval for my data collection.

Through conversation with the research grants coordinator at MUN School of Social Work, it was confirmed that I needed to go through a second ethics review process that was specific to the province of NL. There are two external REB processes in the province, and it was deemed that I needed to seek approval through the more rigorous one: The Health Research
Ethics Board (HREB). This was a lengthy process and not just a matter of “cutting and pasting” my WLU application into my HREB one. In total, it was a three-month-long process (January 2019 through March 2019). This created an unfortunate delay in the project timelines as well as some contradictory requirements between the local HREB authority and WLU REB. Ultimately, I was instructed to follow the requirements of the local HREB. To this end, recruitment for this project began in mid-March of 2019, the details of which follow below

**Recruitment Processes**

**Participant inclusion and exclusion criteria.** The inclusion criteria for this study were as follows: 2SLGBTQIA+ identified youth aged 16-24 years; service or former mental health service users who had the capacity to consent to participation. 2SLGBTQIA+ youth under the age of 16 and over the age of 24 were excluded from this study. The inclusion criteria for service providers was who they were or had been: employed in a publicly funded/not-for-profit service as someone that provided mental health services to youth; were currently or had formerly provided these services to 2SLGBTQIA+ youth; able to consent to participation in this study and aware of/had experience with the discursive impacts of heteronormativity on service provision. Concerning the latter criteria, this was an explicit part of the recruitment process, screening participants for their awareness and experience. Service providers who were not employed in publicly funded/not-for-profit agencies or who had not provided services to 2SLGBTQIA+ youth were excluded from this study. As a result of these criteria, I had two interested youths who were screened out from participation in the study due to age. In total, ten 2SLGBTQIA+ youth and five service providers were recruited for this project (see Table 1 and Table 2 in the section following recruitment for the associated demographic information).

**Recruitment of non-Indigenous LGBTQIA+ youth participants (N=6).**
It is important to note that the recruitment processes for youth participants occurred simultaneously with the interviewing processes. As co-occurring processes, one had a direct bearing on the other and I was able to make somewhat purposive choices regarding the diversity of the sample sought and the geographical representation of participants.

As the initial step to recruitment, I met with a faculty member in the Department of Gender Studies at Memorial University. They offered advice regarding who key contacts should be for my study and put me in touch with the leadership of the local chapter of PFLAG and the Executive Director of Trans Support NL. This meeting occurred during the HREB application phase and it helped to inform the recruitment strategy that I proposed. Despite this consultation, once approved, I realized that my recruitment strategy reflected my newness to the province and my lack of familiarity with the local service system structure and the local 2SLGBTQIA+ community. As a consequence, it proved to be too narrow and a modification was submitted and approved by HREB that allowed for a snowballing process to include additional relevant agencies and pertinent contacts. On the advice of PFLAG, my recruitment poster was placed on their Facebook page by their leadership. It was shared widely by their members. I was also in contact with local campus groups requesting that they post a physical copy of my poster at their respective location or post an electronic version to their website or social media pages, at their discretion. The Memorial School of Social Work tweeted an invitation to participate in the study as well as a copy of my recruitment poster on their Twitter feed. I met with a local mental health professional who was well respected as a provider among the local 2SLGBTQIA+ community. They worked for Eastern Health, which is the local health authority. Unfortunately, recruitment through Eastern Health was not possible as they had yet another REB process and I did not want to delay or complicate the project any further. Nevertheless, the conversation was very helpful and gave me a solid overview of the mental health system and the provincial mental health and
addictions strategy. As a consequence of this meeting, an email introduction was made on my behalf which began the current dialogue with the provincial government local inclusion committee leads. I also sent out emails to individual youth-serving agencies asking to meet with them regarding the participation of their staff and/or clients. As a result of these emails, I met with one local staff group and shared recruitment materials and information on the project. I created a website for my project and the following message was inserted into my MUN faculty and WLU student signature blocks, and was attached to my faculty profile on the School of Social Work website: “Please click on this link to see my Doctoral research project: https://heariamresearchproject.wordpress.com/”.

With recruitment well underway, I made a deliberate effort to seek out trans youth representation given that the first four participants recruited for the study were not members of this community. Accordingly, physical copies of the recruitment poster were dropped off to a local trans-serving health clinic and a face to face meeting with the Executive Director of Trans Support NL was arranged. As a result of this meeting, I was put in touch with a young trans advocate on the west side of the Island. The ensuing phone meeting was helpful on two fronts; I was able to recruit specifically for trans and/or gender non-conforming youth and I was also able to find geographical representation from other parts of NL.

The initial four participants recruited for this study were from the St. John’s area. A fifth youth was also recruited for the project who lived in a smaller town about an hour’s distance from St. John’s. I agreed to meet with them at their local mental health clinic, drove to the meeting, but they did not attend. After several more scheduled meetings and equal numbers of cancellations/no shows, and despite the electronic transfer and acceptance of the interview honorarium by the youth, there was still no interview time arranged. I was uncomfortable with
continuing to pursue participation and a voicemail was left for the youth leaving it with them to contact me if and when interested in meeting. No contact was ever made.

As indicated previously, the recruitment of youth participants from the West side of the Island was facilitated through connection with a young trans advocate who resided in Corner Brook. After an initial phone meeting, he posted my recruitment poster in his Facebook group with an endorsement of the study. The response to this invitation was overwhelming, with eight requests for further information. In total, six youth were recruited from the Corner Brook area, which required that I arrange to spend four days there to conduct a combination of interviews as well as the digital story-telling workshop.

Recruitment of Indigenous 2SLGBTQIA+ youth participants (N=4). Despite having REB approval from Laurier to recruit Indigenous participants when the study was situated in Ontario, the research protocols associated with HREB were different and prevented me from recruiting through Indigenous-specific services in NL. To do so, I would have needed to have had a letter of agreement from each organization before the HREB application. Laurier REB, on the other hand, approved my research study with the proviso that I could approach Indigenous serving agencies about recruitment and that, if there was an agreement, I would need to submit a modification for any required changes to study protocols as requested by Indigenous agencies, Elders, or Community Councils. I discussed this option with HREB and was told that it was in contravention to recent provincial research protocols for conducting research within Indigenous Communities. I was yet again placed into an ethical quandary. As someone new to the province and the city, I felt as if I did not have the established relationships needed to approach the various members of the Indigenous community about recruitment for my research project. I needed time and opportunity to demonstrate my allyship and commitment to reconciliation. I sought advice from friends and colleagues who were from NL and from the Associate Dean and
they agreed with my assessment of my position. After some negotiation, HREB agreed to the inclusion of a statement that would allow me to recruit participants who self-identified as Indigenous and they also approved the use of my recruitment poster, which clearly included an invitation for Two Spirit participation in the research project (see Appendix A).

At the advice of a Two Spirit student in one of my classes, I reached out to the social worker at the local native friendship center, as they had spoken of my project with them, but this was to no avail. Of their own volition, the same student also shared a copy of my recruitment poster on their personal Facebook page, hoping to increase the study’s profile within the Indigenous community. In the end, four self-identified Indigenous participants took part in this research project.

**Recruitment of mental health service providers (N=5).** As with youth recruitment, the interviewing processes for providers occurred simultaneously to their recruitment. The distribution of the recruitment poster, which also included service providers, was as outlined in the youth recruitment section. The process of community engagement to find providers for participation was also as outlined previously in the youth section. In a further effort to recruit service providers, a colleague who graduated from MUN School of Social Work posted a digital copy of my recruitment poster on their alumni Facebook page.

In a somewhat ironic twist given my former positionality as a service provider, finding service providers for this project proved to be a much more difficult task than finding youth participants (which would have been the opposite in Ontario). I sensed that this was due to my lack of connection to this community and concerns about confidentiality. It was explained to me very early on that I should be careful about what I say to people. There is a very protective and tight-knit element to being in community in NL. Everyone knows each other and it is hard to keep “your business, your own”. While I may have laughed initially, I quickly learned the value
of this advice. I had only been in the province for three weeks when a colleague at the school of social work approached me to tell me that I had a lovely home and that they knew where I lived. Surprised, they explained to me that I had moved into the house next to their in-laws. The listing agent had told them that I was coming to NL to take a position at MUN in the school of social work and, in NL, that is all that it takes to “make your business someone else’s”. Accordingly, providers were recruited exclusively as a result of colleague recommendations or personal invitation. The study sample, therefore, reflected very little geographical diversity, with one service provider from the Corner Brook area agreeing to an interview, but needing to withdraw due to time constraints. Additionally, only one service provider worked in 2SLGBTQIA+ specific services, with the rest being or having been employed with universal youth-serving mental health agencies.

**Recruitment issues.** In sum, the recruitment processes associated with this project were fairly straightforward with few complications. The recruitment of service providers for the digital story portion of the project was hindered due to the time commitment required for participation, which resulted in only two digital stories being produced. Similarly, recruitment for youth participants was impacted in part by their age and their stage of life. The youth were busy with school and/or work and it was difficult for them to find the amount of time needed for participation in this project (especially the workshop portion). Also, as a function of “age and stage”, communication was often complicated by their propensity toward the use of electronic messaging and social media as a primary means of contact. In hindsight, I realized that communication would have been easier if I had sought HREB approval to communicate with the youth via text message or Facebook messenger. While email was the approved mode of communication, I found it to be unreliable as the youth were not accustomed to using it as a means to regularly communicate. All things considered, these were minor inconveniences in the
larger scheme of things and in the end they had little to no bearing on the successful completion of this research project.
Sample Size and Demographics

**Table 1**  
Youth Participants (N=10)

<table>
<thead>
<tr>
<th>Pseudonym/Name</th>
<th>Age</th>
<th>Gender/Sexual Identification/Expression</th>
<th>Pronoun</th>
<th>Indigeneity</th>
<th>Place of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bobbie</td>
<td>22</td>
<td>Gay</td>
<td>She/Her</td>
<td>N/A</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Sean</td>
<td>24</td>
<td>Gay</td>
<td>He/Him</td>
<td>N/A</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Kevin</td>
<td>21</td>
<td>Mostly Gay/Male</td>
<td>He/Him</td>
<td>Inuit</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Kaiden</td>
<td>20</td>
<td>Trans/ Asexual/ Gender Queer</td>
<td>They/Them</td>
<td>N/A</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Blair</td>
<td>19</td>
<td>Trans Man/Bisexual</td>
<td>He/Him</td>
<td>First Nations unspecified</td>
<td>Corner Brook</td>
</tr>
<tr>
<td>Enigma</td>
<td>22</td>
<td>Androgynous/Bisexual Gender Fluid</td>
<td>They/Their</td>
<td>N/A</td>
<td>Corner Brook</td>
</tr>
<tr>
<td>Dallon</td>
<td>18</td>
<td>Androgynous/Trans Man</td>
<td>He/Him</td>
<td>N/A</td>
<td>Corner Brook</td>
</tr>
<tr>
<td>Ariel</td>
<td>19</td>
<td>Pan Sexual</td>
<td>She/Her</td>
<td>N/A</td>
<td>Corner Brook</td>
</tr>
<tr>
<td>Jay</td>
<td>22</td>
<td>Gay/Trans Man</td>
<td>He/Him</td>
<td>Mi’kmak Inuit</td>
<td>Corner Brook</td>
</tr>
<tr>
<td>Martin</td>
<td>19</td>
<td>Demi Sexual/Trans Man</td>
<td>He/Him</td>
<td>First Nations unspecified</td>
<td>Corner Brook</td>
</tr>
</tbody>
</table>

**Table 2**  
Service Provider Participants (N=5)

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Credentials</th>
<th>Gender/Sexual Identification/Expression</th>
<th>Indigeneity</th>
<th>Type of Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>JP</td>
<td>MSW</td>
<td>Gay/Male</td>
<td>N/A</td>
<td>Youth</td>
</tr>
<tr>
<td>RJ</td>
<td>MSW</td>
<td>Not Identified</td>
<td>N/A</td>
<td>Youth</td>
</tr>
<tr>
<td>PS</td>
<td>HR dip.</td>
<td>Trans-identified Masculine/Gender Queer</td>
<td>N/A</td>
<td>Trans Specific</td>
</tr>
<tr>
<td>JG</td>
<td>MSW</td>
<td>Bisexual/Female</td>
<td>N/A</td>
<td>Youth</td>
</tr>
<tr>
<td>HH</td>
<td>MA</td>
<td>Not Identified</td>
<td>N/A</td>
<td>Youth</td>
</tr>
</tbody>
</table>
Data Collection Processes

**Phase one: Biographical based narrative inquiry.** This section describes the processes that occurred with both youth and service provider participants. Accordingly, upon arrival, the participant was greeted, offered water, and the honorarium for participation was given. Once seated, participants were verbally “walked through” all aspects of the informed consent form (see a copy of this form in Appendix B). Any questions or concerns were addressed at this time and the participant was asked to sign the consent if agreeable to the content. Once signed and with the permission of the participant, the digital recording began. At this point, I socially located myself as a situated researcher who identified as queer and had used and provided mental health services throughout my lifetime. I disclosed that I had experienced my gender and sexual identities being conflated with mental health issues and I discussed my personal and professional investments in the project. I then invited participants to ask any other questions that they may have for or about me. Once answered, the dialogue commenced.

All conversations began by collecting the required demographic details and with the choice of a pseudonym for participation in the project. With providers, this was a straightforward process, as each chose to use their initials to be identified. For the youths, this was less straightforward and required time for thought. All youth who identified as trans and/or gender non-conforming refused to take pseudonyms, choosing to have their preferred name used. After so many years of being misgendered and epistemically violated by the use of their dead name, these youths were not interested in being placed outside of their authentic selves yet again. This made sense to me and I opted to honour their position as it fit with my choice to privilege the voice of the participant over my own.

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11 The term deadname has been adopted by the trans and gender non-conforming community to identify their name given at birth. All of the trans and gender non-conforming participants were using preferred names, and some had legally changed their name to their preferred one.
Once demographics were collected, the youth and the service providers were asked to share their stories of mental health service provision as a recipient, a provider, or as both. Using the principles of narrative inquiry (Kim, 2016), this occurred in an uninterrupted manner and with no questions asked or prompts given. Exceptions to this occurred only when participants asked for direction or clarification of this process, in which case the conversation was more dialogical, and the interview guide was used to prompt participants for answers. A copy of this guide is attached as Appendix C at the end of this paper but in general, the questions/prompts were open-ended and varied depending on participant status. The youth were asked about their service use experiences as a queer and/or trans individual with specific reference to their sense of recognition in the process as well as any instances/experiences of homo, trans, and/or biphobia. They were also encouraged to share what worked well in their service delivery experiences and to share any recommendations for the improvement of mental health service delivery to 2SLGBTQIA+ youth in the future. Providers were asked about the nature of the services that they delivered to queer and trans youth; their sense of the “safety” of these services and/or the service agency in general; inclusive policies and procedures and areas of service delivery that they perceived needed improvement; as well as the areas of service delivery that they believed were being done well. If the provider identified as part of the 2SLGBTQIA+ community, they were asked about their own experiences of safety and recognition in their work environment (see Appendix C for a copy of the interview guide).

For those participants not requiring prompts, when finished telling their story, the process continued on in a dialogical manner as I went back to what participants had shared and asked about specific parts of their experiences, as per the above stated questions and prompts. Additionally, as transcription of meetings and preliminary analysis of the same was ongoing, emergent themes were brought back to the participants for discussion. 90 minutes was allotted
for each meeting, however, the actual conversations ranged in time between 70 minutes to just over two hours. All meetings took place in a private and confidential setting, with the costs of participant travel being reimbursed. At the end of the conversation and while still digitally recording, I did a debrief with each participant as per HREB requirements using the interview debriefing guide found in Appendix D. As a safeguard, I also ensured that participants had a list of local mental health resources in case any aspect of the interview process created distress for them post-interview.

In total, 15 narrative-based conversations were conducted with study participants, ten with 2SLGBTQIA+ identified participants and five with mental health service providers, three of whom identified as 2SLGBTQIA+. All meetings proceeded without issue and I had no concern regarding participant safety during or after the process. I reflectively and reflexively journaled before and following each of the meetings and, as previously indicated, these entries have been incorporated as the foundational basis for chapter four of this paper.

The conversations had during this first stage of the research process were rich and meaningful and not an extractive or one-sided process. They were marked by a reciprocal exchange of experiences between the participants and me. As indicated previously, my positionality entering into this process was fluid. As a consequence, I found that, in addition to gaining insight into the participants’ service delivery experiences, I was often able to relate to what was being shared and able to offer personal and professional affirmation and support of the same. In sum, each conversation was unique and did not follow a prescriptive euro-western approach to interviewing and data collection.

**Phase two: The digital story telling workshop process.** A digital story is a three to five-minute compilation of an audio/voice track (the story) with digital media (photos, video, music etc.) that is designed to communicate an individual’s chosen personal story (Kim, 2016).
In general, the production of such a project is accomplished in a workshop. The length of the workshop can vary but the format is generally the same. The specifics of the workshops associated with this research project will be shared below. Nevertheless, there were three phases in the workshop process: the development of the digital story; the production of the digital story in the WeVideo™ platform; and the sharing of the digital story with other workshop participants. For the purposes of this paper, the third phase of the workshop has been documented separately from the first two and the details are recorded in “The Digital Story Telling Circle Process” section that follows nearer the end of this chapter.

Due to the recruitment processes for this study occurring on both the west and east sides of the Island, two separate workshops needed to take place - one in Corner Brook with four youth participants and the other in St. John’s with one youth participant. This decision was made for purely pragmatic reasons, as the costs and time associated with transporting participants from the west to the east side of the Island for a combined workshop were prohibitive. Additionally, service provider digital stories were not produced in a workshop format. Although the original intent was to have them join with the youth, it was an unreasonable expectation. The two digital stories completed by providers were done through a one-to-one coaching process, with the individual participant. One youth participant from St. John’s also opted to complete their story in this manner.

**The Corner Brook workshop.** The Corner Brook workshop occurred over two days. Four of the six youth participants recruited from this area agreed to take part in the workshop process. Two others declined, one for medical reasons (he was recovering from gender-confirming surgery) and the other due to concerns about her privacy and the group process. There were no service providers present in this workshop. The workshop was located at MUN’s Grenfell Campus in Corner Brook. Two rooms were rented, one for group work and as a central place to
gathering, eating, and the other as a quiet room for writing and the production of the digital stories. Before conducting this workshop, I had undergone a five-day facilitator’s intensive training with Story Centre™ in Berkeley, California. Accordingly, the format used for the workshop phase of this research project followed the one that I was trained in by Story Centre™.

Day one of the workshop began at 10 am with a light breakfast and distribution of the two-day workshop honorarium to all participants, as well as reimbursement for any travel costs incurred. The later start time was set to accommodate travel for one of the participants and the scheduling of an interview prior to the workshop starting time. Consent was revisited as was the necessity for confidentiality and privacy. Using a circle process, introductions were made. In the case of this workshop, most youths had some sort of previous relationship with one another, which increased the level of comfort in the room. The principles of producing a solid digital story were reviewed and I shared examples of stories produced by Story Centre™ workshop participants to illustrate these principles. Following a short break, we circled back in and I shared my own digital story with the group. This was done in the spirit of reciprocity and transparency. Following circle protocol, participants reflected on my story and provided feedback. At this point, we began the story development portion of the circle. I invited each youth to share their thoughts on what their story might be (they had received previous correspondence from me via email asking them to come prepared to do so). Participants were able to share their initial thoughts and ideas while feedback and support for their ideas were provided by the group. One youth in particular struggled with this process, expressing doubt about their ability to complete a story. The other participants provided support and assurance and the youth seemed to quickly rally, finding an initial idea for the story that they wanted to tell. At the end of the circle, participants set off to write a script that would become the audio track for their digital story. Lunch was ordered for the group and I took the youth who had difficulty aside, assuring them
that their participation was voluntary and that they could opt-out of the workshop portion with no penalty or loss of remuneration. They opted to stay and eat with the group and make a decision after lunch; ultimately, they decided to continue with the workshop for the afternoon. The afternoon was spent working on scriptwriting. By 5 pm or so, all but one participant had a draft of their script. I reviewed the scripts and offered feedback (mostly around length). We ate dinner together, debriefed about the day, and participants left at approximately 6:30 pm.

Day two of the workshop began at 8:30 am. Once again, a light breakfast was provided and reimbursement for daily travel costs was distributed to participants, all of whom returned. The intent of the morning was to record the audio track for participant’s stories and to begin production in WeVideo™ (the production software being used). All participants quickly went about their respective tasks for the day. The first participant ready to go to production had come that morning with all assembled images for their story and was motivated to record. I escorted them to the recording room. I set them up at the microphone and put their script on the screen so that they could see it. It was at this point that things shifted. While reading their script, the participant became uncomfortable with the process. The youth was highly distressed and conflicted about continuing with the recording. They expressed regret about consenting to the digital recording of their interview. A lengthy discussion ensued including three possible solutions to the issue that was at hand:

1. erase all recorded data and withdraw permission for use of interview and digital story.
2. erase the recorded portion of their digital story and opt-out of completion of digital story portion only. Withdraw permission for use of their script.
3. conduct the interview again so that their experience could be heard (which they really wanted) but not digitally record it. Instead, I would manually write down their thoughts using the interview guide as a prompt.
Ultimately, the youth opted to allow me to transcribe the digital recording of their interview with the proviso that it be erased immediately afterward. They also opted to withdraw from the production of their digital story and withdrew permission for the use of their script in the dissertation paper. However, the youth did want to remain for the rest of the workshop, but by mid-afternoon, they decided to leave and not participate in the story circle. Further thoughts on this and my reflexive analysis of what may have happened with this youth, as well as my experience of them throughout the recruitment and interview phases of the project, will be shared in Chapter Four. I was rattled by what had transpired and I was reminded of the courage and vulnerability of the youth participants. Similarly, I was reminded that I was an active agent in their ongoing battle against the systems and structures creating their distress and that, on this occasion, I had unfortunately joined forces with these structures creating undue stress for this particular individual.

The remainder of day two went well, with all participants working on the completion of their stories. Two youth completed their stories early on in the afternoon. The third youth opted to use a different platform for their story. They worked diligently into the late afternoon and managed to have a very rough cut of their story ready to share at the circle. Due to technical difficulties, the story failed to export into a transferable format. In total, two of four stories were completed for inclusion in this project. One remains outstanding at the time of writing, but I hear from the youth periodically and they indicate that they are working on it and that I will eventually receive it for inclusion. Unfortunately, this never occurred.

**The St. John’s workshop.** The St. John’s workshop was scheduled to take place on March 14 and March 15, 2020, between the hours of nine to five each day. All four participants who were recruited and interviewed in St. John’s initially agreed to participate in the workshop. Accordingly, space was acquired on the St. John’s campus of MUN and information emails were
circulated, giving participants a detailed schedule of the workshop, instruction about what to bring, as well as a request to begin thinking about a potential story that they wished to tell. I checked in weekly with participants prior to the workshop, with one participant letting me know that they could only attend on March 15, 2020. After a discussion with them, we decided that this was a feasible option as long as they had a draft script written before attendance. Accordingly, all seemed on track for the weekend.

Five days before the scheduled workshop, one participant let me know that they were unable to attend as they had to make up nursing shifts for their placement hours due to the prior storm-related State of Emergency. On the Thursday before the workshop, the World Health Organization declared the Covid-19 out-break a pandemic and I immediately knew that this would have implications for the workshop. As research initiatives had yet to shut down, I sent an email to the three remaining participants letting them know that the workshop would proceed as scheduled. I also gave them my cell number in case they needed to contact me before or on the day of the workshop.

On the Friday evening before the workshop, I received notice from another participant that they would not be participating due to illness. I reached out to them and let them know that I appreciated their email and wished them well. I also gave them the option to complete a digital story individually with me via a virtual coaching process. They took me up on this offer and the story was accomplished over the following two weeks and has been included in Chapter Four of this paper. The withdrawal of two participants from the workshop meant that I would have just one participant on Saturday and two on Sunday. Determined to press on, I prepped for the workshop.

On Saturday morning I received notice from a third participant that they too were withdrawing due to illness—their email came one hour before the workshop was set to begin. As
with the others, I wished them well and offered them the opportunity to complete a story through a virtual coaching process. They did not respond to this offer. I immediately got in touch with the remaining participant confirming their intention to participate on Sunday. They were in transit (flying back to NL) and said that they indeed planned to attend pending their flight not being cancelled— they said that they would confirm later in the day, but never did.

On Sunday morning, I decided to proceed as if the participant was attending the workshop. I arrived at the location to find that indeed they were present. I explained the circumstances to them, and they seemed unphased by being the only participant. They helped themselves to a light breakfast and I gave them the honorarium and the additional money to cover their local travel expenses. I began the 1:1 coaching process with them by sharing some examples of stories. They seemed confident that they would not take long to produce a script and quickly went about writing. True to their word, they wrote their script in record time. I read the draft and it seemed very long with a lot of extraneous detail; nevertheless, sticking true to the ethical imperatives of the project, it was their story and they were entitled to tell it how they wanted.

We set about recording the voice track. In total, their story was over five minutes long. They recognized that it was too lengthy and immediately began to edit. As with the writing of the script, this was done speedily, and their final version was recorded at approximately three and a half minutes long. They seemed very pleased with the outcome. The voice track was then added to the WeVideo™ production platform.

Following the recording of the voice track, they elected to add music to their story. When I asked about imagery, they responded true to form, deciding that they were just going to use one image for the whole story. Again, I restrained myself, hoping for a change of mind. Within ten minutes, they air-dropped 22 downloaded pictures of rainbows over various parts of NL. The
pictures were then loaded into the WeVideo™ platform. With all components of their story in place, we viewed it and they were extremely pleased with the result.

We then ordered lunch, took a break from production, and chatted. During this time, I asked them to read what I had written about them in Chapter Four of this paper and I showed them the coding structure for the youth transcripts. I asked them for feedback on both and checked in to see if they thought that I had misrepresented them or anything that they had said. They were pleased with what had been written but asked that I add violence and discrimination to the descriptor of their experience of homophobia that took place while they were on an excursion in Europe. I thanked them for their inclusions and have made sure that they are present in the description of her experience. Following lunch, we worked together on the timing of the transitions in their story, added a title slide, tweaked the music track, and then finalized its production in WeVideo™. By 2 pm, they had completed the process and left the workshop with a finalized copy of their digital story.

In retrospect, my gut instinct about the influence of Covid-19 and the declaration of a pandemic was not wrong. In almost every interview conducted, I used the same analogy with participants to help explain how mental health gets exacerbated by inhospitable environments or circumstances. It is really simple but profoundly true: “if you squeeze a lemon you get lemon juice.” The corollary for me is that, if you squeeze someone who is predisposed to mental health difficulties, they will likely experience a flare-up of their issue(s). The declaration of a pandemic is an amazingly scary thing— it is a “squeeze” of disproportional measure. Mental health has not just been the topic of this project; rather, its influence has been felt at every juncture, be it mine or the participants. The timing of Covid-19 and the associated pandemic declaration came far too close to the State of Emergency declared in the City of St. John’s only weeks before. The stress and the “hang-over” of this event were still tangible. The participants in this study were
strong, smart, and resilient beings, but the cumulative effects of these circumstances were just too much. I am grateful that they opted to side with what was best for their individual physical and mental well-being but am also saddened that the opportunity to tell their stories in their own words and voices was missed.

**Phase three: The digital story telling circle process.** As explained above, the third phase of the digital storytelling workshop is a final storytelling circle. For the purposes of this paper, this portion of the workshop has been documented separately and follows herein. Also, as explained above, two separate storytelling circle processes needed to occur for practical and financial reasons.

*A note on Indigenous protocols honoured during the storytelling circle.* Storytelling circles, regardless of format, find their origins in Indigenous traditions (Archibald, 2008). To this end, as a settler and an ally, I sought to honour these traditions to the best of my ability. In doing so, I opened the process by acknowledging the Indigenous origins of the storytelling circle and led from a respectful stance, acknowledging my reciprocal role as both a listener of the stories told as well as a contributor of my own digital story. I abided by the guidance provided through reading the teachings of Jean Graveline (1998), Michael Anthony Hart (2010), Jo-Ann Archibald (2008), and Cyndy Baskin (2005). In acknowledging my settler status, I recognized my inability to act as a conductor (Hart, 2002); rather, I sought to open up space for lived and situated experience (Graveline, 1998) and for participants to sit in the experience of the other (Graveline, 1998). Accordingly, I invited the participants to speak without interruption for as long as they liked about their story and the other participants were asked to respectfully listen and to proceed with feedback only once the storyteller was ready to receive it. This circle process began with the participant to the left of the storyteller and occurred until all who wished to speak had the opportunity to do so. No talking stick was used and the option to pass was provided. The
storyteller was then given the opportunity to respond to the feedback if they so wished. This process continued until all present had the opportunity to share their story and receive feedback. The exact details of these processes in each specific location follows in the sections below. In general, using a circle format allowed for a respectful and thoughtful process that honoured and acknowledged the individual participants’ story. As a former service provider, I am very much aware of the importance and the power of affirmation in the lives of marginalized youth, who often feel unseen and misunderstood. In the case of this project, I believe that the youth left feeling both seen and heard by me as the facilitator and by their fellow participants. At the end of the circle, a “checkout” debriefing occurred where each youth was asked to share their experience of being a participant in the circle. While this practice is divergent from the Indigenous tradition of the circle continuing until the process finds its natural ending, HREB required that a debrief be conducted with participants following each phase of the data collection process.

The Corner Brook digital storytelling circle. As indicated in the section describing the workshop processes, four youth began the digital storytelling workshop process. However, on the second day, one youth withdrew, leaving three youth to participate in the final storytelling circle. An effort was made to digitally record the story circle, but the technology did not cooperate. Consequently, I decided to not delay the process and forfeited the recording choosing to manually record individual participant thoughts on their stories as well as the feedback given to them. I explained the ground rules—that participants would have as long as they liked to speak about their story without interruption and when ready—I would play their recording. Once played, we would go around the circle, with each member offering feedback to the teller. The guidelines for the provision of feedback were that it should be supportive, affirming, and that, if possible, members should speak to the impact of the participant’s story on them.
One by one, participants shared their stories. There was a strangely muted energy in the room and while each participant spoke to the meaningfulness of their story to them, the feedback from the group was minimal, with the exception of one youth who was consistently gracious and supportive of the other’s efforts. Once all stories had been shared, we debriefed about the weekend together. The energy seemed to return to the room at this point, as all participants enthusiastically shared their thoughts about the experience.

In hindsight, one participant’s choice to stay for the workshop but not participate in the final circle likely had an impact on what I experienced as the low energy in the room. Additionally, a second participant’s choice to use a different platform and their frustration with only having a “rough cut” ready may have also contributed to the muted mood. It had also been an intense two days and, retrospectively, I believe that we would have benefitted from another half day. Unfortunately, this was not possible given scheduling constraints and the already onerous participant time commitment necessary for the process. In the end, the feedback indicated that it was a personally gratifying process that was rich for all involved.

The St. John’s digital story telling circle. Given the circumstances surrounding the workshop, as explained above, a modified version of a circle occurred. Accordingly, I showed the participant the story that was created for this project and they shared their final version of their story with me. The feedback regarding my story was positive. They were pleased that I had individually acknowledged each person’s contributions and they were proud that they had contributed to something that had the potential to make a difference. In retrospect, their story was very different from the others produced and I wondered if they felt like my story may have excluded their experiences. They did not indicate that this was the case; nevertheless, I am grateful that they were able to attend the workshop and were able to represent their experiences in their own words and voice in this project.
In providing feedback to the participant, I acknowledged the consistency of their story with what they had shared in the interview. We discussed the irony of what I had highlighted about their impact on me in Chapter Four and its connection to what they chose to share in their story. I complemented them on the positivity of their story and their vulnerability in sharing their truth. In response to my comments, they shared that they felt that the production of their story had brought them full-circle, as they were able to speak to the incident that happened in Europe, explaining that they had previously felt silenced by the university administration. They also shared that the production of their story helped them to see how much of a contribution that they had made while at MUN. They indicated that, at their new university, they felt disconnected and detached. It seemed as if sharing their story put them back in touch with who they desired to be. While not conducted in a conventional circle format, I adhered to the guiding principles as closely as I could, and I do believe that there was mutual benefit from our time spent together in this modified process.

A note on the workshop and storytelling circle processes. The Corner Brook workshop was held on the same weekend that the participants were interviewed. The St. John’s workshop did not follow suit and there was a significant gap between when interviews had occurred and when the workshop took place. This gap was a function of personal and professional life circumstances and, while not ideal, it was unavoidable. It is important to note that I believe that there were unintended impacts on this research project as a function of two workshops being conducted rather than one and the consequential reduction of attendance at each.

In terms of the positive impacts on this project, there were somewhat decreased concerns regarding participant privacy and confidentiality, as the fewer number of people in attendance meant that there were fewer chances for a breach. Additionally, in the case of the Corner Brook workshop, there was an increased sense of group cohesion and intimacy that developed between
participants over the weekend and the time available for me to individually support the participants with their projects was increased.

The negative impacts of having two workshops were similarly related to the number of participants in attendance. To this end, as a function of the size of the group and, similarity, in service delivery experiences, the workshop in Corner Brook seemed to take on somewhat of a “group think”. When participants first met in the story development circle (the initial circle process where participants share their ideas/experiences of what they want to include in their stories), all participants shared negative and painful service delivery experiences, as well as difficulty navigating the system and experiences of waiting for services for far too long. As a consequence, and rightly so, the participants’ responses to hearing common circumstances caused a sense of outrage and the feedback given to one another was highly supportive and endorsing. While this supportive feedback was an unintended positive impact at this stage of the workshop (I would have expected it to occur in the final storytelling circle), it nevertheless may have had a potentially negative effect on the production of individual stories. That is, it may have inadvertently influenced the focus and content of what was included in the individual stories produced. While I cannot say that I wholeheartedly believe that this was the case, my research journal reflects these thoughts and I felt ethically compelled to share them.

In the case of both workshops, the third part (the storytelling circle), may have been impacted by the number in attendance. In Corner Brook, I sensed that, with fewer people participating, nervousness about offering meaningful feedback to one another was increased and participants felt pressured and awkward in doing so. In the case of the St. John’s workshop, holding a “true” circle process was not possible with just one workshop participant and myself. Additionally, the timing of the St. John’s workshop and the story produced via a one-to-one coaching process meant that participants were more distanced from the stories that they had
shared during their interviews. Although I believe that this factor likely had a neutral impact on the participant themselves, it is interesting that both stories produced endorsed the themes emerging from the stories told during their interview and that the time in between allowed for a more retrospective view of their service delivery experiences, as commented on by the participants themselves.

*Service provider digital story production.* As indicated above, it was not feasible to include service providers in the workshop process. This was purely a function of time commitment and geography. Two of five service providers agreed to produce a digital story, which was accomplished through a personal coaching process. I skyped with individual providers to have an initial discussion about what was involved in the process. I also shared a copy of my own story with them. Providers then drafted a script and sent it to me via email. Minimal edits were necessary. The technical aspects of the story production were managed as I worked in conjunction with the service providers using the WeVideo™ platform. Once completed and received by me, their digital story was saved to the same external hard drive containing their digital interview recording and their respective transcript. The same process was followed when working with the one youth in St. John’s who opted to produce their story in this way.

**Transcription and Data Storage Processes**

Despite the triangulated nature of the research design, only the interview portions of this research project needed to be transcribed, as participants provided me with copies of their story scripts.

I transcribed all interviews in an ongoing process throughout the first phase of the research project. While my choice to transcribe the interviews made things much more time consuming, it nevertheless was valuable as it allowed me “to sit in the data” and as such
served as a preliminary round of data analysis. I transcribed the first two interviews using an interactive process of both listening to and watching the video recording of the interviews. Initially, I thought it would be helpful to watch the participant as they communicated. I soon realized that, indeed, it was helpful, but that this process was inefficient and too complicated as I am not a “touch typist” and needed to continuously pause the video to transcribe the interview. I decided that this method was more appropriate to the formal data analysis process, as I could code the transcripts while watching and listening to the participant’s communication patterns to contextualize what they were sharing. On this basis, I transcribed all of the remaining interviews by listening to only the audio recording. This sped the process up considerably but, on average, I spent five to seven hours transcribing each interview. For the most part, there were no recording difficulties and the audio was clear, except for the second interview. Luckily, I began to transcribe it the day after and realized that there was an issue as the audio was lagging, and it was near impossible to understand. I also realized that, due to the lag, the last 15 minutes of the interview were missing. Given that it had been less than 24 hours since the completion of the interview, I was able to reflect on the last 15 minutes and fill it in the best that I could, albeit not verbatim. I also found a transcription program that allowed me to adjust the speed of the recording so that I was able to understand what was being said. All transcripts were time-stamped by speaker change. With the exception of one transcript, the youth interviews were transcribed first, with the four other service provider interviews being transcribed last. The service provider interviews were transcribed in the same manner as youth interviews.

Once transcribed and anonymized, the digital recordings were stored on a secure external hard drive saved under the participant’s pseudonym. The electronic version of participant transcripts, story scripts, and copies of their completed digital stories were also
saved and stored in the same manner. Hard copies of participant transcripts were printed and kept securely locked in my office along with the participants’ consent forms.

**Data Analysis Processes**

Coding occurred through a reflexive process of engaging with the transcripts and the digital recordings. The analysis of narratives is a paradigmatic model:

- It describes the categories of particular themes while paying close attention to relationships among categories; uncovers the commonalities that exist across the multiple sources of data and aims to produce general knowledge from a set of evidence or particulars found in a collection of stories. (Kim, 2016, p. 196-197)

In addition to finding common themes such as the experiences of cis and heteronormativity in service delivery and the need for training for mental health service providers that work with 2SLGBTQIA+ youth, I also sought to highlight the uniqueness’s found in the data as well. For example, I noted the contrasting experiences of the gay versus trans participants while engaged in service provision. The description of the data analysis processes below reflects the procedures applied to the transcripts of all participants of this study.

**Preliminary data analysis.** As previously indicated, the transcription of interviews served as a preliminary round of data analysis. As I was transcribing, I took the time to note any thoughts, observations, and interconnections that I noticed both within and across the interviews transcribed. These notes were then categorized by participant pseudonym in an electronic version of my research journal. I kept track of what I perceived to be emerging themes and used these observations to inform future interview conversations with participants. I made note of any type of inflection that indicated emotion, as well as tentativeness or pause in a participant’s speech and I documented when there was any change in pace/energy in the interview. I was also conscious of my role in the respective interview processes and kept track of times when I felt
like I may have missed an opening for deeper discussion or may have asked questions that were leading or presumptive. The transcription process was iterative, and it built over time, generating possibilities for further thought and reflection on my initial observations. I began considering the influence of internalized cis and heteronormativity on the participants and myself as we talked during the interview process. I was fascinated by this element of analysis and the inherent irony of its impact on the research findings, the details of which will be explored further in Chapter Four of this paper. As mentioned previously, the choice to transcribe all interviews on my own made this a lengthy and time-consuming task; however, at the end of this inductive process of reflection and reflexive transcription, I felt fully situated in the data. What is more, I was grateful for the opportunity to listen (literally) for what the data might be trying to tell me about the story within the stories told by participants.

The formal data analysis processes. The formal data analysis process continued in a similarly reflexive and critically reflective manner. In total, three rounds occurred. I began by reading through each transcript from start to finish without placing any codes on the pages. At this point, I simply recorded my overall sense of what I had read and what had emerged (themes, interconnections, uniqueness’s etc.). I did this in my research journal adding to the categorized notes that were taken during the transcription process. These recordings became the basis for chapter four of this paper.

The second round of formal data analysis was done using the electronic qualitative research platform hyperRESEARCH™. Similar to NVivo™, this program allows the researcher to load electronic versions of transcripts into the software for coding and analysis. It hastens the development of a codebook while allowing for analysis by code within the individual transcript as well as across a group of transcripts.
Accordingly, while listening to the recorded interviews, I read each electronic transcript and recorded my reflections. As with round one of the formal data analysis process, I attached the entries to the previous notes in my research journal. I added any new thoughts, thoughts that endorsed previous thoughts and thoughts that contradicted previous ones. I recorded any new reactions, observations, and interconnections (if there were any) and I paid close attention to participant body language as well. I highlighted any differences/progressions of my thought that had occurred throughout the preliminary and the respective formal rounds of analysis. At this point, I began marking up the transcripts with what I perceived to be codes/themes that had been endorsed through the previous rounds of data analysis. Additional codes that emerged through this third round of data analysis were similarly applied. As stated earlier, the use of hyperRESEARCH™ allowed for the electronic organization and storage of the data analysis process. It simplified the understanding and retrieval of data through the generation of an electronic codebook that linked to specific instances of a code within and across participant transcripts.

In the final stage of the formal data analysis process, themes and subthemes were developed based upon my sense of patterns and connections seen in the transcripts and as organized and recorded in the codebook. Accordingly, the data were organized into broad overarching themes within which subthemes were placed. This was a reflexive task of stepping into and stepping away from the data. It involved seeing both “the forest and the trees” at the same time. This process was a daunting task that felt counterintuitive to the ethical imperatives that had driven this study—and yet my time with the data reassured me that there was a story of the stories to be told. In an ironic twist, I became the “master storyteller” entrusted with this role.

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12 As per agreement with the youth who withdrew from the storytelling workshop portion of the project, I transcribed their interview and deleted the digital recording immediately. As a consequence, I only read this transcript while coding it.
Various iterations of this story were developed as I examined the themes and the subthemes that had become the texts from which the story would emerge. Once satisfied that of the multiple versions that could be told, I had arrived at the one that best represented what the participants had told me, the process was drawn to a close. In a further effort to ensure that the story was accurate, a member checking email was sent to each participant summarizing my sense of their contribution to the research project, highlighting what I thought to be the major contribution of their story, and the impact that they had on me. Participants were invited to respond back to these emails with any corrective, endorsing, or additional thoughts on what I had shared with them. The participant responses to these emails were integrated into the findings chapter of this paper.

**Digital story scripts and reflections from the digital story telling circles.** I did not thematically code digital story scripts or the participant reflections shared during the digital storytelling circles. Rather, they were used as a means to increase the trustworthiness of this research project and to substantiate the credibility of the data analysis process. Accordingly, I searched scripts for instances of statements that supported themes identified in the interview process and through the concurrent insertion of the associated sound bites from participant interviews into the findings chapter alongside the direct quotes transcribed from the participant interviews. The digital stories of those participants that completed one will be presented in their entirety in the following chapter.
CHAPTER FOUR: A RETROSPECTIVE ANALYSIS OF THIS RESEARCH PROCESS

Looking Back in Order to Move Forward

The intent of this chapter, as stated in the introduction of this paper, was “to mark a space for a retrospective analysis of this research experience”. In my life and my clinical practice, I have always been captivated with the analogy of drawing back a bow and arrow as a metaphor for the process of personal growth and learning. As such, I believe that it is in the very act of intentionally pulling backward that the strength, the momentum, and the direction to move forward is found. In effect, the writing of this chapter serves this purpose. Hence, in pulling backward to reflect, I garner the necessary strength and momentum needed to move this study towards closure. To this end, I place my own experiences as a situated researcher in the context of this research process. I will summarize relevant excerpts from my field journal reflecting my thoughts on the impact of each participant on me and the lessons learned from sitting with them and hearing their story. I will also speak to the power of their collective digital stories. At the end of my reflections on individual participants, I have inserted a link to the corresponding digital story (if produced) so that the reader can have the personal experience of the impact of the narratives told. Finally, at the end of this chapter, I speak to the ethical dilemmas encountered while engaging in the research process. I will do so in a mostly anonymized fashion out of respect for individual participant privacy and to honour the overall spirit and intent of the stories shared.

The Story of How I Became A Situated Researcher in this Project

In order to place myself within this chapter as a situated researcher, it makes sense that I share my personal digital story and the process of its development. Accordingly, I attended my first digital storytelling workshop in Toronto in 2017. I arrived at the workshop unsure of the story that I wanted to tell. I did, however, feel like it needed to reflect my life circumstances
from the few years prior: the traumatic and violent death of my sister; the loss of my two aged dogs; my son’s emergent mental health and addictions issues; a recent diagnosis of diabetes; as well as the stresses of working full-time and trying to complete a Ph.D.

I struggled through the first day of the workshop feeling lost and angry and I considered not returning. I knew, however, that this was not an option as I needed to complete my own digital story to be trained as a facilitator for the workshop component of this research project. I continued to struggle through the second day, leaving the workshop early and without a completed script. By this point I was foul and I returned home and went directly to bed, aware that this likely meant that I would not complete the workshop. Unable to sleep because of this possibility, I got up at 3 am to give writing one last try. I attempted yet again to write my script, erasing it and restarting it numerous times. I could not find my story. After wrestling with the process for a few more hours and reflecting on what was happening, I realized that the story that I was trying to tell was disingenuous. It did reflect my life experiences, but they were not the ones that I needed to share.

Linked is my digital story entitled “Girly Girl”. It is the background to the story of this project’s importance to me. It probably should have been entitled “the story that I never intended to tell”. Nevertheless, I am reluctantly doing so now in the spirit of transparency and in an act of reciprocity with the vulnerability that I asked of each of my research participants.

https://www.dropbox.com/s/wfdbtf2feottg3d/KATHY Toronto Dec 2017.mp4?dl=0

Reflections on the Youth Interviews

Bobbie

https://www.dropbox.com/s/wcg0dlu7uvcon0d/Shine All Your Light - Bobbies Story

%281%29.mp4?dl=0
As the initial interview that I conducted, I was unsure of what to expect. Bobbie was the first to reply to my recruitment poster and was eager to “have her say” (as the poster invited). From the “get-go”, it was clear who would be in charge of the interview processes. She handed me her business card, she invited me to a 2SLGBTQIA+ youth event that she was going to that evening, and when I let her know that I was unavailable, she offered to take copies of my recruitment poster with her. As her card indicated, she was an activist and her attitude and demeanour certainly reflected this during my time with her.

Bobbie intentionally told her story chronologically, highlighting her journey as a gay youth who sought mental health services. She was quick to put me gently in check, letting me know that “my generation” was not hers and vice versa. She had a clear agenda and was highly invested in inviting me into her overwhelming sense of hope and possibility. She truly believed in the power of activism to change the world and was determined to be a contagion.

To this end, I learned much of her sense of the progress being made in education regarding gender and sexuality. She shared that, amongst her peers, being 2SLGBTQIA+ was no longer a “big deal”. She endorsed a generational effect in my experiences with hetero and cisnormativity and, thereafter, I incorporated the question of this as a possibility into other interviews conducted when appropriate. Mostly, she spoke to a generalized sense of progress across all aspects of her experiences with mental health service providers, noting that, in high school, she felt like things were not “quite as far along as they are now”.

In retrospect, four things stood out for me from the stories that Bobbie shared: her uncrushable spirit in rising above a devastating experience of homophobia while on exchange as a student in Europe; her unwavering belief in the power of activism to change the trajectory of 2SLGBTQIA+ youth lives and experiences; her unyielding resolve about the progress made in her generation and the associated decrease in stigma, discrimination; and violence and her hope
that trans youth would soon experience a difference in the same as a result of education and activism.

In sum, Bobbie had an overarching positivity that allowed her to navigate the world as a young gay woman without apology or fear, choosing to believe instead in the innate goodness of humanity. Her story impacted me greatly and I was humbled by her insights and the wisdom offered to me during my time spent with her.

**Shawn**

In terms of actually getting the services I found there was a lot of extra steps in there that made it for someone like me at the time was very, very challenging because to me I wanted to see a counselor but having to go through the extra administrative steps took a lot out of me and which sounds menial but …

Shawn was quiet and measured in his interactions. He explained that he was a young professional in the midst of launching his career. Shawn shared his journey as a young gay man who had used mental health services over the past few years freely and openly. He traced his experiences through his late teens until the present. I appreciated the care and balance with which Shawn spoke. He took the time to contextualize his experiences, while ensuring that his perspectives were heard. Shawn, like Bobbie, was quite clear that his mental health struggles were genetic and that being gay had no part in his journey. Also, like Bobbie, Shawn reported positive experiences of being “out” in high school with just one minor instance of homophobia that he could recall. He had similarly positive experiences with mental health service delivery once he had completed the intake process. Shawn endorsed a sense of safety, understanding, and acceptance amongst his peers while in high school and he spoke highly and proudly of his involvement with the Gay Straight Alliance (GSA) and the benefits reaped from his participation in it.

Partway through the interview process, there was a notable change in Shawn’s demeanour when he began to speak to his experiences as a drag artist. As he spoke it became
quite clear to me that he had found a passion that gave meaning to his sexual identity and that fulfilled his need to artistically express himself. For Shawn, drag was a sanctuary and a place where he found affirmation and community. It was also a space for celebration and transformation in his own life and the lives of his friends.

In thinking about Shawn and his impact upon me, I am grateful to have had the opportunity to meet him early on in the research process. His interview, following so closely “on the heels” of Bobbie’s was timely. There were uncanny similarities between the two participants’ respective social locations. They both identified as gay and as cis; both were white presenting, university educated, and raised in middle-class families that were affirmative; and they also endorsed similarly positive but unique experiences of mental health service provision. When considering these intersectional parallels, the role of social location became a focal point that I expanded upon in the discussion chapter of this paper. It informed my understanding of the impacts that their respective self-acknowledged power and privilege had upon these youths’ experiences. In effect, it brought an intersectional lens into the analysis early on and kept me vigilant about its inclusion throughout the rest of the interview and analysis processes.

In addition to this contribution, I was also impressed by the candour of the messages that Shawn shared. In particular, two messages stood out very clearly for me. The first was about access to services and how complicated and onerous that this process could be for youths who struggle with mental health issues. He made it clear that the extra steps needed to get help were a deterrent and that the energy necessary to do so made it a near impossibility for a depressed youth to complete these steps. In a similar vein, Shawn also highlighted the importance of service provider openness and the invisiblizing associated with the heteronormative assumptions that are often made in the intake process for mental health services. In sum, Shawn’s
participation in this research project was a gift that had important and ongoing impacts on the entirety of this research journey. As such, I am grateful for all that he contributed to this work.

Kaiden

https://www.dropbox.com/s/2dmkjmbdmcbv2z1/Kaidens Digital Story.mp4?dl=0

When Kaiden first contacted me about participation, they indicated that they were excited, as they felt that they had a lot to say—and they did. However, their impact on me and their contribution to this study went far deeper than they could ever have known or imagined. Kaiden presented with an odd mix of shyness and confidence. They spoke eloquently and from “the heart”. In an ironic twist of fate, much of what Kaiden shared with me were embedded in the theoretical foundations that had been the basis for this research journey from its inception. In effect, Kaiden brought the works of Judith Butler, Sarah Ahmed, and other authors who I had studied to life through our conversation.

In describing their service delivery experiences as a gender non-conforming youth, they shared moments that equated to being deemed as “other” and invisiblized when forms did not present a gender option that included them. Similarly, once engaged in services, they shared experiences of epistemic violation as they struggled against the continued and, at times, purposeful use of their “dead name”, thereby requiring them to “insist just to exist” (Ahmed, 2014, p. 149). For Kaiden, gender binaries were more than just theoretical—rendering an eating disorders group designed to be helpful as useless and providing opportunities for genuine recognition in service provision impossible. Kaiden’s was a story of strength, courage, and insight that was freely and generously entrusted to me.

When I think beyond the enormous contributions described above and as I speak to Kaiden’s impact on me as a personally situated researcher, I am grateful all the more. It seems to me that, from opposite ends of the age continuum, we have both been on a quest to navigate the
odyssey that is the gender journey; we were both seeking to find “that elusive spot” where one can rest comfortably in their gender identity/expression. There is an ironic comfort in knowing that finding that spot (if it truly exists) is not an innate process and that for others (like me), it comes with both successes as well as near misses and failures. To this end, I celebrate with Kaiden in their ability to find a place and I am in equal awe of their capacity to do so at such a young age.

In sum, Kaiden truly had much to say and then some as their attached digital story conveys. In particular, they identified the need to lift the burden of educating mental health providers off of the queer youth they service; they described the difficulties of living in a rural space as a queer youth and they highlighted the many “small things” that make a “huge difference” in service provision to gender non-conforming and trans youth. To be sure, Kaiden’s wisdom was invaluable, and I was privileged to hold space and to learn from them.

**Kevin**

I think it would be, it would be nice if we, if service providers made more of an effort to be kind of open and I, and I know some of them are not going to be kind of open about their sexuality, but even if, Um, in some way, demonstrating that they are more open to speaking about it too. That would probably make people feel a lot more comfortable.

Kevin came to my study by way of referral from a connection who he had on the west coast of the Island. He identified as a “mostly gay” man who is of mixed ancestry—European on his father’s side and Inuit on his mother’s side. Kevin was a nursing student, and his interview reflected his extensive medical knowledge. To this end, the first hour of the interview was spent with him telling the details of his interactions with the mental health service delivery systems, both in rural west coast NL and also in the urban centers of Corner Brook and St. John’s. It was clear to me that Kevin needed to tell his story in order and detail—this was important to him, as it had been quite the journey. Kevin’s sexual and Indigenous identities were largely absent from
his service delivery experience stories shared to this point. Instead, he focused on the failures of the system to be helpful and to accurately prescribe medications and diagnose. In fact, he was so frustrated by these experiences that he shared that they had become the basis for his choice to pursue a nursing degree—to prove that he could do better for others.

In the second hour of the interview, our dialogue took a less medicalized path, as I used the interview guide to learn of his experiences of navigating these systems as both a mostly gay and Indigenous man. When prompted, Kevin was able to share his thoughts about his sexual identification. For him, it was peripheral rather than central to his identity. He spoke of “passing” and acknowledged his privilege in being able to do so. He, like Bobbie and Shawn, described a middle-class upbringing where he had an affirming parent. He also referenced a safe and affirming school environment, indicating that only very few knew that he was gay. As a caveat to this statement, he did say that a younger member of his family who was three years behind him was “fully out” at the same school with no instances of homophobia experienced and no concern regarding safety. When I asked Kevin to speak to his service delivery experiences as an Indigenous man, he indicated that he also “passed” in this regard and that he had never been asked by a provider about nor had he self-disclosed his Indigenous heritage while in service. He did, however, speak to the medicalized nature of the mental health service delivery system and shared that as an Indigenous man, he felt like it should be more wholistic.

I am grateful for Kevin’s participation in this project and the experiences that he shared. As an “up and coming” medical professional, he expressed his desire to be inclusive in his future practice. He endorsed the need for a casual and interactive style that decreased the sense of power differentials, especially with queer youth patients. In terms of safety and inclusivity, Kevin spoke to the need for providers to have rainbow stickers on doors and affirmative posters hanging on walls. In sum, Kevin offered valuable insight into what his sense of the state of the
mental health service delivery system is in NL in general. To be certain, Kevin had quite the “bumpy ride” getting to where he was, and it was clearly his mission to ensure that this would not be replicated within his future practice.

Blair

They shouldn't state that we have a sex disorder when we don't. It makes you feel like you're less than a cisgender person because they're classifying part of your identity as being a disorder.

I was privileged to meet Blaire through T.J. Jones, the executive director of Trans Support NL. Blair was somewhat of an “icon” in the trans community, having petitioned the government for a human rights violation as a consequence of their refusal to cover the costs of reconstructive masculinization surgery through the provincial health insurance plan. He was a well-spoken and well-informed 19-year-old trans man who graciously and enthusiastically agreed to be interviewed for my study. Blair also self-Identified as Indigenous (First Nations) but, as with three of the four Indigenous youth interviewed for this study, he had lost connection to his heritage by virtue of the colonization of NL and the ongoing conquests to accomplish the same.

Blair was a wealth of knowledge. He explained that he and his parents had started a trans and gender non-conforming youth group in Corner Brook and that they had a total of 55 members. There was also a support group for the parents of these youth as well. His enthusiasm and commitment to the trans community and their human rights were palpable, and I was immediately drawn into his efforts. Through my conversation with Blair, I learned of his positive mental health service experiences, save one, early on in his journey. Blair spoke calmly and with intent as he described the ironic experience of being “diagnosed” as trans via a google search conducted by an intern at his family doctor’s office. He was quick to explain his sense of the incompetence of these actions and contextualized them as an outcome of ignorance due to a
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historic and ongoing lack of medical training in the areas of sexuality and gender. What struck me most about Blair from this and other moments in our conversation was his uncanny ability to harness energy from these occurrences. He was a doer with a sense of hope and possibility that seemed to circumvent “the established and the taken for granted”, turning moments of ignorance and transphobia into opportunities for the possibility of systemic change.

Blair told me stories of being forcibly carried to the women’s washroom and locked inside by a group of peers when he tried to use the men’s washroom. There were instances of transphobic slurs and petitions circulated by classmates (that were endorsed by school administration) to ban a trans friend from the school prom because they wanted to wear a dress and not a suit. This was a young man who had both witnessed and experiences the violence of transphobia, yet he stood undaunted and determined to make a difference for himself and others.

Blair approached our conversation with the same determination as he did his life. He had four objectives for our time together and, by the end of the interview, all had been met—with the addition of a fifth objective one that organically emerged as a result of our conversation and his impact on me. In June of 2019, I supported Blair to begin the process of establishing a foundation to fund the various needs of NL specific trans youth through the transition process. Accordingly, at St. John’s PRIDE as the honorary Grand Marshall, he announced this initiative. In doing so, Blair launched yet another attempt to right the systemic wrongs associated with the Colonial and cis and heteronormative regime that violates the physical, mental, and spiritual well-being of trans and gender non-conforming folk. I am unsure of the number of funds raised to date for this initiative, but I do know that Blair has and continues to be a role model for trans and gender non-conforming youth in the greater Corner Brook area.

Blair’s “Go Fund Me” campaign for his “top surgery” allowed him to travel to Toronto to have what, for him, was “lifesaving surgery”. In total, three other youth from the Corner Brook
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area have followed suit and, in 2019, MCP (the provincial health care plan) began covering the costs of the masculinization portion of gender-confirming surgery as a direct result of Blair’s human rights complaint. Blair is not only a role model for his peers but was also an inspiration for me—I am humbled to have had him participate in this research project and learned very much from him.

**Enigma**

> We are told if you need help, seek help, if you're in a position of mental struggle, talk to someone, reach out to these resources and you reach out for those resources and they're not there. And it's like the very systems that are in place to protect me and others who are vulnerable and minorities and to provide those services sometimes may make it worse.

When Enigma contacted me about their participation in this study, they were greatly hesitant. They felt as if they wanted to participate but also knew that doing so meant speaking to some very painful experiences of disappointment, disillusionment, and denial. In truth I was equally hesitant about their participation as I knew that the level of vulnerability that they felt was overwhelming; nevertheless, they decided to “take the risk” and I am so very honoured and humbled that they did.

As their name suggests, Enigma was a complicated individual who described quite the journey, both in life as well as with mental health service delivery in the province of NL. As with the others, they were well-spoken and had much to contribute with respect to knowledge and experience. From the start of the interview, I felt an immediate comfort with Enigma. There was something very endearing about them and they exuded a warmth and charisma that made the conversation both natural and easy. Enigma resided outside of Corner Brook in a rural community. They had moved around the West and Central parts of the province while growing up and as such they spoke to service delivery experiences or (due to accessibility) a lack thereof from multiple vantage points.
Enigma was a gender non-conforming youth who disclosed issues of family trauma growing up. Additionally, as the grandchild of a prominent public figure, they felt the added pressure to conform and ascribe to hetero and cisnormative standards of gender and sexuality for “the sake of the family”. Accordingly, it was their perspective that the cumulative effects of these circumstances, as well as the constant realities of always “feeling different” and having no point of reference for their gender identity, took their toll. Enigma’s mental health struggles began to manifest when they were eighteen and have led to multiple suicide attempts and hospitalizations. Their experience was an all too familiar one marked by extensive wait times for specialized psychiatric services and a concomitant lack of available psychiatric hospital beds for assessment and stabilization. It was their perspective that this was intensely magnified in the rural communities where they had resided. In January of 2018, after being denied admission to a local hospital, Enigma staged a protest outside of the institution stating that they were denied admission despite telling emergency services that they were actively suicidal. At the time of the interview, finding the necessary supports and resources continued to be an ongoing battle for Enigma.

I learned many things from my time with Enigma. In particular, they highlighted the pressures of growing up as a gender non-conforming individual in what they called “the Texas” of NL. In using this analogy, they spoke to the embedded colonial systems and structures that were obstructive in many if not all aspects of their life. Enigma was the embodiment of the proverbial “square peg being forced to occupy a round hole”, yet what stood out most for me beyond their pain was their persistence for recognition.

Enigma is a youth who has much to offer. They are highly intelligent, articulate, and political, and once receiving the needed supports to help with their ongoing mental health battles, they will indeed become an unwavering force for systemic change. To this end, I look forward to
co-authoring a publication with Enigma post-study. In doing so, I hope that much-deserved space will be opened for their knowledge and insights and their uniquely genuine self and contributions (regarding mental health service delivery) to be duly recognized.

**Dallon**

https://www.dropbox.com/s/rnebxxj10jg8bpi/Indiscriminate%20By%20Dallon%20Kennedy.mp4?dl=0

Dallon was the youngest participant in the study. He was an 18-year-old trans man who was just three weeks from having gender-confirming surgery. Dallon came prepared to share a powerful story of mental health service provision dating back to grade school. He discussed early battles with anxiety and a progressive journey with depression and suicidal ideation. He also spoke about familial issues with the same and how he bore witness to the incompetency and inadequacy of the NL mental health system from a very young age. While not discussing his gender or sexual identity journey, he nevertheless indicated that, from the beginning of service delivery, his gender and sexual identities became conflated with his mental health struggles. To this end, Dallon shared horrific instances of the denial of his genetic predisposition toward mental health struggles and concomitant mistreatment of the same as they were “written off” as a function of his needing to sort through his “gender identity struggles”. As circumstances would have it, all of this changed when Dallon met a psychologist that worked in the emergency department of the local hospital where he was seeking support for a very serious episode of suicidal ideation.

Dallon spoke poignantly and honestly about this meeting and crediting “N” for saving his life. What had become a tangled ball of misdiagnosis and mistreatment leading to his hospital visit, soon became unwound as “N” removed gender and sexuality from the diagnostic criteria and began to correctly treat him for what they differentially diagnosed as an emerging mood disorder. Over time and with N’s support, Dallon was able to attend school again, regain his
social life, and start the process of gender transition. With the support of “N” and two other key medical professionals, Dallon was given his life back.

In my interview with Dallon, he shared important perspectives on the limitation of the mental health resources in the province of NL. He recounted a story of a younger trans friend in a very small community of 300 people and, in doing so, endorsed the even greater lack of resources available and the increased risks associated with rurality. Dallon spoke hopefully and highly of the efforts of the local trans support youth group where he had found community and support for his gender journey. He also shared his intended career path as an inclusive medical provider who would serve trans and gender non-conforming youth who, like his friend, had no supports in their life. It was clear that Dallon had been impacted greatly by his personal experiences of being invisibilized and ignored by the mental health system. It was equally clear that he was grateful to those who had recognized him and who had offered him help; what is more, Dallon was determined to help prevent the possibility that the same negative experiences could happen for others. This ethic of “paying forward” was a theme expressed by several of the participants interviewed for this project and it spoke to my heart as a former service provider and manager. In essence, the youths’ desire to pay things forward reassured me of the power of opening therapeutic space for the fullness of someone to emerge. Hence, in the simple act of “seeing and hearing”, a potential pathway beyond that moment is laid and opens the way for youth like Dallon to help shape future service delivery to 2SLGBTQIA+ youth.

In sum, Dallon’s interview made me hopeful for others who had yet to be recognized rather than categorized by the mental health system and its agents. It served to endorse the absolute importance of training for those supporting 2SLGBTQIA+ youth and the vital need to reach out into rural and outport communities with the same. It was a pleasure to hold space with
Dallon and to learn from him—he contributed much to this research project through the interview process as well as through his very personal and heart-wrenching digital story.

Ariel

... at least I'll get two semesters and who knows, maybe the next treatment I try, especially if I have a more definitive diagnosis, will be one that gets me well enough to be able to just do group therapy or the occasional walk in.

Ariel was a late addition to the research project. Of all participants recruited, Ariel was most concerned about confidentiality, causing her to hedge at participation to one hour before her interview. Even when I arrived at our agreed-upon location, I was doubtful that she would be there. Upon meeting, I took the necessary time to review the consent to participation and to hear her worries about privacy. I agreed to anonymize her information as much as possible and she seemed to settle into the interview and became comfortable quickly.

As Ariel shared her story of coming into her sexual identity, her concern for privacy became clear. Hers was a tale of family pressure to keep her sexual identity unknown and she shared several instances of being closeted while in her small community in NL. In contrast to these occasions, Ariel also shared her experiences of finding solace and support via social media and as a part of her association with a GSA in her high school.

Ariel’s mental health struggles began at a young age. She described disruptive levels of anxiety and depression that she purposely downplayed with her family, friends, and medical professionals. She noted that any discussion of mental health struggles in her family was taboo, not unlike her experience with disclosing her sexual identity. The pressures of being closeted exacerbated Ariel’s mental health struggles as she waited desperately to leave for university. She experienced what she described as the worst period of her life during this time, resulting in her being highly suicidal. Through the support of a peer and by applying her safety planning skills,
Ariel was able to move through this period of her life and go on to University in a larger urban center.

Once at university, Ariel sought mental health supports through university-based services. In this process, some services were better than others. Related to this project, Ariel shared her struggle for consistency in service delivery, as the services that she used would shut down at the end of the school year and began again in the fall, but with a wait time and a different counsellor. She also spoke to experiences where she was made to feel foolish for continuing to engage in service once the prescribed medication began to be helpful, as well as, disagreement between medical personal regarding the course of treatment. Clearly, hers was a story of piecemeal and often disjointed service delivery that, at times left her feeling disrespected, disregarded, and incorrectly diagnosed.

Despite these setbacks, I was struck by Ariel’s hope and her persistence with the service delivery system on campus and the single-session services available in the community. At the time of the interview, she was awaiting yet another diagnostic service that she believed would be the key to understanding the mental health struggles that continued in her life. In sum, I was greatly impacted by Ariel’s story as a former mental health professional who was a proponent of a single session and walk-in therapy. While I do continue to believe in the benefits of such services for some, Ariel was a “walking and talking” example of how such neoliberal outcome-driven services can “fill a gap” without actually meeting the needs of those it is intended to serve.
Jay

I was 18 at the time and um, I hadn't mentioned that I'm trans, but at the time I didn't have anything done about like my appearance, so I was looking kind of female and I was saying to the counselor, Hey, I'm a man, I'm sure. And she would bud in and interrupt and say, no, you're not, you're wrong.

From the initial point of contact with Jay, it felt as if there was a series of strange communications, one after another. Jay had indicated an interest in this study and was in touch with me as a result of an email that was circulated by a group at MUN Grenfell campus unbeknownst to me. I communicated with Jay four times before travelling to Corner Brook, yet I had no confirmation of his participation until 9 pm on the evening before he was scheduled to be interviewed. I was concerned about this, given the oddity of our communication; nevertheless, we arranged a meeting time for the following morning and he also confirmed his participation in the digital storytelling workshop that weekend. When I met with Jay for the interview, my apprehension did not ease—there was something about him that felt very fragile to me. I went through the informed consent process slowly and carefully, addressing any concerns or questions that he had. Jay signed the consent and the interview began. Quite quickly into the process, Jay disclosed a recent hospitalization (I did not learn until much later on in the interview that it had been the week previous). He spoke of having limited living resources and I also noticed that Jay was without a computer for the workshop and, when asked, he indicated that he had a tablet that he would bring the next day—which he never did. Ethically, I was concerned that the honorarium offered for participation in the project was putting Jay into a precarious place of having to choose between his need for financial resources and the best interests of his mental well-being; however, he had come and I was aware that he knew that he could withdraw from the study without penalty at any point as stated clearly on his signed consent form and confirmed verbally during the informed consent process. Despite my initial apprehension, Jay seemed to
settle into the interview well and was motivated to be involved. It did not take long for me to realize why.

Jay’s story was powerful and compelling and he truly wanted it to be heard—a point that he reiterated several times throughout the interview process. In almost every area of his life, Jay spoke to disjuncture and pain. Yet, despite these experiences, he persisted and continued to search for something different. Jay self-identified as Indigenous and spoke of his recent efforts to become familiar with his ancestral heritage and traditions (Qalipu and Inuit). He described the devastating impact of settler colonialism on his family structure when he referenced numerous adoptions and apprehensions that made tracing his ancestry near impossible; however, he was determined to connect and credited his fiancé, an Indigenous man, with helping him in his ongoing efforts.

Jay had endured multiple instances of homophobia, transphobia, and cis and heteronormativity dating back to when he was just ten years old. Always certain that he was male, Jay was forced to give up on his early efforts to find affirmation and support due to a lack of familial and peer support. As with others who had grown up in rural NL, he described blatant instances of homophobic and transphobic bullying, some institutionalized. From puberty on, Jay endured a life of “daily hell”, dealing with dysphoria, bullying, epistemic violence as well as physical pain related to bodily changes. As if this were not enough, once at university, he was subject to outrageous service delivery experiences that, as described (by Jay), bordered on conversion therapy, as well as the denial of gender-confirming surgery processes by his medical doctor. Jay directly connected his current and past mental health issues to these situations, making intricate associations between their impact on him and his increased depression and recent suicide attempt. It is difficult to capture the overwhelming degree to which Jay had and continued to
suffer—his digital story, had he been able to complete it, would have represented his experiences much more accurately and fully.

Reminiscent of Kaiden, it was as if Jay had taken a page from any one of the multiple publications that I had read over the course of this research project and embodied its contents. His pain was palpable and his desperation for recognition unjust. He described a sleepless night just before coming to the interview, where he had spent the entire time strategizing about how not to be misgendered ever again in his lifetime. Ironically, while Jay’s interview was emotionally exhausting for me, it appeared to have the opposite effect on him, as he seemed to gain strength over its duration—almost as if every word increased his determination to be heard and to be recognized.

In sum, Jay had a profound impact on me and this impact has gone far beyond the scope of this study. This was a conversation like no other. It was one of only a very few that I have experienced with youth over my 25 years as a social work professional that will be forever etched on my heart and in my memory. I am saddened that Jay was unable to share his story in his own voice but am honoured to have had the opportunity to hear it from him first hand. It is my sincerest hope that its power has been captured and has been conveyed herein.

**Martin**

https://www.dropbox.com/s/xnmf0ye08wuwpnv/Martin%27s%20Story.mp4?dl=0

Martin was the final interview scheduled with the youth participants of this research project. He was a young trans man who had just newly began the process of social transition. Martin described a long history of mental health struggles dating back to grade 6. He had and continued to struggle with intrusive thoughts of varying kinds and degrees. Martin had a sombre tone to his voice, so much so that I checked in with him at two points of the interview regarding his mood. There was a pervasive sense of “flatness” about him, which he attributed to “a lack of
sleep”. For me, it felt melancholic—as if every ounce of energy and hope had been sucked from him.

As the interview unfolded, I began to understand the sombre tone. The multiple years of mental health struggle and anguish experienced by Martin had virtually gone unnoticed or ignored by those in his life. He found and sought solace in a select few and was absolutely “let down” by a health care provider who chose to medicate his symptoms without making referrals for mental health support. Martin seemed genuinely perplexed at his inability to access mental health resources. As his digital story expressed, he clearly told his family doctor about his struggles with depression to no avail. He referred to other people’s ability to get the help that they needed “as luck”. It was as if, one day, by some chance his, health care provider would hear his plea for help and respond. It is no wonder that his voice and tone were muted: why bother raising your voice if you were just going to continue to be ignored?

By virtue of his story, Martin endorsed multiple themes that had emerged throughout the interview processes with the youth. He echoed the frustration and concern regarding the piecemeal nature of the service delivery system, particularly on the west coast of the Island. He spoke to the lack of knowledge and training regarding 2SLGBTQIA+ youth mental health exhibited by providers and the glaring absence of professional services specific to queer youth. He was grateful for peer support but, like others, felt that it was not enough. Martin also spoke to his fear that the origins of his mental health struggles would be ignored and instead be written off to his gender and sexual identities. Overall, he demonstrated the same unfortunate resilience required by others to continue to fight for help and recognition from a system that not only

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13 My use of this word is intentional and reflects the sad reality that the responsibility for dealing with systemic failure has been shifted on to the capacity of youth to bear its consequences through becoming resilient. It is like some weird “survival of the fittest” mentality that has become state sanctioned and expected, relieving “the powers that be” of responsibility for correction.
ignores but also perpetuates the very issues creating the distress experienced by queer youth like Martin.

In sum, I am grateful for Martin’s participation and all that he shared. In some respects, his participation brought the process of youth interviews to a fitting close, as his story was all too familiar and captured many of the salient themes expressed by others and reflected in the literature. The power in Martin’s contribution, though, was not so much about what he endorsed or confirmed; rather, it was in how it was communicated. The tone of Martin’s voice spoke volumes to the weight of his experience of being ignored and invisible and while this injustice can be captured in the academic literature, its true impact lies in being heard from the perspective of lived experience such as Martin’s.

**Reflections on the Service Provider Interviews**

J.P

I had known J.P for some time prior to the interview. I first met him when he was an MSW student in placement at the clinic that I managed. Hailing from NL, he was quite the welcome addition to the clinic, bringing his positive energy, Newfoundland ease, and wit into a space that was often heavy and overwhelming. I also knew him as an openly gay individual which, at the time, was an exception in the clinic. Based on these things and his love of all things NL, I approached him to be interviewed for the study and he kindly agreed.

I met J.P. at his office while I was in Ontario during the spring of 2019. He engaged comfortably with me but admitted to being a bit nervous. After completing the consents, I asked him to tell me his story of mental health service delivery as a gay-identified man who had both received and provided mental health services.

https://www.dropbox.com/s/rlryanxgpdu7l4/Justins Story %281%29.mp4?dl=0
As his digital story conveys, J.P. has a personal story that reflects his experiences of growing up in rural NL. As part of a religious family, his sexuality was condemned structurally by the oppressive belief systems associated with his church, and he also struggled personally with self-condemnation by virtue of his own internalized heteronormativity. His was a story of palpable pain and as he told it, I was struck by the depth of it. Sitting with him as he spoke caused me to pause—what gave me the right to ask participants to do what I was asking? Was it fair for me to ask these things of people? If J.P., as a thirty-year-old man, was still subject to the level of pain expressed while relaying his story, what was I doing asking youth to do the same thing? I was struggling as the irony of sitting in the very place where I had only known J.P. as a witty, confident, and comfortably “out” gay man was overwhelming. I had no idea of the pain and the process associated with his journey.

J.P. remained composed throughout the interview but was honest about the level of emotion that he was experiencing. He used humour to take breaks from the intensity as needed. In NL, J.P. had provided services in publicly funded agencies and he was currently doing the same in Ontario. Accordingly, he was able to offer a valuable comparison between systems. As the first provider interviewed, his input and recommendations foreshadowed the responses from other providers interviewed after him, irrespective of geography. It also seemed that from his perspective, things in Ontario were not all that much better (something that I had endorsed when undertaking this research project).

As I sat with J.P., I learned about many things, including tokenism, which was later discussed by other queer-identified service providers. He described being one of the very few “out” providers at his various places of employment and the concomitant “asks” that came with being such—committees needing non-conforming representation, caseloads with an over-representation of 2SLGBTQIA+ youth, and clinical consultation to other staff when they had
queer youths on their caseload. He foreshadowed what other queer providers spoke to as the dilemma of being out with parents and clients who were not queer and the fear that they would lose trust in him and want to be transferred to another clinician. J.P. was also the first to acknowledge the lack of staff training, the “fits” and “starts” of the training that was supplied and the danger in declaring “safe space” based on three hours of diversity training. He spoke strongly about the need for intentionality when creating safe space and he endorsed the need for management to have a clear agenda that included training all staff on sexuality and gender.

I was grateful for J.P.’s participation—he contributed so very much through his involvement. As his digital story indicates, J.P. is a champion for the wellness of queer youth. He has admittedly been spurred on by a desire to ensure that no other queer youth would have to endure the same rejection, shame, and judgement that he bore. With this admission, the importance of the presence of J.P.’s pain during the interview process made all the more sense to me. Clearly, he had found a way to harness this pain to make a difference for others. I was honoured that I was allowed to sit in such a profoundly powerful thing with him, if only for a while, and will be forever grateful for his generosity in allowing me to do so.

J.G.

https://www.dropbox.com/s/99r4bw8u3v22rab/Dance in the Rain.mp4?dl=0

As her digital story indicates, J.G. identifies as bisexual and polyamorous. She is a social work practitioner with thirteen years of experience working with children, youth, and families. Like, J.P., J.G. is out in her workplace. As such, she spoke to the tokenism associated with her status as reflected by her caseload. She also discussed the associated dilemma of this by recognizing that it does ensure that queer youths were receiving safe and inclusive services. In discussing this J.G. inferred the need for more staff training but also spoke to the reality that training did not assure safety in service delivery.
My time spent with J.G. was incredibly generative. She was highly insightful and spoke to the impact of heteronormativity on her as an individual and a professional at a depth to which no others did. As with a couple of my interviews with the youth, J.G. was able to take the literature that is foundational to this project and bring it to life as it applied to social work practice. Accordingly, she recounted how heteronormativity and coloniality made discussions of sexuality awkward and uncomfortable with all clients, but especially queer ones. She spoke to how heteronormativity caused her to make assumptions about straight-identified youth even more so than about queer youth and she brilliantly unearthed the taken for granted heteronormative ideal of sexual or gender permanence. That is, the idea that youth who identify as straight and/or cis are presumed to remain as such over their lifetime, whereas a youth who identifies as queer and/or gender non-conforming are assumed to be “going through a phase” or “trying things out”. J.G. also discussed the irony of parents wanting their queer children to receive mental health services, but often only as a corrective measure, again highlighting the narrow, moralistic, and colonial agenda associated with sexuality and gender.

When asked about recommendations for service delivery, J.G.’s responses were equally thoughtful and provocative. As mentioned earlier, she endorsed the need for further training in areas of sexuality and gender but also took this one step further stating that mental health spaces do not just need the information to become safe and inclusive. Rather, she believed that they need bodies that represent these values as well. In saying this, she highlighted the need for inclusive hiring practices with a specific focus on gender non-conforming bodies.

J.G.’s digital story conveys her struggle with coming out in her work environment. She speaks to the vulnerability of doing so and how she was driven on by the need to be authentic. As such, the desire for integrity and wholeness in her work life became an ethical imperative. As a former manager and service provider, I can truly say that the field is so very lucky to have J.G.—
the work done is only as healthy as those who perform it. J.G. greatly enriched my life by the time spent with her and she has yet again confirmed for me that there is an urgent need to fill the gap in the literature about the personal impacts of heteronormativity upon the mental health service provider while working with all youth—but especially queer ones.

One final thought that J.G. shared was her belief that, to work well with queer youth, one needs to be comfortable sitting in the uncomfortable. Indeed, it is the embedded coloniality, cis and hetero normativity that creates this discomfort and I am grateful that she has picked up this mantle and is intentionally embodying this space of discomfort. Perhaps if neoliberal agendas were set aside, more was written about this area, and providers were allowed to embrace their discomfort and not just their expertise in the work, others would join with J.G. to reflexively and wholeheartedly provide safe and inclusive services to 2SLGBTQIA+ identified youth.

P.S.

I don't get to tell people what my gender is because what I actually have to do is I have to contend with other people's perceptions of my gender. It is not defined by me. It's defined by my interaction with the person and their ideas of what my gender is.

I was connected to P.S. through a faculty member at MUN who worked closely with him in the trans community. Our initial meeting was informal as I sought advice regarding the recruitment of trans youth for this study. Meeting P.S. was a gift. Our interactions felt familiar and there seemed to be a comfort that went beyond what is usual for an initial meeting. I learned about his personal story as a transmasculine genderqueer advocate and educator and he put me in touch with others who became critical to the completion of this project. It was during this meeting that I asked P.S. to participate in this project as a service provider. After many failed attempts, we were able to find a time that worked, and I am so very fortunate that we were able.

When I reflect on the time spent with P.S., it is hard to pinpoint any one thing that stands out for me; rather, I am aware that, through conversation, there was a sense of mutual
understanding and I had a deep appreciation for the stories that he told. P.S. wandered between personal narratives regarding his experiences as first, a genderqueer youth to a now, transitioned trans masculine genderqueer adult. He explained that he does not identify as a man but instead, his transition was from feminine to masculine. The narratives shared were rich and provocative and included humour and critical commentary. He spoke to the power of the binary even in the trans community, critiquing the idea that, to be truly trans, you needed to transition from being a man to a woman or vice versa. P.S. spoke to my heart on so many levels: personally, professionally, and theoretically and, at one point, he even joked that, by virtue of his life experience, he was “proud that he came up with Judith Butler’s ideas before he had read her book”.

It was good to share the company of someone who had not only grasped the realities of being a trans person in theory but who had more importantly lived it in reality. P.S. brought with him a history of the changes regarding access to surgeries, hormones, and even blockers. He recalled an incident early on in his life that took place at a clinic in Toronto. In taking initial steps to begin transitioning, P.S. was referred for clinical services. After several sessions where he had discussed his experiences with many things including gender dysphoria, he was instead “diagnosed” as being “gender euphoric”. He explained to me that this meant that the clinician working with him had decided that he indeed was not “trans enough”; rather, he was just euphoric about becoming a man. It was so very hard for me to sit with him and to contain my outrage and disgust—with the stroke of a pen, P.S.’s entire existence was denied by someone who chose to privilege his expert knowledge over the experiences that were P.S.’s life. In sharing this story, P.S. captured the very essence of the basis for this study—I cannot even begin to take in and comprehend the level of this violence inflicted by a system that was set up to help and understand rather than pathologize and invalidate (Daley & Mulé, 2013).
There were so many other important things that P.S. spoke about during his interview, often validating the experiences that many of the trans youth participants had shared. He endorsed their experiences of being othered by health care providers when they disclosed that they were trans. He confirmed the inadequacy of the education and training of most medical providers when it comes to working with gender non-conforming youth. He similarly validated the concomitant experiences of the youth who, when referred to one of the very few providers on the entire Island who had the training and expertise to be helpful, were required to wait for these services for far too long. P.S. was very clearly working with gender creative children and gender non-conforming youth because he was passionate about their lives—he was determined to help ensure that they would not have to endure the multitude of horrific experiences that he had as a younger trans individual.

P.S. is a humble and reluctant role model, preferring to think of himself as someone who can provide hope that things will get better. He welled up as he spoke of the feedback that he received from the parents of children and youth in his groups regarding his ability to provide a hopeful longitudinal view toward the future of their lives. I am very grateful for my time with P.S. I was privileged to share in his experiences and his wisdom. He has made me all the more passionate about this project and has restored my belief in the relevance of its theoretical origins. I have been profoundly impacted by P.S.’s story and, ironically, there are no words that can adequately bring the reality of this impact into existence for me.

R.J.

But my philosophy was that, you know what, this needs to be, whoever's coming in through the door, this needs to be a safe space. So, we had to do a lot of work around that.

R.J. is presently involved in post-secondary education and they have more than thirty years of experience delivering and managing publicly funded mental health support services to
youth in the city of St. John’s. As such, they brought with them a wealth of knowledge both specific to the agencies that they had worked in, as well as across the service sector through their involvement with students in various field placements. While not identifying as part of the 2SLGBTQIA+ community, they nevertheless were passionate in their commitment to safety and inclusivity in service provision and her thoughts on these topics had taken root and evolved over the entirety of her career.

R.J. had been fortunate enough to work for agencies that valued youth engagement. Hence, it was their experience that the voices of all of those who sought and received mental health services were heard. They also believed that, for the most part, their places of employment did fairly well with inclusion and recognized the need to make services “safe for all”. R.J. endorsed many of the conversations that I shared with other service providers. They acknowledged the need for further training for staff regarding issues of sexuality and gender and they echoed other’s thoughts regarding a need for intentionality around making clinical spaces safe and that the responsibility for ensuring that this happens should rest with senior management. They also validated the need for inclusive hiring practices to ensure staff representation of the consumers who used services.

With respect to expanding the conversation, R.J. strongly believed that education for service providers needed to begin in schools of social work and that curriculum needed to be revised to include courses on working with queer, trans, and gender diverse populations across the life span. They similarly advocated for inclusive admissions procedures to social work programs, acknowledging the heterogeneity of those entering into the field for employment in the province of NL. R.J. also believed that, in addition to the need to educate providers of services, education with consumers of these services was necessary as well. They noted that this was especially important in inpatient services and cited examples from other areas such as shelter
and residential programs where staff were attempting to be inclusive, but participants were not supportive of these efforts, creating a general lack of safety for queer and trans clients.

My conversation with R.J. was very much appreciated. They offered an informed and well-rounded view of the service delivery system in St. John’s. R.J. had a balanced perspective and made solid recommendations for service improvements while acknowledging many of the things that were already being done to ensure the safety and inclusion of 2SLGBTQIA+ youth. It was a welcome dialogue that felt encouraging to me as it highlighted the fact that there are many providers in St. John’s who are invested in making a difference to the service delivery system. From a personal perspective, it was gratifying to hear yet again that, as a former manager, my choice to prioritize making services safe for queer youth in the clinic was an important one; at the same time though, it highlighted for me the personal, precarious, and arbitrary natures of this decision-making process. To this end, I am heartened to know that the NL government has made training for all service providers working with 2SLGBTQIA+ youth a priority. I am equally encouraged by the knowledge that there are agencies such as the ones that R.J. has worked in that have taken it upon themselves to ensure safety and inclusion for all of the youth that they serve.

H.H.

… the whole organization is about inclusiveness, it's not perfect cause it's easy to say you're inclusive. It's one thing. It's another different thing to be actually inclusive.

H.H. was recruited for this study through a connection with a mutual colleague. His service history with youth dated back twenty years and his career had transitioned him from teaching to working in various capacities to support youth with mental health and employment difficulties. He was also currently enrolled in a master’s degree in counselling psychology and had associated placement hours in various agency settings in St. John’s. As the final meeting
conducted for this research project, this conversation was helpful as it supported most of the emergent themes and provided a balanced perspective on the publicly funded mental health service delivery system in the City of St. John’s.

The conversation with H.H. very much mirrored the one that I had with R.J. H.H. shared openly and personally about his experiences of working with queer youth and, in doing so, spoke to both the hurdles encountered and the progress that was being made by his organization in this regard. Some of the hurdles experienced by H.H. and the programs that he is associated with were structural. He discussed how the funding attached to some of these services requires participants to be registered in their legal names. In doing so, H.H. acknowledged the violence associated with this condition and he described the tricky “workarounds” that become necessary to balance this requirement with the needs and preferences of trans and gender non-conforming youth. Other hurdles discussed by H.H. echoed the experiences of the other service providers. Hence, he described issues with inadequate staff training and the need for intentionality on the part of senior management to move the mandate for safe and inclusive services forward.

Concerning education, H.H., like R.J. acknowledged that this must be extended beyond agency staff. He stressed the importance of educating partners when working across sectors to ensure that 2SLGBTQIA+ clients are being treated respectfully in circumstances such as work placements and while in the care of other professionals.

About progress being made in his agency, H.H. shared a recent initiative to financially and instrumentally assist trans and gender non-conforming identified clients with the process of a legal name change. He also discussed how, through persistence and management support, queer and trans clients are experiencing less discrimination and safer spaces both within the agency as well as in their community-based programs.
An added benefit to H.H.’s participation in this project was his status and experience as a graduate student in a counselling psychology program. From this position, he was able to speak to the curriculum associated with his studies. Unlike the MUN school of social work, H.H. reported that he has taken various courses where content has included working with diversity and specifically with 2SLGBTQIA+ clients. He was clear that this was an essential part of the training that he received through his program, which is reassuring given that many of those graduating will occupy guidance counsellor positions in high schools as well as clinical positions in community agencies.

I highly valued the information that H.H. shared with me. In effect, he re-confirmed many of the themes that had emerged throughout the conversation with the other service providers and also helped to provide context for some of the experiences shared by the youth participants. In particular, it was timely and reassuring to hear of the name change initiative being launched at his agency, as this was a theme that came up often as a major roadblock both in services as well as in life for many of the trans youth who participated in this project. As with the conversation that I had with R.J., I was left feeling somewhat hopeful about the work being done and the efforts being made toward inclusive and safe service delivery for 2SLGBTQIA+ youth in the City of St. John’s while also recognizing that, as the service providers shared, there is still a long way to go.

**Reflection on my Impact on the Participants and Plans for Possible Youth Mentorship and Post-Study Engagement**

While I have spoken extensively to the impacts of the participants on me as a person and as a researcher I have yet to share my sense of what my impact was on the participants themselves. When pondering this question with respect to the youth participants, I am
immediately drawn to the many references made to my age and to the unlikely interest that someone like me (read old) would have in hearing the mental health service delivery stories of 2SLGBTQIA+ youth. Despite being openly situated as a former service user/provider and a queer person the youths were intrigued by and grateful for my willingness to sit with them and bare witness to their experiences. Overall, my sense is that I represented hope for them – the possibility that their stories could actually make a difference and many, if not all, seemed empowered by the potential of this happening. As a consequence, I believe that the participants were invested in my advancing their perspective and need for changes and in response I felt a responsibility to ensure (to the best of my ability) that this happens.

The conversations with the service provider participants seemed equally as empowering. They seemed gratified to know that despite working in different provinces there was a commonality in our experiences and in our commitment to addressing the impacts of settler colonization, and cis and heteronormativity on mental health service delivery. What is more, I believe that for the queer identified providers, my impact went beyond their comfort in feeling a commonality and empowered in their efforts and that it created a space for recognition of what brought them to their current positions in the service delivery system. Without exception, each shared their desire to ensure that 2SLGBTQIA+ youths are not subjected to the reproduction of the same violence that brought them into services in the first place. They couched these desires in personal experiences and I believe that my presence and participation in these conversations both honored their own personal experiences and supported their professional mandate for safe and inclusive service provision.

In the recommendation section that follows later on in this paper, I propose a co-authorship of at least one manuscript with the project youth participants. While meeting with them, I was inspired by their energy, their intelligence and their commitment to changing the
mental health service delivery system in NL. Many had taken on personal advocacy projects and self-identified as queer activists. Others spoke of the overwhelming burden that they felt was unfairly shifted on to them to educate their service providers about sexual and gender identity. Scholarship of this sort that relates to youth is absent from the literature. These youths are experts in this area and can certainly fill this gap. Going forward, it is my sincere desire to act as a mentor and to support them through the process of getting their paper published in a peer-reviewed journal.

**Reflections on the Participants Digital Stories**

Collectively, the digital stories that were created during this research project are a representation of the unique and personal nature of each participant’s respective mental health service delivery journey—from their perspective. These stories are the “heart and soul” of this research project and, although not every participant is represented, those who desired to be so have been included.

The power of the digital stories produced for this project lies in their authorship and the fact that the stories are being told by their rightful owner, in the words of their choice. This is further strengthened because the stories remain intact, unedited and are presented without interpretation. However, as my digital story about this project conveys, for me, the power in these stories went far beyond their content. I marvelled at the choices made by participants when putting their stories together: the tone of voice used when recording, the inclusion of music and/or sound effects, and the stillness in the background of others. All of these things seemed to be a marker for the mood of the story being told. The choice of imagery was equally interesting to me. For some, there was a movement from dark imagery to light or the inclusion of personal
photographs; for others, there was a seeming randomness to the images chosen that only made sense once the story was complete.

The processes of authoring and producing these stories were varied and as unique as the people creating them. For some, their story came quickly and flowed easily, while, for others, their stories did not and for two participants their story remains untold. Throughout these story production processes, I was amazed by the participants’ vulnerability and their willingness to step into their pain and I was heartened and encouraged by those participants who had found hope and support on their respective journeys. Overall, I was left feeling honoured by the participants’ willingness to allow me to help them and by their trust in me and the intended outcomes of this research project. In short, I was simply overwhelmed by the impact of the participant stories, when told by the participants themselves.

Digital storytelling is a medium unlike any other and I truly believe that, were it not for its inclusion, I would not have found my way to this project’s inception and/or conclusion. Without exception, each story produced allowed me to get a glimpse into what the associated literature review and findings chapters of this project failed to effectively convey. Perhaps that is why I struggled so much with the data analysis portion of this study as, at times, it felt more like performing an autopsy, disarticulating stories from their wholeness to produce the findings.

In sum, it is my sincere hope that, when the reader of this paper heard the digital stories linked earlier in this chapter, they too caught that same glimpse. In doing so, I trust that they were moved to a level of understanding of this project that went beyond the theory and the data presented and were in turn transported to the rainbow road through the lived and situated experiences of the participant and their stories of travelling along it.
The Ethical Issues Encountered During this Research Project

In retrospect, the research processes associated with this project have been impacted by the discursive realities of those things that it sought to uncover. As a consequence, these ironic occurrences have created ethical quandaries for me and, in moving toward the closure of this project, I feel the need to share these instances and my associated thought processes. Accordingly, I will speak to each of the following separately in the section below: 1) The impacts of internalized cis and hetero normativity on me, as a researcher; 2) The impact of dysphoria and coloniality on an Indigenous and trans youth participant, and 3) The cis and/or hetero normativity embedded in participant responses.

The Impacts of Internalized Cis and/or Hetero Normativity on Me, as a Researcher

Very early on in this project, I began to notice moments when I was “caught up” in hetero and/or cisnormative thinking and the replication of its processes through the questions that I asked or the dialogue that I was engaging in while meeting with participants. As a white, cis, and hetero-presenting individual, this should have been no surprise to me—after all, I had spent the majority of my life identifying and passing as a straight person. Also, as my digital story conveys, I have had my struggles related to coming to terms with both my sexual and gender identifications. Nevertheless, in entering into this research project, I intended to uncover instances of hetero and cisnormativity in service provision and not in the very processes associated with doing so.

My first realization of my complicity came when meeting with one of the trans participants from Corner Brook. Fully engaged in a mutually beneficial and respectful dialogue, I asked the youth about their upcoming gender-confirming surgery and specifically if they had therapeutic supports in place to help them post-surgery. Given my training and practice as a clinical social worker, this question was asked without prejudice and with the best of intentions
STORIES FROM THE RAINBOW ROAD

(read as an act that sadly replicated colonial benevolence). Very quickly, the youth responded and “put me in check”, stating that they did not feel like they needed these types of resources to be in place, noting that they had been waiting their entire life for this confirming surgery and were finally going to be free of the horrible dysphoria experienced since puberty. I acknowledged the irony of my question with the youth who thankfully took no offence; I, on the other hand, was rattled by my replication of such oppressive thinking. Going forward, I was ethically compelled to ensure that to the best of my ability, I did not fall into “this trap” again. I made a conscious effort toward this end when meeting with participants and when reflexively analyzing transcripts.

Through this process of analysis, I noticed that I did indeed fall into other occasions, but none as blatant as the one shared above. In short, these conversations happened when meeting with three of the four youths in St. John’s. I will discuss these instances separately, as their circumstances were different; that is, I consciously chose to endorse heteronormative thinking based on my belief that the youths had the right to express their thoughts and tell their stories in the only way that they could. Quite simply, there was a lack of alternative frameworks to help them make sense of their experiences.

The Impacts of Disembodiment and Settler Coloniality on an Indigenous and Trans Youth Participant

As described in Chapter Three, one of the youth participants became unsettled during the recording of his digital story and chose not to complete it. When reflexively writing about this experience after the fact, I noted my complicity in creating this situation and placing the participant in it. I also noted that I believed that I had failed to adequately recognize and acknowledge with him the possible origins of his distress. In the moment, I was focused on supporting the youth through his emotional upset. What I missed was what he was telling me
when he repeated that he did not like being recorded and also that this was true for a lot of trans folks. In hindsight, I recognized that what was creating the distress for this youth was the very thing that he had spent the majority of his time talking about. Hence, during this incident, he was being impacted by disembodiment and a fear that he would, yet again, be epistemically violated and deemed not “trans enough” by those who heard his voice or saw him when viewing his digital story. Sitting with this knowledge made me uncomfortable and I am still left to question the ethics of my decision to encourage him to complete a digital story. As previously indicated, he initially questioned his ability to do so and, in the act of encouragement, I had unwittingly placed him into a space where my desire for him to share his story became privileged over his knowledge of his capacity to complete one. Unfortunately for this youth, this was not an isolated incident, as discussed below.

This same participant identified as Indigenous and, as previously explained, he had shared his experience of the violence that the colonial regime had enacted upon his family and his ability to re-connect with his Indigenous heritage. Similarly, he had also described the epistemic violence associated with the western medical system—instances of gatekeeping that prevented him from receiving a medical procedure and that made accessing hormones difficult. He was clear that the system had exacerbated his mental health difficulties to the point of a suicide attempt. When hearing his story, I had thoughts about many things, but I was especially curious about how his Indigeneity may have played into what seemed to be a denial of his sense of what was best for him and, frankly, an outright denial of his right to access a medical procedure that he desperately sought.

I was puzzled because this youth was receiving services from a medical provider who followed other project participants—all of whom had accessed hormones and medical procedures without issue. In my research journal, I wondered about what made him so different
from the others. He was even required to see a psychiatrist before the medical provider would prescribe him hormones. Was this a function of his perceived mental health fragility? Why was his sense of knowing what was best for him not affirmed when the other participants had found such safety and affirmation in this doctor’s care?

When considering these questions, I reflected on the literature that I had read regarding the construction of Indigenous mental health and, in particular, the report written by Billie Allan and Dr. Janet Smylie (2015). Was what this youth experiencing the racism embedded in the Canadian colonial system of health care that Allan and Smylie discussed? Was he being constructed as unable to know based on his Indigeneity? Was his declining mental well-being a direct result of structural, colonial racism? What might be different if there were Indigenous-led mental health services available to this youth that helped to strengthen his connections to his Indigenous heritage and that used wholistic ways of treatment? Would these services see him differently and refrain from the epistemic violence that he was currently enduring?

The literature associated with this paper certainly provided evidence that this youth’s service delivery experiences were a function of the racist, colonial roots of the Canadian health care system. Further, the fact that he had equally violent experiences with the mental health care provider that he accessed on-campus provided further evidence of the pervasive nature of the colonial roots on which the mental health system is founded here in Canada. My questions and these thoughts were never raised with the youth and I feel ethically conflicted about this. He never indicated that he believed that his service delivery experiences were a result of racism. The stories that he told instead described all that he knew—the pain and the injustices of his experiences and his confusion about why he could not get the help that he desperately sought, yet again evidence of the taken for granted, hidden, and insidious nature of structural coloniality. In sum, it is my greatest hope that this youth will find his way to safe, Indigenous-led mental health
service delivery and that he will finally feel seen, heard, and affirmed—protected from further colonial violence and harm.

**The Cis and/or Heteronormativity Embedded in Participant Responses**

As indicated above, there were times during this project where participants engaged in dialogue in a way that endorsed cis and/or heteronormativity, which became an ethical conundrum for me. At times, I would “gently poke” at these statements, hoping to engage the participants in a conversation about the underlying assumptions. In most cases, when I would do so, the participant would think about their statement and consider its origins. On other occasions I fought my urge to “poke”, recognizing that it was the participant’s story to tell, taking note of the foothold and power that these discourses had on the lives of those who mostly sought to stand against it.

Of interest in this regard were conversations with participants about the impact of hetero and/or cisnormativity on non-queer family members and friends. In general, there seemed to be an idea that, in some instances, heteronormativity was expected and even permissible. Hence, I had one participant tell me that “of course their friends were heteronormative (read homophobic), that they were straight and that they didn’t really prefer to be heteronormative, they just couldn’t help it”. Similar justifying statements were made about family members that were “too old to change” or “lacked exposure to education” or had grown up in rural parts of NL where discrimination was common. In a related vein, while the majority of participants spoke harshly to inadequate service provider training, one participant excused and removed the burden from service providers to self-educate or advocate for more training by choosing to believe that “they did the best that they could with the training and resources available to them”.

There was also evidence of the effects of internalized cis and/or heteronormativity expressed by a few participants. These conversations were especially hard to sit in, as I
recognized that the youths had internalized these discourses due to their hegemonic nature and a lack of alternative frameworks to make sense of their experiences. As a result, I did not question or challenge them when they would talk about sexual identity as being peripheral; discuss their passing, citing gratefulness about their ability to do so; or make statements that suggested that they evaded questions about same-sex partners or were not directly open with friends about being gay.

Finally, there were a few instances when the language used by participants had blatant hetero and cisnormative overtones. This was especially evident when a participant used the term “man of the house” in her digital story, thereby endorsing its associated patriarchal and gendered origins. Other instances were subtler and reflected heteronormative stereotypes such as a participant’s comment that they passed because they “didn’t look gay”. Relatedly subtle but different was my sense of a noticeable decrease in comfort with language (use of pronouns and terminology) when meeting with participants that did not identify as a part of the 2SLGBTQIA+ community. While these dialogues did not endorse language use with cis or heteronormative undertones, there was an increased caution with word choice that felt akin to fear of making an error possibly inferring the conscious effort needed to avoid the use of cis or heteronormative statements.

Chapter Summary

It is hard to articulate how very necessary the writing and inclusion of this chapter was for me. In my gut, I know that the writing of this chapter is likely related to the theoretical and ethical foothold that took root in me after reading the work of Judith Butler (2004) and that it is connected to a form of undoing. As such, it represents my attempt to make visible what will become invisibilized in the findings chapter of this paper: bringing individual participants into recognition for their unique contributions to this work; celebrating the relational and contextually
bound nature of knowledge production; and honouring its unintended extrapolation beyond the connection from which it emerged. I trust that the writing and inclusion of this chapter has served these purposes and that it has made known the invisibilized co-authorship of each participant who took part in this project.

Further, in retrospectively considering my experiences with the participants of this study I have been made all the more certain of this project’s necessity. The participants entered into this study hoping for change. I was particularly struck by their commitment to ensuring that those youths coming after them would not be subjected to the same cis and heteronormative violence that marked their own experiences in a professional space that was intended to be safe and therapeutic. Accordingly, although this project was small in scope and geographically specific its completion was vital as it opened ways for the possibility of joint social activism post-study. Similarly, it provided hope that the bravery of the participants who openly shared their experiences and willingly stepped into vulnerability would be honored. What is more, the completion of participant digital stories ensured that the individual nuances of the stories shared by those who completed one were heard. It is my belief that it is easy to read statistics that describe the plight of 2SLGBTQIA+ youth, acknowledge them and move on. I also believe that it is equally easy to read quotes that reflect participants’ experiences without grasping their significance and the impacts that these experiences had on the participants’ lives. Conversely, it has been my experience that it is much more difficult to do the same when hearing these stories as told by the youths and service providers themselves. As such, the attendant impact of these narratives has the potential to be much more profound as the listener is invited to engage with the participants’ lived experiences as told first-hand.

In sum, it is my hope that this chapter has aptly set the stage for the presentation of the key findings. It is also my sincere hope that the reader will find that the data analysis of the
stories told by the participants honors their telling. Correspondingly, the heinous impacts of settler colonization and cis and heteronormativity on the personal and service delivery experiences of 2SLGBTQIA+ youths and their service providers will be exposed and thematically organized in the following chapter.
CHAPTER FIVE: THE KEY FINDINGS

Introduction

In this chapter, I present the key findings associated with this inquiry or “the story of the stories told” by participants during the data collection phase of this research project. While undertaking this task, I was profoundly impacted by the wisdom of Qwul’sih’yah’maht Robina Anne Thomas, a member of the Lyackson First Nation (Thomas, 2015). Specifically, I felt ethically bound by her assertion that “Storytelling should always be teller-focused and share what the tellers deem important about their experience and should not be about studying what the researcher deems important” (Thomas, 2015, p. 187). What is more, she discouraged the use of interview formats with pre-determined questions and prompts. I was also struck by her keen awareness of personal power in the research process and her ethically reflexive stance. She posed important methodological questions such as “what happens if I ask the wrong questions... what would my research look like?” And she concluded that “It would only be answering the questions that [she] asked and as such [she] would be structuring the process” (Thomas, 2017, p. 187). I took her words to heart and followed her suggestions when meeting with participants.

As a result of carefully following her processes, I found the data analysis particularly challenging. I had an inner resistance to interpreting the stories that the participants had shared for fear that I would be telling my story and not theirs. In Chapter Four of this paper, I describe this experience as one that felt akin to performing an autopsy—disarticulating stories from their rightful owners to make sense of what had happened during the data collection phase. I worked diligently to find what I considered to be a presentation format that was most faithful to what the participants had said. In the end, what came from this process was the first iteration of this findings chapter. It was based on a journey metaphor and while it did reflect and honour the
stories that the participants shared, it was void of critical interpretation. In effect, I had mostly disarticulated the stories told from the theoretical frameworks that had guided this study. What follows is my second iteration of the findings. In this chapter, I still seek to honour the stories told by the participants in a way that is related to the theoretical lenses and overarching research questions that guided this project. I have divided this chapter into two broadly themed sections.

The first section contains collections of stories that give context to the participant’s involvement with the mental health service delivery system in the province of NL. Specifically, these narratives have been placed within six sub-themed areas and they illustrate how the youths and service providers described the personal impact of the hegemonic enforcement of heteronormativity, cisnormativity, and settler colonization. Section two contains collections of stories that relate directly to the participants’ mental health service provision experiences. Accordingly, I have placed these narratives within five sub-themed areas detailing the impacts that cis and heteronormativity; settler colonization; psychiatrization and medicalization; systemic inadequacies; and recognition and hope had on the participants while involved with mental health service delivery system in NL.
Overview of Themes Emerging from Data Analysis

Table 3
Collection One: Background Stories to Participants Mental Health Service Experiences

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<th>Subthemes</th>
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<td>1) Early Impacts</td>
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<td>2) Full Embodiment of Sexual/Gender Identification was made Impossible</td>
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The Background Stories to The Participant’s Mental Health Service Experiences

The Impacts of Cis and Heteronormativity on the Participants Lives

Given the central research question guiding this inquiry, it made sense that all of the youths who took part in this project shared stories that evidenced the impacts of cis and heteronormativity on their lives. Of note is that they often chose to relay stories that fell outside of the context of mental health service delivery. These stories were important, and they needed to be spoken, heard, and affirmed. Effectively, these narratives provided valuable insight into how the cumulative impacts of cis and heteronormativity created social, emotional, and psychological distress and ultimately played a role in the youths’ need to seek out mental health services. Three of the participating service providers also identified as part of the 2SLGBTQIA+ communities and similarly reported personal experiences with cis and heteronormativity. These stories were likewise important, as they provided a vital window into the motivation underlying the 2SLGBTQIA+ identified providers’ desire to work to mitigate the mental distress experienced by queer and trans youth.

Early Impacts of Enforced Cis and Heteronormativity on the Youth Participants

Many of the youths who participated in this project were subjected to the impacts of the hegemonic enforcement of cis and heteronormativity from an early age. Ariel shared her instinctive and early awareness of this enforcement causing her to question its associated constraints:

… when I was little, I would always try and walk out of the house shirtless because I was like, but he’s walking around [shirtless], and our chests look the same. And [my parents] were like, no you’re a girl. You have to have clothes over yourself. You can’t walk outside shirtless… and I was like, why not? (Ariel)
Later on, she recalled a similar incident of instinctively questioning the heteronormatively enforced rules for romantic relationships. She shared, “When I was little… my favourite song was “I kissed a girl” and I was like, what’s wrong with kissing girls…?” (Ariel).

Bobbie had a similar experience as she too recalled an early instance of being aware of the constraints of these same relationship rules:

There was this girl who started in kindergarten with me and I must have had a crush on her because we held hands… and this other girl was like hey we always used to hang out and now we don’t…. and I was like when she started here, we were just friends, but I guess I fell in love with her. Then I stopped because I was like, I think [what I just said] was supposed to be more about a boy and girl and we’re both girls so that wouldn’t work.

(Bobbie)

She likewise recalled an early instance of questioning the criteria associated with the gender binary:

I was with my dad [at a pool] and up to a certain age, children could go into the changeroom with their parents and then after that, you couldn’t. The first time I had to go into the girl’s change room on my own, I remember being in the shower and thinking, what if I was a boy? What makes me a girl anyway? (Bobbie)

Enigma had one of their first experiences of the structural enforcement of the narrow confines of the gender and sexual binaries in kindergarten. They recalled an incident when the class was allowed to play “dress up” and they wore a feather boa beyond the allotted time. As a consequence, they were subjected to heteronormative admonishment from a teacher who required that they take it off. A little later, they spoke further to how their refusal to submit and perform their gender and sexuality within these narrow confines caused them to stand out and feel othered:
At a young age I was experimenting, going in and trying to wear my mom’s makeup and was just like very artsy, gay, flamboyant—that child in school that everyone kind of looks at differently… (Enigma)

Blair similarly described an early incident of realizing that he didn’t fit within the confines of the gender binary, which caused him to also feel like “the other”:

I knew around five years old there was something different about me that no one else could understand… I would wear things that would make me feel really uncomfortable or people would refer to me as female and I’d be like, what? (Blair)

Jay, too, suffered as a consequence of the societal and familial enforcement of cisnormativity. In effect, he became epistemically violated by familial and community refusal to acknowledge his stated gender identity, which over time led to his state of disembodiment while meeting with me (to be addressed further in the discussion chapter). He shared, “I knew that I was a guy when I was a really young kid and I mentioned it a lot until maybe age 10 and then I gave up because I realized no one was respecting it” (Jay). This refusal of recognition was further perpetuated when his family would not support his efforts to use a name that affirmed his gender identity. He shared, “I tried to convince my parents to change my name when I was really young. I was like, you can pick, or I can pick, but they just wouldn’t do it” (Jay).

Finally, Kaiden explained how early on, they recognized the damaging impacts of the enforcement of cisnormativity on their life but were prevented from seeking support for it due to a lack of safety in an inherently cisnormative therapeutic relationship and space:

When I was about 10, I started questioning my gender identity… but I never felt like I could say it. I never felt like [the psychologist’s office] was a safe space at that time. It was just kind of like, you’re here for this [the self-harm]. Let’s pretend all of these other things don’t exist and that they couldn’t possibly influence anything. (Kaiden)
As a consequence of feeling these constraints at such a young age, many of the youths absorbed the discourses that were associated with the enforcement of cis and heteronormativity in their lives. For some, this impacted their ability to fully embody their burgeoning gender and/or sexual identity.

**Full Embodiment of Sexual and/or Gender Identification was Made Impossible**

**Internalization of enforced cis and heteronormativity.** Given the hegemonic power and the taken-for-granted nature of cis and heteronormativity, it makes sense that the youths experienced internalized manifestations of these discourses. What is more, it makes even more sense that they would subscribe to these narratives when trying to make sense of their experiences. For the most part, the youths shared these stories concerning their eventual embodiment of their queer and/or trans identities. For example, while discovering her sexual orientation, Bobbie made sense of her experience by subscribing to the heteronormative myth that being queer is just a phase, out of which one eventually grows. As a consequence, she explained that she thought that she would “eventually like boys” (Bobbie). Ariel shared a similar story as she described her internalization of homophobia and how she too tried to make sense of her burgeoning sexual identity through endorsing yet another heteronormative myth:

So, I was petrified thinking everyone would assume that because I’m in this group [her Gay Straight Alliance], I’m not straight. That was back when I was still trying to convince myself, like if I date a guy, maybe it’ll turn me straight. I was very naive then.

(Ariel)

Lastly, even once acknowledged by Kaiden, they too continued to struggle with their gender identity due to the hetero and/or cis normative standards that they had internalized. Kaiden shared this story about the time before the full embodiment of their gender identification. Of
interest is that this story also surfaces a concomitant internalization of the hegemonically
enforced patriarchal standards for the preferred performances of “true” femininity:

At that point [high school], I knew [that they were trans], but I kind of tried really hard to
compensate and be the girliest, girl, in my class, like I did beauty pageants to try to kind
of fit in, which made me stand out even more. (Kaiden)

Beyond these internalized impacts of cis and heteronormativity, the youths also shared
stories that chronicled the specifics of how they were subjected to the societal and familial
enforcement of the same.

**Societal and familial enforced cis and heteronormativity.** While talking about their
experiences of growing up as a queer youth in NL, many participants shared stories that relayed
their experiences of feeling entrapped by the societal and/or familial enforcement of cis and
heteronormativity. For some, this resulted in their inability to fully embody their queer or trans
identity. Enigma, for instance, described the tremendous weight that they felt as a result of the
enforcement of heteronormative societal and family expectations. Relatedly, this weight was
especially magnified by the fact that they had a relative who was a prominent public figure in the
province. They spoke to the impacts that this had on them, “I remember at that time even
thinking to [myself] you will just have to live your life and just be a straight male—find a
woman to settle down with. You’ll never be able to come out to people” (Enigma).

Jay similarly described how he was impacted by being a part of a family that embraced
the homophobic values of his small rural fishing community. In fact, during our conversation, he
referred to his home town as “the bible belt” of NL, thereby inferring the degree of religious
bigotry that he experienced while growing up (Jay). He explained that, as a consequence of this
bigotry and the condemnation that came with it, he struggled with internalized homophobia
causing him to be reluctant to embrace his sexual orientation.
In the same vein, Blair’s initial inability to fully embody his gender identity came as a result of his concern regarding peer and family reactions:

I didn’t know what the word transgender meant until I was around like 13, 14 when I saw an episode of Jazz Jennings. And I was like, okay, that’s me. But then I was like, wait, how are people gonna react? So, I stopped and pushed it off until I hit a breaking point.

(Blair)

Another participant, Shawn, shared that, as soon as he was aware of his sexual identity, he told his mother but not his father, who was retired from the Canadian military. He explained this reluctance by stating that he had “an open relationship with his mom and that he felt that she would understand more easily than his father” (Shawn). My understanding of this statement is that he feared his father’s reaction due to the homophobic underpinning of the military culture, which would make acceptance of his gayness near impossible. He went on to explain that he was able to eventually fully embody his sexual identity with his whole family and that his father had readily accepted him as a gay man.

At the time of meeting, Martin had just begun his social transition process and was slowly telling family members about his gender identification. While fearful of not being affirmed by all family members, Martin expressed a bigger concern regarding the potential consequences of fully embodying his transgender identity while seeking out mental health support. Specifically, he was fearful that his mental health issues would be solely attributed to his gender identity (Sound Bite); an experience that Dallon had early on in his mental health service delivery journey (Sound Bite).

Several other youths who participated in this project were also subjected to the societal and familial enforcement of cis and heteronormativity. All of these youths explained that, once

14 All sound bites are from the respective participants’ digital story
independent of family, they were able to fully embody their respective gender and sexual identities. Some even described moving to larger urban centers for this very reason. Finally, Kevin was clear that, although he realized that he was gay in high school, he chose not to identify with “the mainstream gay culture” and he indicated that he “still really doesn’t”. He spoke extensively to his privilege as a straight passing man and acknowledged that, as a result, he never really experienced any of the damaging consequences often experienced by those who are more open about their sexuality. Kevin’s story stood in direct contrast to many of the stories told by the other youth participants. In fact, all others shared stories that surfaced the horrific consequences of the homophobia and transphobia that is endemic to the hegemonic enforcement of cis and heteronormativity.

**The consequences of defying enforced cis and heteronormativity.** The participants shared many stories that demonstrated the damaging consequences of performing sexual or gender identities in defiance of cis and heteronormative requirements.

**Institutional oppression and endorsed violence.** For example, Blair shared this story that revealed how institutional oppression was applied to ensure that a classmate complied with the cis and heteronormative standards for “proper attire” at high school graduation. He explained:

… there was a trans woman that I knew that went to my school and she just wanted to wear a dress to grad and the principal called her down and was like, you can’t wear a dress to grad because it is a safety hazard. If you don’t own a suit, then you can’t come.

(Blair)

Jay, in discussing a similar experience, also spoke of institutionally endorsed violence when he attempted to defy the same cisnormative standards for dress at his high school graduation: “…

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15 Read: queer and trans peers who were out in the community
when I graduated, I was like, okay, I’m gonna wear a suit and I got death threats. So, I gave it up—that was the safest… and the school didn’t care. They didn’t do anything”.

**The loss of relationships.** Other youth participants described the loss of relationships as a consequence of discrimination and judgement due to their refusal to submit to the hegemonic enforcement of cis and heteronormativity. Shawn, for instance, spoke of such an incident at his place of employment:

There was a customer who always used to come in and he seemed to really like me. And he came around a lot and we sometimes socialized after work. But once he found out that I was gay, he stopped coming in to see me and I have never seen him since. (Shawn)

Jay also experienced the loss of a very close personal friend as a consequence of school-based bullying, which caused him to be deemed a social outcast by his friend’s family:

I had one friend and she was my best friend for 10 years. I lost her because I couldn’t walk down the hallway with her without other people shouting that we were lesbians…. and it’s not even that she wanted to cut me off—it was that her parents wouldn’t let her around me anymore. I actually had to deal with people’s parents saying that they weren’t allowed to be around me. (Jay)

Lastly, Bobbie shared a similar incident that she experienced as both violent and discriminatory and resulted in her becoming homeless while on exchange in Europe. She explained that her host family questioned her about her sexual identity and that she answered honestly. As a consequence, she was asked to leave the home; additionally, like Jay, Bobbie was deemed a social outcast resulting in the family, stating that she needed to leave immediately because they “were not comfortable with her being around their son” (Sound Bite).

**School-based bullying.** As indicated above, some of the youths also experienced school-based bullying. In particular, the trans participants spoke to its occurrence more often than their
queer counterparts—a discussion that will be picked up in the next chapter. Briefly, participants shared stories of bullying of varying severity. Among the queer-identified participants, Shawn identified an incident of microaggression when an unidentified peer left a “ticket” on his car windshield “for being gay”. Among the transgender participants, Blair shared two specific instances of physical violence that were committed against him. One occurred when he tried to access the male washroom and a second one involved death threats. He explained, “I was getting bullied really badly… people were threatening to kill me. [They] chased me with baseball bats” (Blair).

Jay similarly shared this about his experience of being bullied for defying the cisnormative enforcement of patriarchal standards for femininity: “people bullied me because I refused to grow my hair long. I had my hair cut really short in elementary school and I refused to grow it…” He also recalled cruel school-based bullying that exacerbated the disembodiment that he experienced due to puberty:

Once I got past the whole puberty point, I felt doomed because unfortunately as I was having to deal with that, I was also being really bullied really badly about the [physical] changes I was dealing with. And it was, it was just so hard. (Jay)

Finally, Kaiden shared that they had always been bullied for being different, so much so, that it was easier for them to give in and try to perform their gender according to the associated cisnormative and patriarchal requirements:

I think people picked up that I was trying [to fit in] too hard. I was always labelled as being a lesbian, which really hurt me. So, between that and my gender identity, I tried to kind of be the opposite, but then they were like, oh look, you’re like a lesbian who’s trying to pretend that you’re not. (Kaiden)
Clearly, the costs associated with the youths performing their sexual and/or gender identities in defiance of the structural and institutional enforcement of cis and heteronormativity were high. What is more, the cumulative impacts of these incidents, coupled with the impacts of familial rejection, religious bigotry, and self-imposed judgement (due to internalized manifestations of cis and heteronormativity) created undue distress in their lives. Ultimately, all of the participants reaped the inevitable consequences of this distress, resulting in their coming into contact with the mental health service delivery system in the province of NL.

**Mental distress was a consequence of enforced cis and heteronormativity.**

*Some youth disconnected their mental distress from its origins.* All of the youth participants in this study shared stories about their respective mental health struggles. Of note is that the majority had internalized a bio-medical understanding of these issues, which is understandable given the societal context and the lack of alternate discourses available to help them make sense of what was going on. As a result, most of the youths were unable to make any connection between their mental health difficulties and the cumulative impacts of the distress that they had endured in their lives.

Of particular interest when discussing the participants’ inabilities to make these connections was a conversation that I had with a youth who had significant difficulties with restricted eating. When asked directly about the possible tie between restricting their food intake and the societal enforcement of cis and heteronormative ideals, they vehemently denied any link; instead, they shared that “it was very much a jealousy, envy, sports performance, anxiety thing”. They added “[there were] many other things going on, like trying to fit in with parents and socially… just a lot of that stuff”. This statement evidences the impacts of an internalized medical discourse. As such, the participant appeared to be prevented from recognizing a potential tie between their distress as a queer-identified youth and their efforts to fit into a cis and
heteronormative world, defaulting to the bio-medical descriptor of anxiety to explain their experiences.

Amongst the youth who participated in this study, the most common consequence of the internalization of the bio-medical discourse was that the participants attributed their mental health struggles solely to their family genetics. One participant explained:

there’s a long, long history of mental health issues within my family, between like my grandmother and my mother… and even on my dad’s side. It’s not severe on my dad’s side, but it’s still there and I believe that I would still have these issues if I weren’t trans.

A second participant clearly stated, “I feel like with respect to mental health and sexuality and gender they are all totally separate—at least for me they are” (anonymized quote). They went on to explain that they made this assertion because there was an extensive history of mental health difficulties in their family.

_A lack of affirmation as a source of youth mental health struggles_. Other participants made direct links between their mental health struggles and an attendant lack of affirmation. For instance, one participant shared that:

a lot of my issues, a lot of my mental health stuff goes back to being trans because I find that, there’s just so little acceptance at least around here and like, you know, my parents don’t accept it and I have lost a lot of family and friends because of it.

Relatedly, another participant explained that they experienced an increase in their mental distress due to familial enforcement of heteronormativity. This occurred when their parents literally forbade them from fully embodying their sexual orientation in the community. They shared, “that was the first time that I was ever suicidal, it was after I came out [to my parents]”.

Finally, one other participant articulated how not being out as queer significantly affected their mental well-being. They shared “I think around 17 my grades started declining, my weight started dropping. I, I really started feeling the impacts of hiding who I was…”.

The mental health costs associated with the youths being open about their sexual and gender identity were high. What is more, this occurred within the context of non-affirming environments, increasing psychological distress. As a consequence, all of the youth participants reported experiences with some form of “anxiety” and “depression” to varying degrees. Additionally, two of the participants expressed their distress through their bodies, restricting their food intake. Tragically, four of the youths could not bear the undue distress caused by heteronormativity and homophobia and became suicidal; three were hospitalized, two for life-threatening attempts.

Three of the five service providers who took part in this project identified as a part of the 2SLGBTQIA+ community. While sharing their stories, it became very obvious that they had also suffered the consequences of the hegemonic enforcement of cis and heteronormativity on their lives (Sound Bite). In turn, these experiences allowed them to enter into their therapeutic work from a situated perspective and it forged a connection and commitment to the services that they were providing that went far beyond their respective professional training and memberships (Sound Bite).

Impact of enforced cis and heteronormativity on 2SLGBTQIA+ service providers.

J.P. was a gay-identified clinical therapist who grew up in rural outport NL. He came out to his family as a teenager and was immediately met with familial rejection and religious bigotry and discrimination. He shared:

when I came out, it was within 24 hours that I was approached by random people on the street asking me if I was gay because talk had spread that fast… I was in youth group and
the religious youth leaders that I had looked up to for seven years cornered me in a room with the Bible – it was a terrible experience. (J.P.)

He continued, explaining that these experiences had become part of his motivation for his work: “and for me, these are some of the huge underpinnings, I don’t want kids to ever have to go through this… I want to help others have a different experience in the world” (J.P.).

P.S., a trans masculine identified professional, likewise shared his reason for working with his organization: “I’m trying to ease or to mitigate. I don’t want these kids to deal with the same shit that I did. I want them to be able to walk into a doctor’s office and be told, oh, you’re trying to [transition]. Okay, this is what we know, not oh, what does that mean?”

On a similar but slightly different note, J.G., a social worker who provides clinical counselling to youth, shared her story regarding coming out and embodying her own sexual identity and relationship status: “there is this constant [pressure] of having to weigh the risks and benefits of how you’re going to interact in a room, in a given relationship, in a given conversation…it’s always there, not knowing what people are going to think of you”. In sharing this story, J.G. indicated that her battle with institutionalized heteronormativity in her workplace and internalized homophobia helped her to better understand the struggles of some of the youth that she worked with.

These providers also shared stories that similarly demonstrated how having been personally impacted by cis and heteronormativity uniquely impacted their work. For example, J.P. addressed the personal implications of the societal enforcement of cis and heteronormativity on his work as a queer-identified professional, explaining:

I will change my demeanour with certain families based on how they present in the room. Which is totally therapeutic, you have to kind of do that, to match. But when I’m reading a file and it says the family is quite religious and the dad comes into the room with the
child, I totally sit up straighter. I don’t cross my legs. I make sure I might not say certain words, which is totally internalized homophobia. (J.P.)

Similarly, J.G. shared stories that indicated ongoing concerns regarding client rejection, a consideration of the merits of coming out to her clients, as well as the nuances of navigating clinical spaces as a queer or transgender professional.

**Indigenous Youths Experienced Specific Impacts of Settler Colonization**

There is a long history of intentional erasure of Indigenous peoples in the province of NL (Robinson, 2014). As an example, there is an ongoing contested belief that the Beothuk were completely eradicated in 1829. Chief Mi’sel Joe of the Miawpuk First Nation has called this belief into question, insisting that many Beothuk fled to the mainland and integrated with neighbouring groups in an effort to escape settler colonization (Hopper, 2013). He also further contends that the Beothuk ancestry remains on the Island through intermarriage with the Mi’kmaq First Nation (Hopper, 2013). Of note is that Chief Joe has battled with the NL government for years, demanding the availability of genetic testing to disprove the lie of the extinction of the Beothuk.

Along with these colonial attempts to erase Indigenous peoples and their history from the province of NL, there were concurrent acts of violence and injustice that were further intended to assimilate and eradicate the Original peoples of the province (Robinson, 2914). Accordingly, there remains an injurious legacy from the removal of Indigenous children from their homes and cultures and the placement of these same children into the residential school system and adoptive settler families (Blackstock, 2019; Esquimaux, 2020; Methot, 2019; Spear, 2014).

The impacts of this colonial violence were evidenced in the data collection phase of this project. As a consequence, although four of the youth participants identified as Indigenous, only two of the four youths had knowledge of and a connection to their heritage. Jay was the only
participant to speak directly to his experiences of the harmful impacts of settler colonization on his life. He shared:

It’s complicated. I’m trying to reconnect after honestly years of being really disconnected from it. It’s really difficult to get access to a lot of information, especially like a family tree in terms of adoption and stuff like that, it is a big issue for me. There’s been a lot of like closed off adoptions and you know Indigenous people being adopted by white people. I can’t find any birth records or death records so I can’t find much on myself. So, it’s been really hard to connect. (Jay)

Reconnecting to his heritage was a priority for Jay. He had taken courses while in university to learn more about the history of his Nation and was actively soliciting the support of his partner, who was also Indigenous and closely connected with the community. Jay expressed gratitude for his partner’s support and was hopeful that he would be able to feel reconnected to his Indigeneity very soon. When asked about connections to any type of Indigenous wholistic mental health supports, he was unaware of any available to him but, with the support of his partner, was hoping to find some.

Kevin, the only other participant to identify a connection to his Indigenous heritage, did not speak to any personal impacts of settler colonization on his life apart from his experiences while in service provision. These contributions will be presented in the following section of this chapter.

Section One Summary

In sum, the first section of this findings chapter contained collections of stories that provided context to the participants’ involvement with the mental health service delivery system in the province of NL. Specifically, these narratives were placed within seven sub-themed areas and they described how participants were personally impacted by the hegemonic enforcement of
heteronormativity, cisnormativity, and settler colonization. In Section Two, I present collections of stories that relate directly to the participant’s descriptions of their service provision experiences. I present five themes that participants stated impacted their experiences of the mental health service delivery system in NL: cis and heteronormativity; psychiatrization and medicalization; settler colonization; systemic inadequacies; and recognition and hope.

**The Participants’ Experiences of Mental Health Services in the Province of NL**

To provide context for this section, it is important to note that there are no 2SLGBTQIA+ youth-specific mental health services offered in the province of NL. There are also no Indigenous-led mental health-specific programs. A local Mi’kmaw knowledge keeper told me that the youths would go to community Elders and Knowledge Keepers for support (assuming that they had a connection to their local community). Accordingly, the first point of contact for all of the youth participants was through the medical system and specifically via the central intake unit at their Regional Health Authority (RHA) or, more often, through their family physician. For trans participants, this was especially true, as many sought referrals to psychiatry to qualify for gender-confirming surgeries. There are local community-based 2SLGBTQIA+ support groups offered by some youth-serving agencies as well as peer support groups but none of these resources offer professional mental health counselling services. The availability of these services is also impacted by geography, as those living in rural and outport communities have fewer resources and limited accessibility.

As a consequence, the youth sought out supports and services from a broad array of service providers. Therefore, the term ‘service provider’ is used to refer to mental health

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16 There are Four Regional Health Authorities (RHAs) across the Island of NL. The Eastern Health Authority manages programs and services in the Greater St. John’s Area. The Central Health Authority manages programs in the Greater Grand Falls-Windsor Area. The Western Regional Health Authority manages programs in the Greater Corner Brook Area and the Labrador-Grenfell Regional Health Authority manages programs and services for all of Labrador.
professionals employed by the RHAs; mental health professionals within hospital-based outpatient clinics; school-based guidance counsellors; campus-based mental health professionals; family physicians; emergency room psychiatrists and social workers; mental health liaison nurses; and the nurses and social workers employed in a specialized inpatient eating disorders program.

Cis and Heteronormativity and the Participants’ Experiences of Mental Health Services

All of the youth and the service provider participants reported that they had been subject to the impacts of cis and heteronormativity upon their service provision experiences. The stories reflecting these experiences have been placed into three collections and are shared below.

Youth participants were not asked about their gender or sexual identities. Many of the youth participants stated that they were not asked to identify their sexual and/or gender identities during service provision. This was most evident during the intake processes to mental health services. As a consequence, cis and heteronormative assumptions were made by their providers.

Kaiden spoke candidly about their experience sharing, “I went there [the eating disorders program] for my orientation and on the application stuff there was never anything about a preferred name or pronouns, so it was just assumed once again that I was cis female”. They continued, “so, it was awkward for all of my intake appointments because they were going by the wrong name because, by this time, I was using my preferred name” (Kaiden).

Shawn similarly encountered assumptions about his sexual identity when first meeting his new service provider who, during intake, asked if he had a girlfriend rather than a partner. Kevin had the same experience, noting that he was not asked about his sexual or gender identification during his initial meeting with his provider and that his embodiment of a cis male identity caused the provider to assume that he was also straight.
Relatedly, Ariel shared this thought about the potential for assumptions to be made by providers during counselling situations. She explained:

I have some friends who are trans and just looking at them you generally assume they’re cis female and in reality, they might be trans male or they might be non-binary. Like you don’t know unless you ask. And in a counselling situation—you need to ask. (Ariel)

Lastly, Bobbie echoed the experiences of her peers, indicating that she was never directly asked about her sexual or gender identification during intake to services; she did, however, share that once she began receiving counselling, the service provider made no assumptions about her sexual or gender identity and that they eventually realized she was queer-identified.

**Service providers lacked education and awareness of sexual and gender identity**

Many of the youths noted that their service provider had inadequate knowledge about gender and sexual identity. As a consequence, some of the youth also stated that they felt the burden of having to take on the task of educating their service provider.

For example, Blair shared this experience with a resident at his doctor’s office when first seeking out trans-affirming medical and mental health care supports. He explained:

… he [the resident] kind of had a gist when I explained that being trans meant that I was born female, but I’m a guy and I think that was the basis of all he knew… It was just over his head. So, he just did a Google search [using the word transgender] and asked if I had this symptom, this one, this one, and then he’s like okay [implying that he fit the criteria] I will get the doctor now. (Blair)

Similarly, Martin echoed Blair’s experiences when seeking out a referral for mental health supports as a trans youth. His experience with his family doctors was that they lacked specific knowledge about gender identity. He explained “my doctor didn’t even know what the word trans meant until recently. He had to look it up” (Martin). Unfortunately for Martin, this
lack of knowledge had a concomitant impact on his doctor’s ability to be helpful with the distress that he was experiencing in his life. He explained, “I’ve told them [the doctor] about it, but they don’t really do much… I guess they really don’t know what to do for me” (Martin).

Kaiden, when eloquently speaking about their experiences within an eating disorder program, spoke to the ongoing burden that they felt about needing to educate those providing them with services. They explained:

… so, it feels like the person receiving services has become more of a teacher than a learner. I’ve gone through a lot of services and instead of learning how to better deal with my life, I feel like I put a lot of energy into teaching other people… I think that’s something they should be getting from their job and I should be able to take a break and go and just get services. (Kaiden)

Lastly, Bobbie shared stories that described the school guidance counsellors as ill-equipped due to a lack of education and knowledge regarding sexual diversity and school-aged children. Other participants discussed similar experiences with school-based counsellors, most indicating that they believed that “they did the best with the education and training that they had” (Enigma).

The service providers endorsed the stories shared by the youth participants. All spoke to inadequate knowledge and a need for education and training in areas related to sexuality and gender as the major contributor to the youths’ negative service provision experiences. J.P. shared that providers often do not know how to answer youth and parental questions regarding sexuality and gender. J.G. concurred and added that even the awkwardness associated with addressing issues related to sexuality and gender diversity with clients and their families spoke to the embedded cis and heteronormative curriculum in the various educational programs that the service providers had attended. H.H. similarly shared how something as simple as asking
employees to add pronouns to their signature blocks and to use them when introducing themselves to clients became an opportunity for the embedded cis and heteronormativity in service provides education and training to rear its ugly head. He shared:

it’s just easier for us to do this [use pronouns] versus having to figure [them] out… and it’s just an indication of how we’ve been educated to think—we find it awkward to talk about or ask somebody about their pronouns… (H.H.)

Both R.J. and H.H. referenced their sense of their colleagues’ knowledge of their inadequate training and knowledge base, which they believed caused them to fear making errors. P.S. concurred stating, “I think that there is a lot of fear around not knowing how to do things right”.

R.J. shared an additional example of a colleague who asked for training specific to working with 2SLGBTQIA+ youth. In turn, this led to an influx of queer and trans youth on their caseload, despite their feeling of being ill-prepared to be helpful. Relatedly, J.P., a queer-identified provider, noted that 2SLGBTQIA+ service providers are also in need of ongoing training to remain current on issues related to sexuality and gender. In fact, he shared that, as a cis male, he sought out training specific to working with trans youth, noting that his employer and fellow social workers mistakenly assumed that, because he was gay, he intuitively understood how best to support trans and gender non-conforming youth.

Finally, J.P. also raised caution about the dangers of limited and one-time diversity training and concern about the staff uptake of this type of education. He referenced a very specific conversation that he had with a youth at an initial meeting. The youth explained, “I don’t like that you guys had pride flags around here because that tells me it’s a safe space and I don’t feel safe here.”
Impacts specific to trans and gender non-conforming participants.

Being deadnamed and the use of incorrect pronouns. The trans and gender non-conforming youth participants identified that the service providers purposefully used their deadnames and used the wrong pronouns during service provision. For example, Kaiden explained: “even though my pronouns were written on the top of my file, apparently they were read, but they were disregarded every time I was spoken to”. At the time of service, Kaiden was also using their preferred name, which providers similarly ignored and instead opted to use their deadname. Kaiden expressed their frustration with providers who questioned why they had not made a legal name change, stating that they’re “so tired of that question, especially because it’s like, it makes it sound like it’s just as simple as changing it and of course it’s not, it costs money, it’s time and there are lots of implications of that”.

Jay had a similar experience with his campus-based service provider, who purposefully used his deadname and incorrect pronouns, he shared:

When I first met them, I didn’t have my name legally changed and they wouldn’t use my right name ever. And they would not use my right pronouns ever, especially if any third person had to be involved. They would still call me the wrong name, the wrong pronouns fully knowing the difference. (Jay)

He continued, “So, like it really shows they don’t have any respect. I understand that people slip up, but when people are that adamant about it, it doesn’t feel like a slip-up. There’s a difference between a slip-up and being hateful” (Jay).

H.H. is a service provider who manages an employment program that provides mental health supports and employment skills to at-risk youth. He added to the conversation regarding the use of deadnames in mental health service provision. While certainly not speaking to the intentional and blatant use of them, he did flag the cis and heteronormatively bound systemic
origins of these issues as experienced by participants like Kaiden when using government-funded programs such as his and those that require the use of a health card. He explained:

The biggest issue that we find, and it’s quite a big one, is that we are federally funded. So, there are requirements… like we have to use their legal name for them to sign up for the program because they [the funder] have to check names and social insurance numbers and match them up. (H.H.)

He continued explaining that his program was in the process of finding workarounds; nevertheless, H.H. acknowledged that, for many of their trans youth participants, this was an especially difficult set of circumstances.

**Being purposefully misgendered.** Jay was incredibly vocal about the damage that he felt as a consequence of the intentional and blatant denial of his gender identity during his service provision—which went far beyond the use of his deadname. He was eager to share these experiences:

> When I heard of the study, I was like, this is my chance to like mention that this has happened. You know, it was my chance to get it out really. And even if this goes nowhere, at least I got it off my chest and I’m happy with that. … it was really damaging. (Jay)

Accordingly, Jay referenced instances when his mental health service provider outrightly challenged his gender identity and denied his self-knowledge about the same. As a consequence, the provider refused to acknowledge his gender identity and continued to intentionally misgender him throughout the entirety of his service provision experience.

**The erasure of gender identity.** Kaiden added to this dialogue when they described how the content of a treatment group at their eating disorders program caused their gender identity to become erased. Specifically, they expressed that the presentation of group content based on the
gender binary was unhelpful. Further, they felt that these presentations held no treatment value for them or any trans and/or gender non-conforming youth (Sound Bite).

R.J., one of the service providers, also spoke about the negative impact of reproducing binary gender categories within mental health services: “we have to stop [designing services] according to how biology defines you [and design services based on] how you identify yourself… what if you don’t necessarily identify with a binary gender category? How do we work with that?”

P.S., another service provider, stated that the continued and purposeful use of gender binaries in service delivery is justified by the psychiatric profession. He explained, “it comes from a place of ignorance and them [psychiatry] not actually appreciating that what we’re doing is expanding language and access to identities” (P.S.).

Judgement. Finally, two of the youths shared stories that indicated that they had felt judged over the course of seeking out supports. For example, Dallon explained his hesitancy to use his local emergency department due to a fear of being judged by allied medical professionals:

Like even if it’s not a mental health issue, if I’m going into the emergency department, they ask me what medications I’m on and I have to disclose that I’m on testosterone… I try to explain to them that I need it and that it’s not because I want to bulk up. And their reaction is always like, and they don’t necessarily express it verbally, but you can see the judgment in their body language, and it makes me so uncomfortable. (Dallon)

Enigma too described their experience of feeling judged while seeking out services. Like Dallon, they believed that while the providers did not blatantly endorse cis and heteronormativity, their impacts were still very much present. As such, they surfaced in
Enigma’s service delivery experiences manifesting themselves in “a silent judgement from some providers at times” (Enigma).

The impacts of cis and heteronormativity on the service provision experiences of the participants in this project are undeniable. The stories included in this collection confirmed this reality with numerous others being left unshared due to space constraints. Unfortunately for the 2SLGBTQIA+ youth participants, the concrete manifestations of these discourses were not isolated but rather worked in tandem with others. The participants were also impacted by psychiatrization and medicalization in their service provision. The stories that reflect this reality are shared in the following collection.

**Psychiatrization and Medicalization and the Participants’ Experiences of Mental Health Services**

From the conversations had with participants, it was very clear that the 2SLGBTQIA+ youth desired to be fully seen and heard in their service delivery experiences irrespective of context. Even though many of the youth sought out psychiatric and medical supports for their mental health concerns (as explained in the first section of this chapter), they nevertheless identified some resistance to falling under the totalization of the biomedical and psychiatric gaze. The stories that reflect the participant’s thoughts on the impacts of psychiatrization and medicalization on their service provision are presented below.

**The conflation of gender and sexual identities with mental health.** Dallon was the first transgender participant to speak out about his sense of having his mental health struggles conflated with his gender identity. He explained, “the first psychiatrist that I had seemed good. And then once I started talking about my gender identity, automatically all my problems were because I was trans…” (Dallon). These experiences angered Dallon greatly. Martin, a newly identified trans man, shared his concern about the same fate befalling him:
I’m not sure even how they [a mental health service provider] would react if I were to say, well I’m trans, or I’m demi [sexual]. And it makes me feel nervous to get help because they could be like, your depression is because you’re trans, or your anxiety is because you’re trans, but that’s not how it works. (Martin)

Evidently, Martin’s fears were not unfounded, as Dallon’s experience was not an isolated incident nor was it exclusive to him. Enigma concurred:

It’s [mental health struggles] correlated with your sexuality. It’s like it is implied, they’ll never say it out front, but it’s like they’re trying to say that your anxiety is because you’re gay or you’re really depressed because you’re attracted to men. (Enigma)

Two of the service providers endorsed what the youth had shared through these stories. They spoke extensively to their own sense of how mental health difficulties can become conflated with gender and/or sexual identification in mental health service provision. J.G. explains:

their [the clients] mental health issues are often conflated with their sexuality. So, the assumption is if you’re coming here it’s because you’re queer and that makes you depressed right? Maybe the issues are connected to their sexuality but not automatically. Maybe if they are connected it’s because of society and not because of the youth. (J.G.)

P.S. wholeheartedly agreed, noting that he had both personally experienced conflation as a trans individual as well as in his role as a peer support facilitator:

People think that being trans is a mental illness or a disorder… I can even attest to that personally, but it’s the social stress for sure [that causes mental health distress]. If you don’t see yourself existing anywhere, you don’t see yourself represented and people don’t validate your own self-identity you are gonna have mental health struggles… (P.S.)
Being “named and framed”. Without exception, the youth participants in this study had been subjected to the psychiatric profession’s ability to “name and frame” their gender identifications and their mental health struggles. For instance, all of the participants in this study who identified as trans and who sought publicly funded gender confirmation surgery were obligated to occupy the diagnostic category of gender dysphoria. As a consequence, these participants all subscribed to psychiatric discourses to understand themselves.

Notably, it was not just the trans youth participants who subscribed to psychiatric understandings and descriptors of themselves. Rather, all of the youths had limited access to an alternate understanding of their struggles and therefore subscribed to diagnostic language to understand their distress. Accordingly, when discussing their experiences of their mental health struggles, they referred to themselves as being depressed, clinically depressed, anxious, bipolar, anorexic, and experiencing PTSD.

Jay also shared a story that served as yet another testimony to the power of the psychiatric profession to name and frame. In this instance, it seems as if his psychiatric diagnosis was used to discredit his knowledge of his gender identity and his desire to begin the process of physically transitioning. He explained, “I had to see a psychiatrist to get on to testosterone, which isn’t usually the case here—but since I had some mental health issues, my doctor wanted me to” (Jay). In requiring Jay to obtain a psychiatric assessment, the physician indicated they did not trust or validate Jay’s own experiential knowledge of his gender identity. In other words, rather than assuming that Jay was competent enough to make this decision for himself, his doctor deferred to the psychiatrist’s pronouncement of his competence before prescribing hormones to him.

On a broader level P.S., a trans masculine identified service provider, shared what he equated to be a continued movement within psychiatric and medical circles to impact how trans
identities are seen and understood. He contended that these movements went far beyond the act of just psychiatrizing trans youth identities to actually diagnostically categorizing them into extinction. He explained:

It is called Rapid Onset Gender Dysphoria (ROGD),¹⁷ it is a relatively new thing. It is the idea that being trans is a trend. One kid comes out as trans and then six of their classmates come out as trans and so on. And a lot of [psychiatric] professionals are using that as a way to question and to delegitimize the existence of trans youth identities. (P.S.)

Finally, J.G. added to this dialogue, describing the long-standing influence that psychiatry has had on the naming and framing of youth who choose to perform their gender and sexual identities in defiance of cis and heteronormative prescriptions. In doing so, she shared her belief that these youths often fall under the historical impacts of being deemed as ill and/or deviant. J.G. further explained that, in her experience as a social worker, the parents of 2SLGBTQIA+ youth often require their children to seek out mental health services as it is their perception that their child is mentally unwell and in need of therapy because they have deviated from gender and sexual “norms”. Sadly, it was also her sense that these same parents had missed the reality that the mental distress that their children were experiencing was in part due to the very familial judgement and rejection that had brought them into services. She elaborated, “It is like there’s this absolute right way to be which is heterosexual... And anything that isn’t absolutely heterosexual is considered deviant” (J.G.).

¹⁷ “In online reports, parents have described cluster outbreaks of gender dysphoria (exhibiting marked and persistent identification with the opposite sex and persistent discomfort (dysphoria) with his or her own sex or sense of inappropriateness in the gender role of that sex). Their child appeared to rapidly develop a gender dysphoria and/or transgender identification in the context of a peer group where multiple members became gender dysphoric and/or transgender was identified around the same time; the child’s immersion in social media was often associated” (Littman, 2018, p. 573)
The trans youth participants distress is medicalized and unheard. As stated earlier, many of the trans youths in this study (and particularly those on the west side of the island) relied on emergency psychiatric services and their family doctors for both crisis and ongoing mental health support and intervention. As a result, it was only logical that these professionals would view these youths’ distress with a medicalized lens. What is more, given the lack of training and education regarding sexual and gender diversity identified in the previous collection of stories, it is also little wonder that these youths felt that the nature of their distress was unheard. After all, it must be particularly disheartening to know that managing ongoing societally enforced distress is not as simple as a pharmacological fix, especially when this fact goes unrecognized and unacknowledged by the service provider. Nevertheless, these youths had little choice about where they received help and, therefore, persisted in their hope to be fully seen and heard. As a consequence, they were often exasperated by their medicalization.

Enigma spoke extensively about this and they expressed the exhaustion that they felt as a consequence of enduring multiple unhelpful hospitalizations: “… you go through so many times going to the hospital for help and just being prescribed different medications. You just get tired of it and eventually you just reach a point of self-defeat”.

Both Dallon and Martin shared their respective experiences about medicalization by their health care providers. Martin, like Enigma, felt defeated and explained, “I’ve been on the antidepressant for a few years. They [the doctor] wants me to come in every month to see how I’m doing, but they don’t ever refer me to someone”. Martin is clearly articulating the absolute lack of recognition that he felt from his physician and his sense that his distress held little value to them (Sound Bite). Dallon poignantly stated, “they would give me medications and stuff, instead of like trying to find the problem and treat the problem. They would only treat the symptoms with more medications”. Unfortunately, Dallon’s experience is not surprising, given
the lack of understanding that most medical professionals have regarding the discursive origins of the distress experienced by trans youth. In fact, it is highly unlikely that this physician had any knowledge of the source of Dallon’s mental health struggles whatsoever.

The collection that follows broadens the conversation on the medicalization and psychiatrization to stories that reveal the impact of settler colonization on mental health service delivery.

**Settler Colonization and the Participants’ Experiences of Mental Health Services**

As previously indicated, the Indigenous participants in this study experienced the personal impacts of settler colonization on their lives. As a function of the assimilation and erasure of Indigenous peoples in the province of NL, just two of four Indigenous participants were able to indicate any connection to their heritage beyond the knowledge of its existence. What is more, the fact that only one of these participants was able to speak to any personal impacts of settler colonization on their life is further evidence of its historical and ongoing legacy. Indeed, the Indigenous peoples of this province have been deeply impacted by the continued disconnection from ownership of their land by an ongoing denial of self-governance and through unending enforced assimilation into settler institutions and culture. It makes sense, therefore, that settler colonization had impacts on the service delivery experiences of not only the Indigenous youths who participated in this project but also through the pervasive ways that colonialism is structurally embedded within the mental health service delivery system. Accordingly, all participants in this project were subjected to its impacts with the most heinous consequences being reserved for the Indigenous youth.

**Indigenous identities were erased during service provision.** The youth participants in this project entered into a mental health system that is deeply rooted within the settler-colonial regime. As a consequence, those participants who identified Indigenous heritage were subjected
to the ongoing erasure of their identities during their mental health service delivery experiences. Kevin shared this story about his multiple interactions with the mental health service delivery system in western and eastern NL. He explained, “I don’t know if I’ve ever had a provider ask me about my heritage if I was Indigenous. I don’t think it’s ever come up” (Kevin). When discussing the erasure of Kevin’s Indigenous heritage, Kevin described it as an inadvertent oversight rather than a direct result of the embedded settler colonialism in the service system. When questioned about why he thought he was not asked about his Indigenous heritage, Kevin explained that he sensed that he was “settler presenting” and so assumptions about his whiteness were likely made. Kevin also shared that he never self-disclosed his Indigenous heritage while receiving services. I wondered if this was a choice based upon the legacy of shame and disconnection from Indigenous identities. I also wondered if he had an intuitive sense that, in making such a disclosure, he may have been subjected to the structural racism endemic to the Canadian healthcare system as well (Allan et al., 2015).

Other stories told by the participants described the pervasive impacts of settler colonization on the mental health service delivery system beyond the continued erasure of Indigenous identities during intake to service provision. While the majority of the participants were unable to make connections between these impacts and their colonial origins, they nevertheless spoke to them in the stories shared below.

**Mental health services were rooted in western colonial thought.** None of the services provided to the youth participants were Indigenous-led and they were therefore permeated by the principles of western colonial thought. Hence, they were biomedically based and viewed the distress of the youths apart from the contexts from which these issues emerged. Further, they were non-wholistic, with a sole focus on the youths’ psychological wellness. All other aspects of the youths being were ignored and alternate or wholistic publicly funded alternatives for
treatment were not available to participants. Accordingly, all of the services received by the participants were predicated on a western, rigid, and non-wholistic construction of mental health. **There was a lack of relationality in service provision.** Both the non-Indigenous and Indigenous participants spoke to a lack of relationality in their service delivery experiences. Of note is that this inherent absence of relationship stands in direct contrast to the principles guiding Indigenous-led mental health services, which focus on a shared sense of connection and community between the provider, the family, and the participant (Allen et al., 2020).

Martin and Shawn, both non-Indigenous participants, addressed the lack of relationality that is built into the neoliberal models of single session therapy often used by the youths as a stop-gap measure while seeking ongoing services. As a consequence, Martin expressed a hesitation to begin seeking this type of support. He explained, “It’s hard to open up without a connection. It’s hard to open up to someone if … you don’t know anything about them” (Martin). Shawn continued this dialogue when he spoke to his experience at a publicly funded short-term counselling clinic. He explained that he had opened up and shared his struggles with depression and anxiety to someone he thought would be his ongoing counsellor only to find out that he needed to repeat his story once again when referred to further services. Ariel, also a non-Indigenous participant, spoke about her sense of a lack of relationality in the services offered at her campus counselling center. She explained, “it’s mostly students on their clinical placements, so I’ve had a different person each semester … I hated having to constantly reintroduce myself to all of them” (Ariel).

Lastly, and as shared previously, Jay, an Indigenous youth participant, discussed a horrific lack of relationality in his counselling experience that went far beyond concerns about piecemeal service delivery. He shared the impossibility of establishing a trusting relationship with his counsellor as she continuously misgendered him during service provision. To make
matters worse, he sensed that he was essentially “forced” into working with this individual due to a lack of any other counsellors at his campus-based service. Jay was very vocal about this point explaining that “once [he] is strong enough, [he] will write them a letter explaining why [he] believed that they should never see another trans client again”.

There was a lack of wholism in service provision. Indigenous-led and designed mental health services are wholistic by nature. According to Elder Jim Dumont (2013), who is Ojibway-Anishinabe of the Marten Clan, Indigenous-led mental health services are:

Based on the four directions—the physical, the mental, the emotional, and the spiritual [and] all are necessary for mental wellness at the individual, family, and community level. [This] balance and interconnectedness is enriched as individuals find purpose in their daily lives…; hope for their future and those of their families…; a sense of belonging and connectedness within their families and to community and culture; and finally a sense of meaning and an understanding of how their lives and those of their families and communities are part of creation and a rich history. (First Nations Mental Wellness Continuum Framework, 2015, p .4)

In contrast to this model, many of the youth participants spoke out about their service delivery experiences as they related to the non-wholistic, western, and biomedical underpinnings of the mental health service delivery system in the province of NL. For instance, Kaiden, one of the non-Indigenous participants, poignantly captured the impacts of the narrowness of western gender binaries on the mental health service delivery system in the province and ultimately on the lives of the trans and gender non-conforming youth that it serves. They stated that,

our system is very much, I find binary, like they had to write a note at the top of my file. There was no other option. You have to be a box legally. And then that kind of translates to you being a box socially. (Kaiden).
As previously indicated, both R.J and H.H agreed and referenced the narrowness of the western gender binary and its concomitant impact on how services are delivered, especially when it comes to offering mental health services that are residential and require one to identify as either male or female to gain access. From a similar yet different stance, Kevin, an Indigenous participant, shared his perspective on the narrowness of the western healthcare system in general:

we are definitely still too biased towards the medical model. We are too much on the biological model. Right? Especially when it comes to treatment... so we really need to be looking kind of more wholistically at things… (Kevin)

Enigma inferred the same when commenting on what they perceived to be the rigid and non-wholistic nature of the western construction of mental health. They explained, “… massage therapy, physio, all of this kind of plays in with mental health for me because if you’re experiencing physical pain… it is very much connected with your mental health” (Enigma).

Finally, Bobbie also weighed in on Enigma’s point. She too believed in the power of wholistic treatments, such as massage therapy, when dealing with mental health issues. It was her view that the system needed to broaden its focus and make para-medical services available as a part of mental health treatment.

Thus far, the stories shared in this section of the chapter clearly demonstrate that the participants in this project suffered harm, violence, inequitable access to affirming mental health services, as well as many other unique service delivery consequences as a function of their 2SLGBTQIA+ identities. The next collection of stories makes a slight pivot and contains participants’ narratives regarding their navigation of a mental health service delivery system that they experienced as effectively broken.
Service Delivery System Inadequacies and the Participants’ Experiences of Mental Health Services

The stories contained herein reflect experiences that, at first glance, may not appear to be directly related to the participants’ queer and trans identities; rather, they seemed to represent some of the common difficulties that all youth might encounter while trying to navigate the mental health service delivery system in the province of NL. Having said this, I believe that there are larger issues at play that need to be taken into consideration.

In Canada, only six percent of our total healthcare budget is spent on mental health; as a result, only one out of five youths who need mental health services receives them (Jing, 2019). This creates a backlog within the system, resulting in waitlists for services that are up to one year or longer (Jing, 2019). The repercussions of these realities are sobering, with Canada having the third-highest youth suicide rate in the industrialized world (Jing, 2019). Statistics such as these are an abhorrent reflection of the value that the Canadian government places on the lives of those youths who struggle with mental health issues.

Set against this backdrop, the experiences of the youths who took part in this study make perfect sense. On second glance though, these experiences must also be considered in the context of the participants’ intersectional identities, which concurrently increases their mental health distress while decreasing their value to society. Accordingly, many of the participants in this study discussed their frustrations with a system that is not only ill-prepared to meet the needs of all Canadian youth but that also serves to exacerbate the degree of their already unbearable distress as a 2SLGBTQIA+ identified youth.

**Difficulty finding mental health services and complicated access.** Irrespective of geography, accessibility to safe and affirming mental health services is one of the major deterrents to finding mental health supports for 2SLGBTQIA+ youth (Elliot et al., 2014; Ellis,
Bailey, & McNeil, 2015; Kilicaslan & Petrakis, 2019; Russel & Fish, 2016). The stories offered by the participants in this study were consistent with this prior research.

Dallon shared this concerning his experience: “I knew that there were resources that were out there, but the problem is that there’s not enough of them and they’re not publicized enough, and not enough people really know that they’re actually there if they need them”. J.P. endorsed Dallon’s experience when he reflected on his service delivery days in NL. He recalled that the lack of visibility of mental health services created issues with accessibility for 2SLGBTQIA+ youth. He explained, “there wasn’t any visibility about these services, and they weren’t easily accessible. It was hard to be an advocate in a system like that” (J.P.).

Other participants also spoke about their difficulties accessing ongoing appropriate mental health supports. Enigma was denied appropriate ongoing mental health service despite presenting at the emergency room of their local hospital in a highly suicidal state. Unfortunately, Enigma’s issues with accessing the system continued. They also shared that they experienced the triage systems into mental health services as equally obstructive, stating that “You have your intake appointment and they put you on a list and put you in a box and prioritize you and say, your concerns and your life issues aren’t as important as someone else’s” (Enigma).

In a similar vein, Shawn was very vocal about his sense of the onerous nature of the access processes into mental health services. He shared, “In terms of actually getting into the services I found that there were a lot of extra steps in there that made it for someone like me at the time very, very challenging” (Shawn). He further explained that, as someone struggling with depression, finding the energy to follow through with a mental health referral was difficult enough without the added unnecessary administrative complications.

Martin, Dallon, and Enigma shared stories indicating that their entrance into mental health services was complicated by having to go through their respective family doctor. Each
expressed frustration with what they felt was a complex and lengthy route into the appropriate mental health resource. As an example, Enigma explained:

… family doctors would say, well, I’m not a psychologist, I’m not a psychiatrist. I don’t specialize in that so I’m not going to treat you for anxiety or any sort of the mental health issues that you’re going through. I’m just going to write you a referral and there’s nothing we can do for one or two years. (Enigma)

**Rurality impacted some participants’ experiences.** Rurality was also noted by some participants as a factor in their experience of service system inadequacies. For example, Ariel shared that, once referred for mental health services in her small town, she waited to be “picked up” for some time, only to find out that the counsellor who was assigned to her case was a family friend. As a result, she declined services and opted to wait to receive them until she moved across the province for school.

Enigma offered this commentary on their experience with what they perceived to be the inadequacies of the school-based mental health service delivery system in rural NL:

… Where you find the bad ones [school based mental health supports] is in the more small, rural, isolated communities… you wouldn’t have such a good experience with the guidance counsellor there. Whereas in [names city] the school systems are more on the ball. (Enigma)

Finally, Dallon shared a story about a younger trans youth who he was friends with on social media. This particular youth was located three hours outside of the closest urban center in a community that was very much cloistered by cis and heteronormativity. As a result, there were no safe or affirming local mental health resources available to them, leaving Dallon to make up for this inadequacy through providing virtual peer support.
Lengthy wait times for psychiatric services. Enigma spoke extensively to their experience of trying to receive psychiatric services. They shared multiple stories about how the lack of psychiatric resources had impacted them and how the wait times for these services had exacerbated their mental health difficulties. They explained, “after maybe six months to a year of trying to seek help, I was told that the wait time for a psychiatrist was two to three years” (Enigma). They continued, “… I’ve had to wait way longer than what you should have to wait for them” (Enigma). To emphasize their point, they further shared that they had just recently received a phone call from the Central Health Authority for psychiatric support—a referral that was made four years before their move to their current town of residence, which falls under the jurisdiction of a different Health Authority.

Dallon confirmed Enigma’s experience of a long wait time and the exacerbation of his mental health difficulties:

I have really, really bad anxiety. That pretty much prevented me from leaving the house, going to classes, being able to pay attention and focus on things. So, I pretty much had no quality of life because I didn’t have any of the skills that I needed to be able to cope with what I was going through, and I was on the waitlist to see a psychiatrist for two years.

(Dallon)

Difficulty accessing trans affirmative mental health supports. The trans participants recounted issues with being able to access timely trans-affirming mental health care, which was exacerbated even more at the time of data collection as the province was still requiring those wanting gender-confirming surgery to go to Toronto for a psychiatric assessment. On the west coast of the Island, participants reported extremely limited resources for mental health care provision. In fact, only one of the five trans participants was able to find ongoing mental health resources, with all others accessing campus-based or peer-support resources. Blair was the only
participant to access safe, helpful, and affirming mental health supports without much wait or complication via a referral to someone in the community through his doctor’s office.

Participants’ responses to the service system inadequacies.

*Activism and advocacy.* Perhaps most notably, Blair and Enigma used public forums to express their outrage regarding their service delivery experiences while accessing the mental and general healthcare systems in the province. For Blair, this involved launching a human rights complaint against the government of NL and for Enigma a public protest in front of their local hospital. As a consequence of these efforts, Enigma found some short-term gain, as the local news outlets picked up their story and they were able to receive the assessment that they sought; however, over the long term, they remained without appropriate mental health supports. Blair, on the other hand, successfully petitioned the government and, as a consequence, the legislation was changed regarding access to gender-confirming surgeries in the province and the provincial coverage of its costs. Unfortunately for Blair, this came too late and he ended up paying out of pocket and travelling to Ontario for his surgery; nevertheless, Blair’s social action efforts have opened the doors for many other gender non-conforming youth and adults to have this surgery in province.

Other participants engaged in their own forms of self-advocacy to gain access to the services that they desperately needed. For example, Enigma described their efforts to secure mental health services in this way:

*Just trying to get the resources and to get pointed in the right direction for mental health supports, it’s just been really hard. I feel like I’ve had to do most of the work myself. And I just feel like you need to be your own advocate and you need to fight for any kind of mental health care here.* (Enigma)
Similarly, Jay who attributed all of his mental health struggles to devastating experiences of being disembodied by gender dysphoria, used self-advocacy to secure access to a hysterectomy after being denied a referral by their physician. As previously discussed, his access was presumably denied due to his physician’s psychiatrization of his gender identity and her denial of his competence to make decisions regarding his physical transition without psychiatric consultation. He explained:

And since I am trans, a hysterectomy is usually something a lot of trans guys go through, I really want it. And I’ve been fighting and fighting and fighting and like they [the doctor] wouldn’t approve it… So, when I was on the psych ward, I told them you’re going to have to put in a referral because it’s just going to be years and years and years of me fighting with them to get a referral because I really need one. So, they put in a referral to a gynecologist, which you need in order to get a hysterectomy here. (Jay)

The use of the internet and social media to find support. Many participants shared stories regarding their use of the internet and social media for 2SLGBTQIA+ specific information and support. Blair described using the internet to search for private clinics in Toronto that offered gender-confirming surgery. As referenced earlier in this chapter, Kaiden shared that their use of the internet had provided them with initial information on gender identity and Dallon used social media to provide peer support to a friend. Martin similarly turned to friends on social media, as did Ariel when they had little emotional help or supports available to them in their communities. Relatedly, Ariel credited her social media friends with keeping her alive until she could get to university after her parents had forbidden her from being out in her community. Martin also sought mental health services for intrusive thoughts on the insistence of his online friends.
Finally, Enigma and Jay both turned to the internet for information regarding sexual and gender identity when unable to ask questions or seek support due to the taboo nature of this information in their religious homes and communities. Jay further sought information about transitioning from a Facebook group who provided peer guidance and support to him.

Along with the endorsement of the existence of many service system inadequacies leading to negative impacts for the 2SLGBTQIA+ youth participants, they also spoke to instances of positivity while receiving mental health services.

Participants’ Positive Experiences with Mental Health Services

In the context of discussing their mental health service provision experiences, many of the participants shared stories that reflected instances of positivity. These stories have been placed within the following three collections and reflect: the moments when the youth participants felt recognized during their service provision; the presence of hopefulness about the mental health service delivery system in the province of NL; and the presence of allies within the youths’ mental health service provision experiences.

Feeling recognized during service provision. Recognition was something that was desperately sought by many of the youths who took part in this study. Unfortunately for some, their experiences with being affirmed (particularly by service providers) were largely absent and fleeting at best. Others, however, had found moments of recognition while in services that were valuable to them and they shared these stories in the context of their positive service delivery experiences.

Kaiden spoke about the difference that recognition meant for them in their service provision experience:

When the nurse [at the eating disorders clinic] was going through all of the admission stuff … she asked me my pronouns when none of the other team members did. And that
meant the world to me at that point. I was so sick… it was just something about her asking and writing it down. It just made me feel comfortable. (Kaiden)

Similarly, Jay who had experienced the violence of being purposely misgendered and unrecognized by his service provider, shared this positive experience with being recognized during a hospitalization:

… people in the hospital were respectful, they were careful and asked me where do you want to stay? Do you want to stay with a man? Do you want to stay with a woman? And it was really nice that they cared enough to ask. (Jay)

There is a common element to all of the stories shared above that is very sobering. The fact that these participants were grateful and seemed surprised to be the recipient of care that should be expected as a standard for all individuals using mental health services is an unfortunate statement. Ultimately, it speaks to the youths’ inherent knowledge of the value that their lives actually held to the majority of the service providers that they had encountered.

**Feeling hopeful about the mental health service delivery system.** There was not an overwhelming sense of hope about the service delivery system amongst the youth participants. However, one participant in particular carried enough hope for all who participated. As an activist and advocate for systemic change, Bobbie was the most vocal about her sense of what has changed within the system and about the potential for even more change to occur. She shared the following story as an example of her perception that increased service provider knowledge was already offsetting the degree to which heteronormativity was impacting service provision in the province of NL:

There was one moment where, the counsellor asked if I had romantic feelings for the person who I had jealousy with, and I found it really interesting that there wasn’t a heteronormative assumption about me. (Bobbie)
As the conversation progressed, she further espoused her belief that “things were moving in the right direction” (Bobbie). She cited evidence such as preferred pronoun use, increased awareness of trans issues, and the presence of educational programs in gender studies to support her conclusion that “there’s more education, there are more conversations, so you know there’s less stigma” (Bobbie). In other words, she conveyed her belief that these changes would somehow infiltrate the service delivery system in the province of NL.

Allies found within the service delivery system was another cause for hopefulness for some of the youths who participated in this project. Dallon, for example, described a time when he sought the support of a local community physician to help him gain parental affirmation of his gender identity:

… if they [his parent] would say something really, I guess that could be very easily considered as transphobic, [the provider] would just like shut it down immediately and be like, no this is not happening? They were amazing. (Dallon)

As Dallon’s digital story also indicates, there were three other mental health care providers who he identified as allies (Sound Bite). Similarly, Blair referenced a counsellor that he saw pre-transition as an ally and a resource to the trans youth group in Corner Brook. He explained that he would frequently reach out to them when in need of resources and materials and that they were very helpful in providing them.

Enigma had hope about a potential shift in the attitudes and awareness of service providers that stemmed largely from the fact that many of their peers were now entering into the workforce. Akin to Bobbie’s belief of a generational effect concerning the uptake of cis and heteronormativity, Enigma also seemed to endorse the belief that their generation was far more open to sexual and gender non-conforming individuals and that, ultimately, this could make a difference to the mental health service delivery experiences of queer and trans youth.
There was a much stronger endorsement of hope in the service delivery system amongst the service providers. For example, J.P. and P.S. supported Enigma and Bobbie’s belief about the impact of a generational effect. They believed that the up-and-coming generation of 2SLGBTQIA+ identified youth represented hope and the possibility for system delivery change. Concerning a reduction in the stigma associated with being part of the queer community and its impact on service delivery, J.P. shared this: “Now with my generation, and I’m not that old, like 15-20 years ago it was more about sexuality, right? Are they gay or straight or bi? And now it’s like that’s very, very normalized”. P.S. was a little more direct about his hope for future service provision and he relayed this message: “But it gives me hope to know that like these kids that I see in the [trans] youth group, the young people that I see in this group … will eventually take over and… they’ll blow things up.”

Many other service provider participants referenced what they perceived to be improvements that had already been made in their places of employment. In general, these changes would all be considered simple to make; nevertheless, as the youth participants indicated “the little things made a huge difference”.

R.J. referenced the existence of gender-neutral washrooms in her former agency as evidence of a shift in inclusivity. She similarly described a fledgling sense of overall hope for some of the youth-serving agencies in the Greater St. John’s Area. She shared, “You know, that’s the thing. I mean, some of the community-based organizations like [names five agencies] here have done, a lot of really good work. Like, you know, they’ve got the space to have the conversation now” (R.J.).

Relatedly, H.H. expressed hope in the acquisition of funding for new initiatives:
We’ve managed to get some funding to have a youth leadership coordinator, so that’s going to be a youth position, but it’ll be a paid position. They’re going to develop some policies and procedures and hopefully, help even at the Board of Director level… (H.H.)

With specific reference to an issue identified by a youth participant about their lack of capacity to change their legal name, he shared this about the second initiative:

And [name of agency] has just started a program. We were kind of doing it informally before by paying for it. But we have a program now and a staff member at our outreach that will help youth legally change their name and any documents that are considered a barrier to their employment.

Chapter Summary

In this chapter, I presented the key findings from the youths’ and providers’ stories. It was my intention to honour the stories told by the participants while placing them within the theoretical frameworks that guided this project. Accordingly, the data was divided into two broadly themed sections. The first section of this chapter contained collections of stories that gave context to the participants’ involvement with the mental health service delivery system in the province of NL. Specifically, these narratives were placed within seven sub-themed areas and they described how the youths and the service providers were personally impacted by the hegemonic enforcement of heteronormativity, cisnormativity, and settler colonization.

Section two flowed from the first, as it contained collections of stories that related directly to the participants’ mental health service provision experiences. Five sub-themed areas were presented, detailing the impacts that cis and heteronormativity; settler colonization; psychiatrization and medicalization; mental health service delivery system inadequacies; and recognition and hope had on the participants while involved with mental health service delivery system in NL.
The next chapter marks a space for a discussion of these findings. I will speak to them in relation to the central guiding research question. I will summarize their implications for social work practice, pedagogy, and research and I will place them within the related literature. Finally, I will share my recommendations and those made by the participants for improvements to the mental health service delivery system in the province of NL.
CHAPTER SIX: DISCUSSION

Introduction

The central driver of this research project was a consideration of how heteronormativity influenced mental health service delivery and how it impacted the experiences of 2SLGBTQIA+ youth and those who provided mental health services in the province of NL. Over time and due to continuous learning and the operationalization of the research question, this inquiry became broader and to include a consideration of the impacts of cisnormativity, psychiatration, medicalization, settler colonialism, and rurality as well. Through the use of narrative inquiry and the production of digital stories, it became evident that all of these discourses had very real and concrete impacts on the lives and service delivery experiences of the participants. It was equally clear that the participants also experienced the exacerbation of their distress by a system that lacked funding, resources, and the capacity to service clients in a timely and appropriate manner. Despite these negative experiences, the participants also spoke about times when they felt positive about their experiences with the service delivery system.

This chapter begins with an overview of the main themes that emerged from the findings chapter. These themes are placed within the related literature to demonstrate how they build on and support the body of associated knowledge. Following this overview, I discuss the findings as they relate to their implications for social work practice and pedagogy. I then bring forward recommendations based on these implications. Finally, I consider the limitations of this study and suggest areas for further research and potential post-study projects and social justice initiatives.
Figure 2: A Visual Overview of How I Made Sense of the Findings
An Overview of the Main Themes Emerging from the Findings

When considering the findings in relation to the central research question and the context of the related literature, four overarching themes emerged: 1) the 2SLGBTQIA+ youth participants experienced the discursive impacts of settler colonization, cis and heteronormativity, and medicalization/psychiatrization; 2) these impacts brought the youths into contact with a mental health system predicated on these very same discourses; 3) while receiving mental health services, the youth participants experienced the continued discursive impacts of settler colonization, cis and heteronormativity, and medicalization/psychiatrization, in addition to impacts related to service system inadequacies; and 4) the participants made helpful suggestions for service system improvements but the underlying issues remained largely unaddressed.

The Youth Participants Experienced the Impacts of Settler Colonization, Cis and Heteronormativity and Psychiatrization/Medicalization

The findings of this study demonstrated that, long before the youth participants arrived at the mental health service delivery system in the province of NL, they had experienced the damaging impacts of living in a world dominated by colonial, cis, and heteronormative prescriptions. In fact, it was these very impacts that ultimately played a role in the youths’ need to seek mental health supports. As was previously noted, the participants themselves often disconnected their mental health issues from the associated structural and systemic origins, despite speaking in abundance about them. Accordingly, the participants described horrific instances of homophobic and transphobic judgement, violence, and discrimination while growing up. They also spoke openly about the societal and familial rejection of their sexual and/or gender identities.

Within the associated literature, there is extensive evidence that supports these lived realities (Craig, Austin, & Alessi, 2012; Daley & Mulé, 2014; Fergusson et al., 1999; Hadland et
This literature also indicates a statistically positive relationship between the youths’ distress as a sexual and/or gender non-conforming young person and poor mental health outcomes.

For the most part, it was the gender non-conforming and trans participants that were able to make a connection between their mental health struggles and the distress that they experienced growing up as a gender non-conforming youth. In fact, all but one of the queer youths stated that their mental health difficulties were the result of a genetic predisposition. Notwithstanding, all of the participants described their distress employing biomedical descriptors and diagnostic language. As indicated in the findings chapter, this made sense, given the lack of alternate discourses available to legitimize and help the participants make sense of their experiences. Unfortunately for the participants, their experiences with the mental health service delivery system were not much better. They experienced the continued negative impacts of enforced settler colonialism, cis and heteronormativity and psychiatrization/medicalization, during service provision.

The Youths were Brought into a Biomedically Based Mental Health System Predicated on Settler Colonial and Cis and Heteronormative Values and Norms

Sarah Ahmed (2014) discusses institutional norms and contends that, like walls, these norms become concrete and foundational over time. She further argues that these institutional and public spaces assume that certain bodies will access them and that, over time, this becomes concretized, enabling only those bodies to flow through their space (p. 147).

The institutional norms upon which the NL mental health system is predicated are not dissimilar to other mental health care systems in Canada. Indeed, this system is deeply rooted in a western biomedical framework (Georgaca, 2013; Kirschner, 2013; LeFrançois, 2013). As such,
Concerning this study, it therefore makes sense that all the youths shared stories reflecting the impacts of these underpinnings. Notably, these stories were shared more often by the trans and gender non-conforming participants. Also, of note were the stories shared by Jay. Identifying as both trans and Indigenous, he was not only subjected to the same consequences as his peers but also to the egregious impacts of the systemic racism (read: colonial violence) that is inherent to the Canadian healthcare system (Allan & Smylie, 2015).

The youth participants experienced the discursive impacts of the mental health system’s norms and values and the impacts of system inadequacies.

Invisibility or being rendered unintelligible. Judith Butler (2004) described one of the most common discursive consequences of heteronormativity as being rendered unintelligible or invisible by virtue of sexual or gender identity. As such, she argued that individuals are rendered invisible when there are no actual categories of recognition that allow them to become culturally intelligible or coherent (Lloyd, 2007). As the findings demonstrated, this became a reality for the youth participants in this project as, for the most part, the culture of the Newfoundland and Labrador mental health service delivery system prevented them from becoming fully recognized. The providers failed to ask the youths about their Indigenous, sexual and gender identities and proceeded with services based on colonial, cis, and heteronormative assumptions. What is more, their invisibility was further perpetuated by the administrative processes associated with intake into these mental health services. In fact, all of the trans and gender non-conforming youths reported that the associated paperwork had predetermined categories for gender that did not represent them and that essentially erased their existence from the service system.
Lives of little value and unlivable lives. Butler (2004) argued that lives for which no categories of recognition exist are unlivable (p. 18). She further posited that these lives also hold little value to society. Evidence of these realities surfaced through the numerous stories told by the participants in this project. There were several instances when the youths indicated that they felt like their mental health needs were ignored or did not matter to their provider. Two participants clearly voiced that their mental health situations were not deemed a priority. Both waited for extensive periods for appropriate mental health supports and both were brought to the literal brink of lives that were unlivable through suicide attempts.

Some participants felt the double burden of being invisible to their medical providers as a 2SLGBTQIA+ youth while, at the same time, feeling that their mental health needs were not being acknowledged. Quite simply, how many times can one ask for a referral for mental health services before believing that their needs do not matter or that their lives hold no value to their service provider?

One of the participants poignantly captured the essence of a life that is not valued and concretely rendered unlivable. To this end, they spoke of their struggle to survive on their disability pension, stating that they experienced daily food insecurity. They also discussed how the constraining nature of the western construction of mental health exacerbated their struggles and denied the wholistic nature of their pain and their need for access to treatments beyond those that are pharmacological. Others shared stories of attempting to challenge the constraints that they experienced only to be shut down by the very system that created their circumstances. Ultimately, many of the youth and two of the providers opted to move from their respective communities in search of a space that allowed them a more livable life—free from judgement, violence, and discrimination.
Epistemic violation of trans participants. The findings of this inquiry also determined that, during mental health service provision, the trans youths were subjected to purposeful acts of misgendering, the use of their deadnames, and the use of their incorrect pronouns. As a result, they became epistemically violated (Spivak, 1988). Consequentially, their very existences were delegitimized by service providers who employed cis and heteronormative discourse to construct their identities and to nullify their knowledge of their sexual and gender identities. One of the youths spoke extensively to these occurrences in their digital story. For another participant, their epistemic violation by a physician resulted in their needing to get psychiatric approval to begin the process of physically transitioning. The physician also refused the same youth’s numerous requests for a referral for a hysterectomy, continuing to invalidate their knowledge of their needs as a trans man.

The disembodiment of trans participants. Further to their epistemic violation, all of the trans participants described issues with disembodiment. This process occurred when they were forced to stand outside of themselves, unintelligible as defined by the binary lens of gender (MacNeill, 2009). One participant, experienced continued struggles with his mental health due to his being disembodied and in a continuous state of trying to re-make himself in order to become intelligible and brought into existence as a culturally coherent man. Relatedly, the psychiatric profession required that all of the trans youths employed bio-medical language to legitimize and bring their distress into existence. Without doing so, they would have been denied the right to gender-confirming surgery. Accordingly, the youths used the diagnostic category of gender dysphoria as an explanation for their mental health distress.

The participants’ distress was pathologized, medicalized, and psychiatrized. As discussed in the literature review, the Diagnostic and Statistical Manual (DSM) is the “matrix” through which the bio-medical construction of mental health and the construction of psychiatric
identity categories are substantiated. Recent literature (Daley & Mulé, 2014; Drescher, 2014; Kilicaslan & Petrakis, 2019; Russel & Fish, 2016) troubles the pathologizing of the distress related to queerness and trans identities and exposes the cis and heteronormative function of this process.

The findings of this project substantiated the lack of alternate discourses available to the youths to make sense of their experiences. Consequently, many participants knew themselves solely as someone who was genetically pre-disposed to being mentally unwell rather than someone who had suffered the mental, spiritual, and emotional consequences of living in a hetero and cisnormative world—a world that required their insistence to exist both figuratively and literally (Ahmed, 2014).

Upon entering the biomedically based mental health service system in NL, the youths’ construction and understanding of self was confirmed. Correspondingly, the performances of their distress became pathologized, medicalized and psychiatrized by their service providers. Taken together, these processes consolidated the location of the youths’ mental health issues within their biology, thereby decontextualizing the consequences of their distress from their societal and structural origins (Daley & Mulé, 2014, p. 1307). What is more, these processes were to the benefit of the NL mental health service system as they shifted the participants’ focus away from its complicity in upholding the very same discourses that brought the youth into its care.

**The participants were subjected to service system inadequacies.** The participants shared multiple stories about the impacts of service system inadequacies on their mental health service delivery experiences. As a consequence, these stories became a substantial part of the findings chapter and recommendations in response to these experiences dominated the participants’ suggestions for the improvement of service provision to 2SLGBTQIA+ youths.
The literature written in this area corroborated the participants’ stories with particular focus on the need for increased service provider training and education (Gandy, Carter & Portwood, 2013; Kilicaslan & Petrakis, 2019; Sheriff, Hamilton, Wigmore & Gambrone, 2011). Beauregard et al. (2016) added to this dialogue, noting the additional need for ongoing clinical supervision when practicing with LGBTQIA+ individuals. A search of the literature specific to 2SLGBTQIA+ youth feeling the burden of needing to educate their service provider about gender and sexual diversity produced no results. However, Grant et al. (2011) supported this finding in the outcomes of their research with adult transgender service recipients. Also, as indicated in the literature review, there were myriad articles that endorsed the participants’ issues with accessing mental health services and that highlighted the need for safety and affirmation in these services (Daley 2012; 2011; 2010; 2003; Brown, Rice, Rickwood, & Parker, 2016; Elliot et al., 2014; Ellis et al., 2015; Kilicaslan & Petrakis, 2019; Russel & Fish, 2016). Lastly, there was also a NL specific article that supported the participants’ experiences of lengthy wait times for trans-specific services at urgent care clinics and hospital emergency rooms (Temple-Newhook et al., 2018).

The participants made helpful suggestions for service system improvements, but the underlying issues remained largely unaddressed. When asked for suggestions to improve service provision experiences for future 2SLGBTQIA+ service users, many of the youth participants focused on specific elements of the service delivery process. They were concerned about the visibility of available services and made suggestions about establishing clearer pathways into these services. They were also concerned about the number of steps required to access services and recommended streamlining the intake processes. Relatedly, several participants made recommendations regarding the paperwork for intake into mental health services. To this end, they recommended changing forms so that they do not include
predetermined categories for gender to give queer youths the option to declare their sexual identification if they so choose. There were also associated recommendations made that advocated for the inclusion of spaces for preferred names in addition to legal names, as well as for the inclusion of preferred pronouns, should service users want to share them.

Given that one of the more common pathways into mental health service in NL is through the family doctor, several participants recommended that physicians include questions regarding sexual and gender identity as a standard part of their regular annual physical check-up processes. It was the participants’ perspective that this might remove the burden of having to come out to their provider. They also believed that it might decrease the stigma attached to membership in the 2SLGBTQIA+ community.

There were several recommendations made by participants with direct application to the specific services that they had accessed for mental health supports. Concerning campus-based services, they referenced the lack of full-time staff, which made service delivery inconsistent and made the development of a trusting and lasting therapeutic relationship near impossible. Accordingly, they recommended that full-time complements be increased. Relatedly, others suggested that the waiting period be waived at the start of the academic year for students accessing these services from one academic year to the next and that students are given the same counsellor for the duration of their service provision. As the findings indicated, one participant had concrete recommendations regarding the content for patient groups at eating disorders programs. It was their experience that the presentation of materials based on binary gender perspectives was unhelpful and held no treatment value for trans and/or gender non-conforming youth. They suggested that the content for such groups needed to be revised to remove all references to binarized masculine and feminine ideals and all other material that endorsed cis and hetero normative beliefs and discourses.
Apart from the recommendations specific to particular services, participants also made generic recommendations to help improve the quality of their experiences once they were in mental health services. Broadly, all of the participants endorsed creating openness in the service delivery experience, which extended beyond eliminating cis and heteronormative assumptions on the part of mental health service providers. They recommended that offices and meeting spaces be safe, comfortable, and inclusive. Specifically, they suggested that they include rainbow flags, posters declaring offices to be “safe and inclusive”, and gender-neutral washrooms. There was also a sense that, to increase comfort, spaces should be less clinical (read sterile) and seem more personal.

There were additional recommendations made by the youth participants that endorsed three interconnected areas: an increase in mental health funding, an increase in mental health resources, and an increase in service provider training. The latter recommendation was unanimously endorsed and there was agreement that this training should be done by those who are a part of the 2SLGBTQIA+ community or those who identified as allies.

The service providers that participated in this project made three distinct recommendations that they believed would help to improve service delivery to 2SLGBTQIA+ identified youth. Several providers indicated that hiring practices needed to be changed to increase diversity and to facilitate the representation of the diverse base of mental health service users. This change was especially pertinent to the need to hire gender non-conforming service providers. They also added that, irrespective of gender and/or sexual identification, all staff hired needed to be committed to ensuring safety. Relatedly, it was suggested that the responsibility for this commitment needed to go beyond the staff who did the clinical work with the youths. Hence, several providers endorsed senior management led, organization-wide commitment to safety and inclusion. The final recommendation made supported the youths’ suggestion about the need for
increased training and education for service providers. This recommendation was unanimously endorsed by the service providers who saw this as the most pressing concern.

The vast majority of the recommendations made by the participants in this study were in response to specific issues encountered during service provision. As evidenced in the section previous to this, these issues are well documented in the literature. They are, therefore, not unique to mental health service provision or in the province of NL. The suggestions for remedies to these ills are equally well documented (Gandy, Carter, & Portwood, 2013; Kilicaslan & Petrakis, 2019; Sheriff, Hamilton, Wigmore, & Gambrone, 2011; Temple-Newhook et al., 2018; Wagaman, 2014). Yet, these same issues persist.

As the subtitle of this section suggests, the recommendations made by the participants were helpful and their implementation would go a long way toward improving the mental health service delivery experiences of 2SLGBTQIA+ youths in the province of NL. As such, addressing procedural and administrative impediments to services is necessary, as is providing training and education to service providers who lack knowledge regarding sexual and gender diversity. Ensuring that paperwork is inclusive and that service delivery spaces are safe, and affirming is vital. Eliminating programs that are entrenched in traditional notions of sexuality and based on gender binaries and ensuring that staffing complements reflect the diversity of the clientele using the services are imperative to positive service delivery experiences. In the context of this study, these are reasonable first steps toward improving mental health service delivery to 2SLGBTQIA+ youth. These recommendations made by participants need to be shared and acted upon by the mental health service delivery system; however, without also disrupting the structural realities of the associated post-structural discourses, the possibility for true system change remains improbable, if not impossible.
The delivery of mental health services in the province of NL depends on the daily performances of those who provide services. As a result, the system is never static nor stable and is in a continuous state of flux. Relatedly, the performative nature of the providers’ service delivery opens up the possibility for the re-articulation of how these services are performed and ultimately delivered to 2SLGBTQIA+ youth. A case in point is the belief shared by the participants that services will improve via a generational shift. In other words as more trans and gender non-conforming people enter the field, the field will have to respond accordingly. The implications emerging from the findings of this inquiry offer promise for change to a system that has long been entrenched in discourses that promote violence, delegitimization, and erasure of 2SLGBTQIA+ youth identities while in services.

The findings of this study surfaced the need for the disruption of the hegemonic discourses that underlie the mental health service delivery system in NL. Doing so creates the best chance for the possibility of a significant service delivery system change and an improved service provision experience for 2SLGBTQIA+ youth. Otherwise, the system will remain in a continuous cycle of trying to fix only what is tangibly broken: that is, the symptoms of its disrepair such as long wait times, inadequate service provider training, etc. As a consequence, the systemic and embedded nature of the discourses at the root of its folly go largely unaddressed. I posit that the implications of this finding have a bearing on three areas: social work pedagogy, social work practice, and social work policy.

*An acknowledged tension in the recommendations.* At the outset to this section, I wish to acknowledge an identifiable tension within the recommendations made in relation to the implications of this study. In a not so ironic twist, this tension represents the disjuncture of my previous life. As a full-time administrator in the children’s mental health sector, I found myself in a continual state of straddling the divide between acknowledging the colonial, biomedical, and
cis and heteronormative underpinnings of the clinic that I managed, while being charged with addressing the symptoms of systemic disrepair as described above.

The reality of this divide is that, to keep the system as it is functional, both things had to happen at the same time. As such, I became complicit in the masking of the root problem while focusing on fixing its symptoms. Many of the recommendations made in the following section appear to be serving the same masking function. Evidently, I have been invited to become complicit once again as I sit in what feels to me as an inescapable purgatory somewhere between post-structural heaven and structural hell.

In making the recommendations as I have, I sought to find a middle ground (purgatory?) by suggesting that things like training and education be rooted in a post-structural lens. The intent of these recommendations is to increase awareness and to open the possibility for a shift in practitioner lens and, therefore, individual performances of social work practice. The reality is that these performances will still occur within a structure that, by its nature, works against a disruption of its foundation.

For a time, I considered the merits of examining the abolitionist literature to consider its application to the field of social work service delivery to 2SLGBTQIA+ youth. However, that became a rabbit hole that I realized would take me out of the scope of my original research question. The question of abolition or reform does linger for me, though, having gone through at least three system transformations with no real improvement to the mental health service delivery system. In general, each transformation was a glorified exercise in “moving around the deck chairs” and nothing really more than that. As I move forward in my scholarship, I may pick this question up again as a potential area for research.
Implications and Recommendations

**Social work pedagogy.** The associated body of literature demonstrates that social work pedagogy has an uneasy relationship with the topic areas of sexuality and gender (Hicks & Jeyasingham, 2016). It similarly reveals that content matter specific to 2SLGBTIA+ identity and issues is glaringly absent from social work curricula in most BSW and MSW programs across Canada (Hillock, 2016). As a consequence, this content is relegated to the periphery and taken by some social work students as an elective course (Hillock, 2016). According to Cosis, Brown and Cocker (2011), the topic of social work practice with 2SLGBTQIA+ people is underrepresented in the literature and interest in this area remains on the margins of practice and teaching. This absence of course content (Giertsen, 2019) coupled with a lack of critical discussion about sexual and gender identities leaves BSW and MSW students lacking for information and skills when working with 2SLGBTQIA+ service users. Recent literature (Inch, 2017; Logie, Bogo & Katz, 2015) confirms that students graduating from social work programs often feel ill-prepared to work with queer and trans clients.

Given this current academic climate in schools of social work across Canada, it is not surprising that students who identify as part of the queer and trans communities often feel on the margins. They also frequently experience homophobic and transphobic oppression while at school (Austin, Craig & McInroy, 2016; Denato et al., 2016). Relatedly, there has been a recent and much-needed call from scholars within the social work academy for a “queering of the classroom” (Wagaman, Shelton & Carter, 2018). Hence the lived experiences of 2SLGBTQIA+ students and faculty would be invited into the academic space, thereby making the presence of queerness in the academy visible.

Mulé et al. (2020) undertook a content analysis of the current CASWE accreditation standards as they relate to the 2SLGBTQIA+ community. The initial outcomes of this review
demonstrated that 2SLGBTQIA+ content is not adequately represented in the accreditation standards for schools of social work. In response to this outcome, the authors provided recommendations that support the integration of 2SLGBTQIA+ explicit standards into the CASWE accreditation process (Mulé et al., 2019, p. 288).

The implications arising from the findings of this study are highly applicable when considered in the light of the current pedagogical state of the schools of social work across Canada. There is a clear and pressing need to introduce content within the core curricula of BSW and MSW programs that are explicit to sexual and gender identity. This content should address the colonial, biomedical, and cis and heteronormative constructions of mental health. It should also help to inform social work students about the unique mental health needs of 2SLGBTQIA+ youth and adults and invite them into a dialogue about how best to support these needs through social work practice. While Recommendations One and Two are intended to have Canada-wide implications, the remaining three Recommendations are NL-specific.

Recommendation one.

- A) Content must be developed that is specific to gender and sexual diversity. It should highlight the impacts of colonial, biomedical, and cis and heteronormative constructions of mental health and make the connection between the presence of these discourses and the unique mental health needs of 2SLGBTQIA+ children, youth, and adults.
- Content must be developed that teaches students about how to address the mental health needs of 2SLGBTQIA+ individuals. Content must also be developed that critically interrogates psychiatrization and medicalization and social work’s role in these processes, particularly related to sexual orientation and gender identity.
Further content should also be developed that addresses and explores the connection between colonization and psychiatry.

- B) I recommend that this content be added to the BSW and MSW core curricula of all Canadian schools of social work that do not currently offer this content. Given that this recommendation arises from the findings of this project, I call on the Memorial University School of Social Work to take the lead on the development and introduction of this content into their curricula.

- C) I recommend that BSW and MSW courses provide content that gives the students the opportunity to discuss both the risks and responsibilities of positioning oneself as a 2SLGBTQIA+ advocate within the conventional service delivery system and as one who believes that the system needs to change to better serve this population. I also suggest that placements be developed that allow students the opportunities to critically engage in dialogues with their supervisors about these risks and responsibilities. At a minimum, students should be given assignments that engage them in exploring tangible ways to make a difference in service delivery to this population. Students also should receive the message that the mental health system is in need of change and that this can happen through the efforts, representation and visibility of 2SLGBTQIA+ identified service providers as well as through the active allyship of cis and straight identified colleagues.

**Recommendation two.**

- That the CASWE require all Canadian schools of social work to add the content suggested in recommendation one to the core curricula as stand alone courses for their BSW and MSW programs as a requirement for accreditation.
Recommendation three.

- That the service provider training recommended in the Provincial Mental Health and Addictions Strategy (Citation?) be modeled on the principles of recommendation 1a.

Social work practice. The findings of this study surfaced the absolute necessity of increased service provider training and education. The youth participants and service providers endorsed this need and the literature associated with the practice of social work with 2SLGBTQIA+ youth corroborates this finding (Gandy, Carter & Portwood, 2013; Kilicaslan & Petrakis, 2019; Sheriff, Hamilton, Wigmore & Gambrone, 2011).

In the context of the implications arising from the findings of this study, the nature of the training offered to the service providers becomes relevant. Indeed, as Mulé et al. (2019) suggested, the training needs to go beyond generic equity and diversity-based content to discuss the specifics of the varying gender and sexual identities of the clients who seek out services. The following recommendations are being made regarding service provider training:

Recommendation four.

- Youth service users should have input on the content of service provider training. This training should be based on the lived and situated experiences of the youths who use or who have used services in the province of NL. Youth-serving agencies should make this training mandatory and ongoing (onsite and available during paid work hours) for all staff members of community-based agencies and not exclusive to those providing mental health services. The content of this training should be modeled on recommendation 1a.

- Participants should be invited into a collaboration to develop a youth informed service provider training program. The Newfoundland and Labrador Association
of Social Work (NLASW) should also be invited to collaborate via an invitation to circulate a survey to its membership regarding their training needs for working with 2SLGBTQIA+ youth.

- Upon completion of the collaboration, it is proposed that the NLASW require bi-annual completion of this training program as part of its continuing professional education requirements.

**Recommendations to fill identified gaps in the service delivery system.** The findings illustrated that the 2SLGBTQIA+ youth service users came in to contact with the system as a result of the distress that they had experienced due to enforced settler colonization, cis, and heteronormativity. Unfortunately, this distress was exacerbated by the enactment of the same type of enforcement while receiving services.

There is a notable absence of 2SLGBTQIA+ specific mental health services in NL. This absence is compounded by a general lack of visibility for the 2SLGBTQIA+ community, as they are without a central hub to gather or house community-based, peer support services. Quadrangle NL is a community based, not for profit organization that is leading the efforts to establish a central 2SLGBTQIA+ hub. Should it succeed, this would be a logical place to house professional mental health services for queer and trans youth. To this end, the following recommendation is being put forth:

**Recommendation five.**

- Provincially funded LGBTQIA+ specific mental health services should be created to service LGBTQIA+ youths up to the age of 18 and transitionally aged youths 19-25.

- These services must be LGBTQIA+ led and staffed. Mental health service providers should be identified as experts in working with LGBTQIA+ youth, with
preference for employment given to those who identify as part of the LGBTQIA+ community.

A similar gap in services has been identified with respect to Indigenous-led wholistic mental health healing spaces. This gap is a function of the continued impacts of settler colonization as there is an expectation of assimilation into the western mental health discourse and practices. It also perpetuates the erasure of Indigenous identity, the delegitimating of Indigenous ways of knowing, and the denial of self-sovereignty via Indigenous-led mental health services and initiatives. It is therefore recommended that:

**Recommendation six.**

- Provincially funded, Indigenous-led, wholistic mental health spaces must be created. Youths up to the age of 18 and transitionally aged youth 19-25 will be served within this space.
- It must be Indigenous-led and priority must be given for the employment of members of the Mi’Kmaw, Beothuk, Innu, and Inuit communities of NL.

**Social work policies and procedures.** The service provider participants were adamant that changes needed to be made at senior administrative levels in order to ensure an environment that was safe, inclusive, and affirming for 2SLGBTQIA+ youth. The service providers advocated for these two recommendations to be made regarding agency level policies and procedures:

**Recommendation seven.**

- Local youth-serving agencies must engage in hiring practices that ensure that their staff represent the diversity of the clients that they serve.
Recommendation eight.

- Local youth-serving agencies do an audit to guarantee that they have policies and procedures that ensure a safe and inclusive work environment for both clients and employees.
- This audit should be done yearly to ensure that the policy and procedures in these areas remain current.

Limitations

Limitations related to demographic homogeneity.

- While the youth participant demographics reflected a good mix of sexual and gender diversity, there was homogeneity in the sample based on areas including race, ethnicity, and education. For example, all youths, except two, were white. Eight of ten youths were currently attending or had previously graduated from a post-secondary institution. All of the service providers recruited for the project were white-presenting and resided in urban settings.

Limitations related to Indigenous representation.

- Indigenous representation was limited by HREB research protocols, which prohibited the recruitment of Indigenous participants unless a letter of agreement was issued by the Indigenous research partner prior to going through the ethics approval process. As a result, the recruitment of Two Spirit youth participants was impossible. As a consequence, there were no Two Spirit participants.

Limitations related to geography.

- Due to the majority of participants attending post-secondary institutions, eight of the ten youth participants were receiving services in urban centers. All of the providers were providing services in urban centers. Due to the cost and distance
from the mainland, the recruitment for this study was limited to the Island of Newfoundland; therefore, the experiences of participants who resided in Labrador were absent from this study. The attendance at the digital storytelling workshop was impacted by geography. Due to recruitment on two sides of the Island, two workshops became necessary. As was noted in the methodology chapter, geographical limitations similarly affected the digital storytelling circle processes limiting participant numbers and causing a modified process to be necessary in St. John’s.

Methodological limitations.

- Also, as noted in the methodology chapter, the time requirements for the digital storytelling workshops were onerous and made attendance for many participants impossible. The methodological consequences of this were three-fold: 1) service providers were unable to attend workshops and instead completed digital stories via a 1:1 coaching process; 2) many of the youths expressed interest in attending the workshops but, due to busyness and school obligations, were unable to find the time to do so; and 3) the original intent of this project was to have youth participants and service providers sit in circle to hear and reflect on one another’s stories. The latter was not accomplished due to points one and two.

- The original intent for the inclusion of service provider perspectives was much broader than accomplished. Due to the size of the data set, a choice was made to use the service provider data to simply provide context for the youths’ experiences.
Finally, the small scale and Newfoundland specific focus of this project make the outcomes highly pertinent to this province but limited in their usefulness to mainland provinces and beyond.

**Pandemic and “stormaggedon”\(^{18}\) Related limitations.**

- The final storytelling workshop was impacted by the declaration of a Covid-19 pandemic and the after-effects of a winter snowstorm that shut down the city of St. John’s for five days in January. As a consequence, the initially confirmed attendance of four youth participants shrunk to one participant and the length of the scheduled workshop changed from two days to one day. As a consequence, only one digital story was produced in this workshop and another was completed via a 1:1 individual coaching process.

**Future Research Directions**

Some of the limitations of this project give rise to the opportunity for future research projects and align with my desire and commitment to continue researching at the intersection of social work and mental health delivery to 2SLGBTQIA+ youth. As a result, I intend to undertake the following research projects:

1) **A Labrador based replication of this research project.**

   - Having learned much from the undertaking of this project, I would modify the data collection and workshop processes to replicate this project in Labrador. Given the remote nature of the communities, geography becomes a challenge, as will access to broadband for the digital workshop portions of the project.

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\(^{18}\) Stormaggedon is a term that was coined locally to describe the blizzard that sent the City of St John’s into a state of emergency that resulted in a lockdown for five days in January of 2020.
2) **A comparative analysis of the Newfoundland and Labrador research outcomes.**

- The intent of this project will be to understand the contextual nuances of the NL service delivery system and to discern if issues with service delivery differ or remain consistent between sites. This research will explicate the nature of the consistencies despite geography and suggest service delivery improvements that are specific to Labrador.

*Proposed Youth Engaged Scholarship and Social Justice Initiatives Post-Study*

In honouring the commitment of the youth to this project and in keeping with the guidance given to me by Kathy Absolon, I intend to invite the youth participants to engage with me post study on three specific projects.

1) **Co-Authorship of a manuscript for publication.**

- I intend to invite the trans and gender non-conforming youths to engage in the process of co-authoring a manuscript that centers their experiences of feeling the burden to educate their service provider about what it means to be a trans youth. As earlier noted, there currently are no studies in this area. As a youth-led project, they will have the first authorship, and I will support them in the development of the structure and content of the manuscript and also help them to find a journal for submission. I will continue to support them in the revision and submission processes until the manuscript is accepted for publication.

* Participants will be financially compensated for involvement
2) **2SLGBTQIA+ youth digital stories presentation to social work students at Memorial University.**

- The youth participants will be invited to share their digital stories with students in my Social Work 3311 courses. All participants will be asked to complete a digital story allowing those who have not completed one to do so and those who wish to modify their story to do so. The intent of this presentation will be to allow the youths’ experience to educate students about the impacts of hetero and cisnormativity, settler colonization and medicalization/psychiatrization on social work practice with 2SLAGBTQIA+ youth. These students are just entering into their first practicum placement. This class will be conducted in circle format, allowing participants to speak to their stories and students to provide supportive feedback to the youths.

3) **The development of a youth-informed service provider training program.**

- Participants will be invited into a collaboration to develop a youth informed service provider training program. The Newfoundland and Labrador Social Work Association (NLASW) will also be invited to participate via an invitation to circulate a survey to its membership regarding their training needs for working with 2SLGBTQIA+ youth. Upon completion of the project, it is proposed that the NLASW require bi-annual completion of this training program as part of its continuing professional education requirements.

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19 Social Work 3311 is taught concurrently with the third year BSW student placement and focuses on the integration of social work theory to practice.
CHAPTER SEVEN: CONCLUSION

This project represents a long journey from inception to completion. Retrospectively, it found its very early beginnings seven years ago, in a paper that I wrote for a reading course. In a review of that paper, it is interesting to see the seedling nature of this project as I pondered: whether a Butlerian analysis of mental health could make a difference in, or a contribution to, the field of social work. Specifically, I queried its utility for analysis of mental health service provision to youth (de Jong, 2013). As this project took form and shape through the writing of my comprehensive paper and my dissertation proposal, this question lingered. How could I move this project from its highly theoretical analysis of the discursive impacts of recognition through Diagnostic and Statistical Manual (DSM) diagnosis and operationalize this analysis so that it would make a difference in the world of lived and situated mental health experiences (de Jong, 2017).

In my heart, I dreaded the prospect of this project coming to an end. I recognized that, upon completion, I would be forced to answer that “lingering question” and would necessarily come face to face with this project’s ultimate utility. In consideration of this task, I contemplated the following questions. Did the outcomes of this project create the potential to make a difference where they mattered? That is, could they help to make the service delivery experiences of 2SLGBTQ1A+ youth service users in Newfoundland and Labrador (NL) safer and less violent? Could they aid in the youths being truly seen by their providers and might they increase the likelihood that the youths’ distress will be understood apart from its pathologization? And what are this project’s contributions to the body of social work knowledge? What is the value added by the completion of this study and who could benefit from access to this literature? The outcome of my contemplation of these questions follows in the sections below.
The project’s contributions to the potential betterment of the NL service delivery system and the practice of social work with 2SLGBTQIA+ youth. The recommendations made in the previous chapter contribute to the potential betterment of the NL mental health service delivery system and the practice of social work with 2SLGBTQIA+ youth. I posit that:

- the recommendation put forth for “increased service provider training and education on gender and sexual diversity” helps to contextualize this need and has the potential to help inform the current government directives regarding training and education contained within the provincial mental health and addictions strategy (2017). It also ensures that the training provided goes beyond generic equity and diversity training and that it addresses the root causes to inadequate service provision to 2SLGBTQIA+ youth.

- Further, this same recommendation creates the potential for senior administration of local youth-serving agencies to prioritize and commit to this type of ongoing training for all staff and employees.

- The recommendation that “content be developed that is specific to colonial constructions of gender and sexual identity and that this content be added to the BSW and MSW core curricula of all Canadian Faculties and Schools of Social Work programs increases the potential that graduates from the Memorial University of Newfoundlan (MUN) School of Social Work will acquire early and foundational knowledge of this topic area. It is hoped that this knowledge will impact upon their practices with 2SLGBTQIA+ youth.

- Further, this same recommendation has the potential to aid in an increased understanding of the mental health struggles faced by 2SLGBTQIA+ youth and
an increased understanding of the discursive impacts of settler colonization and cis and heteronormativity on service provision.

- The recommendation that the “Newfoundland and Labrador Association of Social Workers require their registrants to complete (on a bi-annual basis) continued professional education credits in the area of working with 2SLGBTQIA+ individuals” increases the potential for current and more informed service delivery to 2SLGBTQIA+ youth.

- The recommendation that “local youth-serving agencies engage in hiring practices that ensure that their staff represent the diversity of the clients that they serve” creates the potential for the increased hiring of sexual and gender non-conforming staff members, thereby increasing the visibility of sexual and gender non-conforming individuals and addressing the inherent cis and heteronormativity that underlie traditional hiring practices.

- The recommendation that “local youth-serving agencies do an audit to ensure that they have policies and procedures that ensure a safe and inclusive work environment” opens up the potential for local senior administrators to address inadequacies in these areas.

- The recommendation that “provincially-funded LGBTQIA+ specific mental health services be created to serve youths up to age 18 and transitionally aged youths 19-25” creates the potential to fill this gap in the service delivery spectrum.

- It also creates visibility for the LGBTQIA+ community who are currently without any central hub or meeting space.
o The recommendation that “Indigenous-led wholistic mental health spaces be created for youths up to the age of 18 and transitionally aged youths aged 19-25” creates the potential to fill this gap in the service delivery spectrum.

o The recommendation that it be Indigenous-led supports the right to self-sovereignty and serves to disrupt the impacts of continued settler colonization. It further supports the recommendations of Royal Commission on Aboriginal Peoples (RCAP) and Truth and Reconciliation Commission of Canada (TRC) with regard to promoting reconciliation and Indigenous self-determination and resurgence.

o Finally, a recommendation was made that the “CASWE require (as an accreditation standard) that all Canadian schools of social work add content on gender and sexual identity/diversity to the core curriculums for their BSW and MSW programs”. This recommendation increases the potential for the assured and broad uptake of this content matter by all Canadian Faculties and Schools of Social Work.

The project’s contribution to the body of social work knowledge. In a review of the literature associated with this project, there is a notable focus on the barriers that 2SLGBTQIA+ youth experience while trying to access mental health services; however, very little is written about the actual service delivery experiences of those youths who managed to access mental health supports. There is a similar lack of information about the service providers’ experiences with the impacts of heteronormativity on service provision to 2SLGBTQIA+ youth and an even greater paucity of information on these topics that is specific to the province of NL.

This inquiry sought to step into these gaps. Accordingly, it was grounded in the lived and situated experiences of the 2SLGBTQIA+ youth mental health service users and those who
provided these services in the province of NL. As such, it addressed the identified gaps and it extended the literature as no other project of its kind had been undertaken within the province. Further, through the use of a queer theory lens, the cis and heteronormative underpinnings of the mental health service provision system were exposed. Recent literature has begun to take up this same mantle (Hadland et.al, 2016; Hunt 2016; Kilcaslan & Petrakis, 2019; Wilson & Cariola, 2019). This research project added to this growing body of literature, further shaking the silent and hegemonic hold that allows cis and heteronormativity to dominate mental health service provision and the research in this area.

Overall, the strength of this project’s contribution to the body of knowledge lies in its potential to make a difference in the practice of social work with 2SLGBTQIA+ youth within the province of NL. Clinical social work practices have long been a site of oppression for most 2SLGBTQIA+ youth (Edmonds-Cady & Wingfield, 2017). There is an extensive history of benevolently cloaked violence in its practice and the concomitant erasure and denial of the same (Blackstock, 2019). The findings of this study clearly demonstrated the impacts of settler colonization and cis and heteronormativity in the service provision experiences of the youths who took part. The service provider participants confirmed the presence of the same. As has been noted, the hidden and taken for granted nature of these discourses cause them to become obscured by the neoliberal outcomes-based rhetoric and focus of our mental health systems. Hence, what becomes critically important is that the presence and the impacts of these discourses be named and made visible to those who work within and manage these systems.

The outcomes of this study make the centering of this information possible. They are NL specific; their timing aligns with the provincial mandate to overhaul its addiction and mental health service delivery systems; and they represent the actual recommendations of the
2SLGBTQIA+ youth consumer and the voices of those who provide the services. Accordingly, they make a significant local contribution to the body of knowledge.

Concluding Reflection

As this project draws to a close, I am simply overwhelmed by its completion. Throughout the past seven years, it has felt like a shadow that accompanied me wherever I went, regardless of its invitation. Every part of my life has been touched by this project and I cannot fathom being without it. It is, therefore, my sense that, although this project is complete, it will continue to accompany me, but no longer as a shadow. I can now see its true form and shape and I am able to sit retrospectively in its substance and all that it has taught me. And so, I take these things with me, forever accompanied by their impacts—and for that, I am truly grateful.
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The First Light Native Friendship Centre of Newfoundland and Labrador; Workshop Handout January 2019.


Appendix A

Recruitment Poster: (HREB NL Edition)

Your opportunity to GET INVOLVED
Share your story...

Are you between 16–24 years old?
Do you identify as LGBTQ2S?
Have you received mental health services?
Or are you a provider of mental health services to LGBTQ2S youth?

If so, your participation in a research study on LGBTQ2S youth experiences of mental health service delivery would be appreciated.

Please contact Kathy de Jong, MSW (Principal Investigator) at dej07388@mylaurier.ca

If you have any questions about your rights as a participant please contact the Health Research Ethics Board at (709)777–6974; info@hrea.ca
Appendix B
WILFRID LAURIER UNIVERSITY

Consent to Take Part in Research

TITLE: "Hear" I am: Uncovering mental health service delivery experiences through the stories of LGBTQ2S youth and their providers.

INVESTIGATOR: Kathy de Jong, PhD Candidate, Faculty of Social Work, Wilfrid Laurier University, dejo7388@mylaurier.ca

SUPERVISOR: Dr. Shoshana Pollack, Professor, Faculty of Social Work, Wilfrid Laurier University, spollack@wlu.ca

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

discuss the study with you
answer your questions
keep confidential any information which could identify you personally
be available during the study to deal with problems and answer questions

Introduction/Background
Many studies focus on the barriers to accessing mental health services for queer youth, but there is very little information about the actual experiences of those youth who do access mental health supports. This study will give LGBTQ2S youth ages 16-24 the opportunity to share their stories of service delivery. Mental health service providers will also be invited to share their experiences of working with queer youth. This study is important as it has the potential to help shape future service delivery so that it reflects the actual voices and needs of queer youth service users in the province of Newfoundland and Labrador.

2. Purpose of study:
The purpose of this study is to understand how service delivery to LGBTQ2S youth is influenced by the belief that: people fall into two genders (male and female) with naturally assigned gender roles; that being “straight” is the only “normal” sexual orientation, and that sexual relationships should happen between people of opposite sexes.
3. Description of the study procedures:
This study has three parts. Part one is an interview that will happen with the researcher in the location of your choice. During this interview you will be asked to talk about your experience with mental health services as an LGBTQ2S youth or as a provider of publicly funded services to these individuals. I will begin by asking you to tell me your unique experience as a recipient or provider of services. I will do so without interrupting or guiding you. Following this, the interview will take the form of a conversation. I will go back to the story that you just told me and ask you some specific questions about your experiences. These questions will be based on a guide which I will share with you. You can ask me any questions during our conversation. You can choose not to answer any of the questions asked or you can stop the interview at any time without penalty.

Parts two and three will happen in a 3-day workshop. On days 1 and 2, you and the other participants of this study (there will be 15 in total, 10 youth participants and 5 service providers) will develop and produce a digital story. This story will reflect your experience with the mental health system as an LGBTQ2S recipient of mental health services or as a provider of the same. On the third day you will be asked to participate in a story telling circle by sharing your digital recording with other participants who will also share theirs with the group. I will lead this process and it will have clear expectations and guidelines.

You will be offered a copy of transcripts from your interview, your digital story and your participation in the talking circle. If you choose, you can provide feedback on the themes that emerged from the process via email, telephone or through Skype. These reflections will be included in the final research report. You will have ownership of your digital recording for your personal use. At the end of the study, you can choose whether or not you want to continue having contact with the researcher and whether or not you wish to receive a copy of the final research report. It is hoped that a collaborative process will happen after the study is complete that allows for information to be shared, by participants (who so choose) and the researcher that will help to inform mental health system delivery in Newfoundland and Labrador.

4. Length of time:
is expected that the interview will take 90 minutes or will last until you want to end it or feel you have said all that you wanted to say. The workshop will occur over three days and each day will be seven hours in length. If you choose to review transcripts from your interview, your story or the story circle this will take approximately one hour for each or three hours of your time in total. You will be compensated for your time. A ten-dollar gift card will be given to you at the beginning of the interview and a thirty-dollar cash honorarium will be given to you at the beginning of the workshop. If you choose to withdraw you can do so without loss of compensation.

5. Possible risks and discomforts:
During or after the interview and/or the workshop, you may experience some emotional discomfort as a result of sharing potentially uncomfortable experiences. During or after the workshop you may also experience emotional or physical tiredness due to the intensity of the process as well as feelings of vulnerability from sharing information with others in the group. If this is the case, you are encouraged to talk to the researcher. All participants will be provided with a list of local resources for further support if needed. The Principal Investigator is a trained clinical therapist. Should you need immediate support at any point, I will stop the process and
provide support to you. Once you are feeling settled, you will be given the option to continue on with the process. If you wish to stop, I will provide you with a list of local resources in case you need further support. I will also follow up with you later that day to determine next steps regarding study participation.

6. Benefits:
It is not known whether this study will benefit you.

7. Liability statement:
Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?
Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However, it cannot be guaranteed. You will be sharing your story and experiences with others present in the workshop. In checking the box below, you agree to keep the information shared by others in the workshop confidential. If you wish to share someone else’s information you must have their express permission to do so.

I agree to keep all participant information shared with me confidential unless I have their express permission to do otherwise. □

When you sign this consent form you give us permission to
Collect information from you
Share information with the people conducting the study

Access to records
The members of the research team will see study records that identify you by name. Other people may need to look at the study records that identify you by name. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information
The research team will collect and use only the information they need for this research study. This information will include your:
Name
Age (for youth)
Foster/Adopted for Youth
Clinical designation (for provider)
Number of years in the field (for provider)
Type of service employed by (for provider)
Gender identification
Sexual identification
Preferred pronouns
Preferred Pseudonym for participation in the study
information from study interviews, digital story and digital story circle participation
Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years past the completion of the dissertation project.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored in the Primary Investigators home office. Kathy de Jong (Primary Investigator) is the person responsible for keeping it secure.

**Your access to records**
You may ask the Primary Investigator to see the information that has been collected about you.

**9. Questions or problems:**
If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study. That person is: Kathy de Jong

Principal Investigator’s Name and Phone Number:
Kathy de Jong, 709-864-4716

Or you can speak to my supervisor:
Dr. Shoshana Pollack, 519-884-0710 x. 5220

Or you can talk to someone who is not involved with the study at all but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office at 709-777-6974
Email at info@hrea.ca
Signature Page

Study title: "Hear" I am: Uncovering mental health service delivery experiences through the stories of LGBTQ2S youth and their providers.

Name of principal investigator: Kathy de Jong

To be filled out and signed by the participant:

Please check as appropriate:
I have read the consent. Yes { } No { }
I have had the opportunity to ask questions/to discuss this study. Yes { } No { }
I have received satisfactory answers to all of my questions. Yes { } No { }
I have received enough information about the study. Yes { } No { }
I have spoken to Kathy de Jong and she has answered my questions Yes { } No { }
I understand that I am free to withdraw from the study. Yes { } No { }
at any time without having to give a reason without loss of compensation
I understand that it is my choice to be in the study and that I may not benefit. Yes { } No { }
I understand how my privacy is protected and my records kept confidential Yes { } No { }
I agree to be digitally recorded Yes { } No { }
I agree to take part in this study. Yes { } No { }

_________________________________________  __________________________  __________________________
Signature of participant                      Name printed                  Year Month Day

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_________________________________________  __________________________  __________________________
Signature of investigator                      Name printed                  Year Month Day

Telephone number: ___________________________
Appendix C

Interview Guide

1) Review and sign informed consent with participant

2) Welcome and introduce myself, as researcher/participant

3) Introduce the intent of the study and how the interview connects to it

4) Ask participant basic demographic information:
   - Name
   - Age (for youth)
   - Nation (for Indigenous participants)
   - Off reserve/on reserve (for Indigenous participants)
   - Foster/Adopted
   - Clinical designation (for provider)
   - Number of years in the field (for provider)
   - Type of service employed by (for provider)
   - Gender identification
   - Sexual identification
   - Preferred pronoun
   - Preferred Pseudonym for participation in the study

5) Ask participant to introduce self and tell their story of mental health service delivery

6) Begin conversational part of narrative inquiry using prompts and questions as appropriate to their story:

Prompts for youth

- Can you share your story of how you came to the place of being involved with mental health services? How did you understand your involvement, and did it impact on your sense of self/how you made meaning of who you are?
- Were the services that you were involved with generic child and youth mental health services or were they LGBTQ2S specific? Did you have a choice in service provider?
- As a queer/trans/Indigenous LGBTQ2S individual, did you feel that you were “fully recognized” during your service experience? Does the terminology used in society/your service provision experience feel inclusive of you or did it exclude your identity?
- If so, how? If not, how not?
• Did you experience homophobia, biphobia, transphobia, racism, colonialism etc. during your service provision? If so, can you share this experience with me?
• Are there things that you can share with me that did work for you in your service delivery experience?
• Are there things that you can share with me that didn’t work for you in your service delivery experience? Can you share examples of when you are able to stand up to these instances?
• Do you have any suggestions/ideas for how service provision to queer/trans/Indigenous LGBTQ2S could be changed?
• Is there a particular story/metaphor that best captures your overall service delivery experience as an LGBTQ2S youth?
• Is there anything important for me to know about you and your service delivery experience that I haven’t asked of you or that you haven’t shared.
• How has this process today been for you? In any way have you felt like it has been unhelpful to you, if so how? In any way have you felt like it has been helpful for you, if so how?

Prompts for service providers

• Can you share your story of how you came to the place of being involved with the delivery of mental health services? How do you understand yourself as a helper and does it impact on your sense of self/how you made meaning of who you are as an individual?
• Are the services that you are involved with generic child and youth mental health services or are they LGBTQ2S specific?
• How did you come to choose to work with LGBTQ2S youth?
• If provider identifies as LGBTQ2S - As a queer/trans/aboriginal LGBTQ2S individual, did you feel that you are “fully recognized” in your workplace? Does the available terminology feel limiting to you as an individual and does it limit you in your service provision?
• Is your workplace a safe space for individuals to be “out”? If out and employed in a generic children’s mental health agency, do you ever experience any instances of tokenism – do you end up with all the queer kids on your case load?
• Does your workplace actively engage in making itself a “positive space” if so, how?
• Do you experience yourself getting caught up in heteronormativity (e.g. Homophobia, biphobia, transphobia) when meeting with youth? If so, please explain how this is manifested.
• How have/do you intentionally resist heteronormativity in your work?
• Do you have any suggestions/ideas for how service provision to queer/trans/aboriginal LGBTQ2S could be changed?
• Is there a particular story/metaphor that best captures your overall service delivery experience as a provider to LGBTQ2S youth?
• Is there anything important for me to know about you and your service experience as a service provider that I haven’t asked of you or that you haven’t shared.
• How has this process today been for you? In any way have you felt like it has been unhelpful to you, if so how? In any way have you felt like it has been helpful for you, if so how?

7) End interview process, thank participant and explain next steps/timelines – give my contact information should participant wish to be in touch with me. Offer numbers for local mental health resources/support to participants should they need them as a follow up to the interview process.
Appendix D

Interview Debriefing Guide

1. How was this experience for you today?
2. Do you have any ideas or suggestions that could have made this better for you?
3. Was there anything in particular that stood out for you as something to do more/less of during the interview process?
4. Would you like a list of local resources for support in case you need to talk with someone about any feelings this process may have generated for you?