Beyond Affirmation: Queering the 2S/LGBTQ Initialism in Mental Health

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Unceded traditional of the Sḵwx̱wú7mesh Úxwumixw (Squamish), səlilwətaɬ (Tsleil-Waututh) and xʷməθkʷəy̓əm (Musqueam) Nations; Wosk Centre for Dialogue

This document summarizes the recently convened meeting of of 25 mental health and other healthcare practitioners (e.g., nurses, housing support workers), researchers, students, peers, and patient partners to discuss challenges, needs, and experiences of 2S/LGBTQ people accessing mental health care. We have created this report to highlight key questions and insights from the discussions, as well as next steps and questions which warrant further investigation. A list of attendees and email addresses (to support networking) is provided in the Appendix.

I. Motivating purpose

2S/LGBTQ+ people desire and deserve affirming mental health care but often do not receive it. There is a challenge of how to measure this and communicate this to service users, which was the motivation for creating MindMapBC. We therefore wanted to investigate what else we can do and what questions we can ask practitioners, ultimately in order to generate research ideas for some of us to carry forward. Our goal was for attendees to uncover and pose research questions to make the healthcare system more accessible for 2S/LGBTQ+ people.

By bringing an interdisciplinary group of scholars and practitioners with lived/living experience together to discuss these questions, we exposed problems with the current state of 'affirming' 2S/LGBTQ mental health care and identified research questions that have yet to be answered. This work aligns with strategic research priorities of the British Columbia healthcare system; as such, funding was provided by Michael Smith Health Research BC.

Our meeting was motivated by three foundational questions:

1. It can be difficult for 2S/LGBTQ people to find supportive mental health care. **Why are clients struggling to find good mental healthcare in the first place?**
2. There is limited content on 2S/LGBTQ-focused therapeutic approaches in mental healthcare provider training programs. **Why aren't practitioners getting the training they need?**
3. We are still coming out of the era of pathologization of queer sexualities and transgender identities, and so we can appreciate how the affirmative therapeutic model (i.e., treating

2S/LGBTQ identities as normative aspects of human gender and sexuality rather than pathologies) has become dominant. **What comes after 'affirming' care?**

II. Findings, part 1: Challenges in the context of 'affirming' 2S/LGBTQ identities in mental healthcare

Four concurrent discussions focused on aspects of 'affirming' mental healthcare that deserve critical attention: (a) the 2S/LGBTQ initialism; (b) definitions of 'affirming' care; (c) professionalism; and (d) the value of embracing shared identities (between providers and clients). Below we summarize influential discourses from the day. The topics were identified by meeting participants and reflect top-of-mind concerns when presented with the motivating questions outlined above.

(a) Challenges of the initialism

The 2S/LGBTQ initialism is an important connector/unifier for political and community organizing; however, we identified multiple limitations to a monolithic framing of the populations we are trying to serve.

- Order matters: placing "2S" at the front of the initialism is an important step to emphasizing how Indigenous concepts of gender and sexuality precede—and are fundamentally different from—western constructs. How can other letters within the initialism—especially "T"—be similarly prioritized, especially acknowledging that significant political barriers trans people are experiencing.
- Rather than rely on a fixed initialism, we should listen to the community(ies) we are serving. One participant described this as "queer flow", which they described as going with language that is prioritized and preferred by the particular communities at hand.
- The initialism is inadequate in representing other intersecting identities and experiences, erasing meaningful differences across race, socioeconomic position, neurodiversity, among others.
- The initialism is sometimes used in misleading ways. For example, some will say a program or service or study corresponds to 2S/LGBTQ people but in reality it predominantly (or exclusively) represents cis G/L people.

(b) 'Affirming' is hard to define / standardize

In order to understand the limits of the affirmation model, we first needed to define what is meant by 'affirming' care. Often this is operationalized as a checklist; when all (or most) of the criteria are met, an affirming approach is said to be established. We challenged the 'checklist' approach, noting that what 2S/LGBTQ mental health care clients most want and need cannot be neatly categorized in a list. Some participants reflected that "words matter less than intent" and wondered how we could standardize something that is so personal in nature?

Even when affirming criteria are rigorously developed and applied (e.g., the list of 'affirming' questions asked of service providers being added to the MindMapBC database) we

acknowledged that there is insufficient data to evaluate whether these screening approaches actually work (i.e., directing 2S/LGBTQ service users to affirming care experiences). We reflected on how queer people often rely on a 'whisper network' to find a good ('affirming'?) provider, meaning they ask other queer friends and queer professionals which providers are trustworthy given their own social positioning. These knowledge gaps point to a need for more research on the nature and benefits of affirming mental health care (see list of future research questions in Section V, below).

(c) Professionalism

Counselors and therapists in Canada are governed by various federal or provincial licensing bodies, including provincial colleges of social work, and provincial associations of counseling, psychotherapy, or psychology. These governing bodies establish the norms that govern practice which practitioners must follow, and which training and education programs are aligned with.

In our discussions, we considered how codes of ethics and standards of practice fall short in queer contexts, especially as they relate to self disclosure, boundaries, and dual relationships (i.e., where multiple relationships exist between practitioner and client). These standards of practice generally view mental health care through a patriarchal, colonial, and cisheteronormative lens, and can constrain practitioners in multiple ways, limiting how professional practice is conceptualized.

Self Disclosure

Generally, principles of ethics and standards for counselors and therapists discuss the challenge of crossing boundaries, becoming too close with clients, and blurring professional parameters of the therapeutic relationship. However the reality is that many members of marginalized communities, such as those who are 2S/LGBTQ, prefer to work with a practitioner with similar identities, based on previous practitioners who were not able to understand their lived experiences. However for many practitioners, telling their client that they may be 2S/LGBTQ will feel like they have inappropriately shared personal information that is not applicable to their counseling experience.

We discussed how practitioners become challenged and feel unsupported by organizational and professional standards in wanting to navigate self disclosure (e.g., a queer or trans therapist working with queer or trans clients). While practitioners recognize the potential benefits of self-disclosure for clients, there is no (or little) guidance on how to do this. We also recognized and differentiated the experiences of self disclosure for practitioners who are 'visibly' queer or trans and therefore may be readily identified, as compared to those who are not visibly identified. This is an added layer of complexity to navigating self disclosure, which should be an issue that is openly discussed.

Boundaries

In instances such as what was named above, practitioners may worry that their 'self disclosure' has crossed a professional boundary, and that they have violated their ethical and fiduciary

responsibilities. Notions of boundaries are governed by discourses of objectivity or neutrality. These are challenged particularly when practitioners are themselves 2S/LGBTQ and wish to disclose personal identities in ways that are safe and even therapeutic.

Dual Relationships

Similarly, the notion of dual relationships, that is, maintaining clear and separate boundaries between community, professional, personal, social, and activist spaces, does not apply for practitioners who wish to work with members of their own community, those who may be racialized, 2S, queer, trans and/or non binary. Most standards of practice currently lack support and guiding principles that are more appropriate to this framework of practice.

(d) Shared identities

In an ongoing survey of MindMap users, the majority indicated that they would like to see their own personal identities reflected in their mental health care providers. We reflected on why shared identities are important in this context, and noted that shared identities may often be a proxy for screening out stigmatizing providers. In other words, shared identities may be more important than meeting a standardized set of affirming criteria.

Some limitations to this include times when a community member wishes to see someone who is clearly positioned outside of their community, in order to maintain privacy and confidentiality. Alternatively, a service user may be comfortable to seek a practitioner with expertise within a specific practice approach or area of specialty, without needing any shared aspect of identity or lived experience.

We also noted some other limitations of the shared identity approach to mental health care. First, if someone is multiply marginalized or holding intersectional minority identities, they may have a difficult choice to make when finding a provider (e.g., if I cannot find a Black trans mental health practitioner, is it more important to find someone who is Black or someone who is trans?). Second, shared identities may lead to assumptions made on the part of the provider; if a social identity is common, there may be less clarification or probing of what it is about that identity that is shaping the client's life and mental health. Lastly, in a context where most mental health services are inaccessible and unaffordable, we questioned whether emphasizing shared identities was realistic. A prerequisite to this kind of matching should be improving equitable and affordable access to care.

III. Findings, part 2: Toward a 'not-knowing' and culturally humble stance

In another small discussion group session, we focused on one question: how do we shift from an 'affirming' model to instead identifying and acknowledging 'harms' & being accountable to redress them? This relates to the concept of a 'not-knowing' stance in therapy. The benefit of such a stance is it can build trust with clients by being willing to acknowledge and correct where 'harms' (or mistakes, missteps) have occurred.

This shift from measuring and cataloging ‘affirming’ providers to instead acknowledging cultural humility and the potential for harm was productive; however, we struggled with how such an approach would be operationalized. We identified barriers to participation in such a model, including that providers are embedded within professional bodies, colleges, and organizations that may default to taking disciplinary action when harms are identified. The contemporary culture of western healthcare practice also promotes a stance of ‘expertise’, which works against the goal of this shift. We were also concerned that this approach is more of a ‘problem-focused’ approach (vs. strengths-based).

In our discussions of promoting a ‘not-knowing’ stance, we identified other promising practices that could help us expand beyond the affirmation model. Some of us asked instead how we can encourage providers to be more curious (related to humility). We came back to the idea of having a crowd-sourced review system (“Yelp” for mental health services), though this may create liabilities for the person operating the system and does contravene professional standards. Finally, if we’re not going to be problem-focused, we have an opportunity to do something radically different. We talked about queering practices as the cisheteronormative discourses steeped in heteropatriarchy and colonialism have caused particular harm for Two-Spirit, racialized, queer, trans, and non-binary communities accessing mental health services.

IV. Summary of learnings

In reflecting on the 2S/LGBTQ initialism, queer context adjustments to notions of professionalism, shared practitioner/client identities, and 2S/LGBTQ affirming care, we concluded that we need all of these to continue contributing to equitable mental health care for 2S/LGBTQ people. None of them are sufficient in isolation. Further, over-emphasizing any of these aspects of queer mental health care can create a distraction or give a false sense of confidence in the practice. A practitioner could ‘check all the boxes’ on our affirming checklist and still not adequately meet the needs of a 2S/LGBTQ client. For example, a practitioner may know what each letter of the initialism means and may be aware of the well documented adverse mental health effects of social isolation, stigma, and discrimination, but they will still have been educated in a cisheteronormative counseling framework that has not been amended to meet the specific needs of these populations.

We therefore call for expansions and radical reimaginings of the affirmation model. Our goal—if we can state one—is to get back to a humility/not-knowing stance, and to keep a curiosity about what is missing, and what comes next after ‘affirming’ care. Attention to intersectionality is lacking in the current literature regarding affirming care, due to the Eurocentric nature of cisheteronormative counseling frameworks. These should be amended to serve racialized and Indigenous populations.

V. Possibilities & next steps

The following questions arose throughout the day and may be answered through future studies. We are especially interested in practice-oriented research, meaning research that clarifies the nature of queer mental healthcare beyond the 'affirmation' model, as it is practiced by those in the forefront of effective and inclusive care.

- Can we quantify the discrepancy between demand and support for queer affirming practitioners? We noted that there are far more 2S/LGBTQ people looking for affirming care than there are providers prepared to offer this (at least explicitly). If this were quantified, we could build the case for expanded funding/resource allocation for 2S/LGBTQ affirming & tailored services.
- How are affirming practitioners bridging their knowledge of approaches to help other practitioners learn how to do this? → A qualitative or mixed method study focused on mental health providers (e.g., those indexed in MindMap as affirming)
- How can more appropriate counseling frameworks be developed that are based on queer, trans, racialized and Indigenous knowledge, teachings and cultures?
    - We need improved understanding of intersectional affirming care. → This is a topic of focus in interviews Samira Karsiem will be doing with respondents to the ongoing MindMap survey.
    - How can these frameworks then be taught to mental health providers?
- There is no single 'best approach' for working with queer people. Rather, there needs to be a continual holistic focus on the relationships and learning of the client and therapist. How do queer client/practitioner dyads intentionally or unintentionally queer the practice, and what can this tell/teach us about better models for mental health care generally (for cishet people as well)? → Ethnographic study of providers/clients with shared identities?
- Several participants called for more arts-based methods to open other ways of expressing identity, gender, sexuality. One participant suggested a photovoice study about the 2S/LGBTQ initialism, asking research participants to generate images that reflect their relationship with or resistance to the umbrella term.
- How is 'harm identification' ('not-knowing stance'; interpersonal humility) practiced in mental health care with 2S/LGBTQ clients?

One research idea emerged that would potentially address many if not most of the questions listed above. Our proposal is to purposively sample 'mental health' practitioners (broadly defined, i.e., including people working in shelters, outreach programs, social services, etc.) who are enacting forms of care that go beyond affirmation and ask them to share how they do it and how it can be transferred to other practitioners.

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