HELP-SEEKING BEHAVIOURS OF ADULTS FROM SEXUAL AND GENDER
MINORITIES LIVING WITH PSYCHOLOGICAL DISTRESS

by

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Table of Contents

List of Tables

List of Figures

# Abstract

Increasing research has highlighted certain health disparities experienced by lesbian, gay, bisexual, transgender, queer and other gender/sexual minorities (LGBTQ+) peoples, particularly in relation to poorer mental health outcomes (Keuroghlia, Ard, & Makadon 2017; Kidd et al., 2016). Using a mixed-methods design, this study explored help-seeking with various mainstream, traditional, and/or complementary medicine practitioners among LGBTQ+ and heterosexual, cisgender adults living with psychological distress in the Halifax Regional Municipality (HRM). An online survey revealed that psychological distress, experiences of mental health discrimination, and help-seeking behaviours differed based on gender identity, sexual orientation, and mental health diagnosis. A focus group revealed unique experiences of LGBTQ+ patients that influence treatment adherence and outcomes, and emphasized how discrimination, patient-practitioner rapport, and insurance coverage were primary factors affecting help-seeking. These findings indicate that the health care system in the HRM needs to be improved to provide more accessible mental health services to LGBTQ+ patients.

*Keywords*:  Mental health, LGBTQ+ health, Depression, Anxiety, Psychological Distress, Help-seeking, Alternative/Complementary Medicine.

## List of Abbreviations and Symbols Used

*-2LL*         Deviance (*-2 \* log-likelihood*) for Logistic Regression

CBPR        Community Based Participatory Research

DDI        Distress Disclosure Index

GP        General Practitioner

HCP        Health Care Practitioner

HRM        Halifax Regional Municipality

ISMI        Internalized Stigma of Mental Illness Scale

K10        Kessler-10 Measure of Psychological Distress

LGBTQ+        Lesbian, Gay, Bisexual, Trans, Queer, and other sexual/gender minorities

NPMI        Negative Perceptions of Mental Illness

*OR*        Odds Ratio

PCA        Principal Component Analysis

PI        Principal Investigator

PLE        People with Lived Experience (*of mental illness*)

PPMI        Positive Perceptions of Mental Illness

PTSD        Post-Traumatic Stress Disorder

SS        Stigma Scale

TCAM        Traditional, Complementary, and Alternative Medicine

# CHAPTER 1

# INTRODUCTION

People who are members of sexual and gender minority groups are diverse with respect to age, ethnicity, religion, socio-economic status, and residence (Daley & MacDonnell, 2011). They are often referred to as the Lesbian, Gay, Bisexual, Transgender, and other Queer identities (LGBTQ+) community (see Appendix C for a glossary of terms). It has been estimated that around 2 to 14% of the global population identify as LGBTQ+ (Gates, 2014; Taylor & Peter, 2011; Shields et al., 2013), yet the proportion of resources allocated for their health needs is substantially lower (McKenzie, Khan, & Mulé, 2019; Taylor & Peter, 2011). Recent calls to action demand policies that bridge the inequities in the provision of LGBTQ+ health (McKenzie et al., 2019). This inequity is particularly problematic because LGBTQ+ individuals are also disproportionately affected by various health problems relative to the cisgender and heterosexual population, with much of the literature focusing on their increased risk for mental health problems and psychological distress (Dean et al., 2000; Garnets, Herek, & Levy, 1990; Makadon & College, 2007; Meyer, 1995; Ross et al., 2018; Wolitski, Stall, & Valdiserri, 2008). Despite variation between the sub-groups comprising this community and the intersecting identities of each individual, members of the LGBTQ+ community experience stigma, prejudice, and discrimination as a result of pervasive and institutionalized homophobic, transphobic, heterosexist, heteronormative, and cis-normative foundational ideologies in our society (Balsam & Mohr, 2007; DeHart, 2008; Hequembourg & Brallier, 2009). Discrimination against LGBTQ+ peoples can manifest in a variety of ways that are often covert or unintentional, including defining LGBTQ+ issues as marginal to the concerns of the general population, constructing LGBTQ+ peoples as difficult to study or as too political or too sensitive (De Gruchy & Lewin,

2001). Not unexpectedly, discrimination and stigma have been shown to be a key factor in predicting the increased risk for psychological distress, depression, and other mental health symptoms among members of the LGBTQ+ community (Pitoňák, 2017).

Clinicians, public health researchers, and officials have come to realize that LGBTQ+ individuals have unique health care needs relative to age-matched heterosexual and cisgender patients (Dean et al., 2000; Human Services, 2001), and several calls to improve research and better understand health disparities among the LGBTQ+ community have been made (Graham et al., 2011; Human Services, 2001; Lancet, 2011). Despite this acknowledgment and calls to action, the consideration of these factors continues to be overlooked in the training of health care providers and in the provision of health care (Bauer et al., 2009; Colpitts & Gahagan, 2016; Mayer et al., 2008; Mulé et al., 2009; Röndahl, 2011). Consequently, LGBTQ+ peoples are likely to experience barriers that hinder one's capacity to access health care services that meet their needs (Bradford, Reisner, Honnold, & Xavier, 2013; Mayer et al., 2008). Furthermore, several studies have demonstrated that LGBTQ+ patients are likely to experience acts of homophobia and transphobia when accessing health care services (Bauer et al., 2009; Bradford et al., 2013; Colpitts & Gahan, 2016). For example, most health care providers (HCPs) make the assumption that a person's gender identity is congruent with their biological sex assigned at birth without any consideration of gender-queer identities, which contributes to what has been described as "the erasure" of transgender people in health care systems (Bauer et al., 2009). These experiences can alienate LGBTQ+ patients, thereby affecting how they access or avoid health care services (Dean et al., 2000; Mulé et al., 2009; Ryan & Chervin, 2000).

Poor relationships between patients and HCPs have been noted as a factor that discourages patients from continuing to access mainstream health care (Kannan & Veazie, 2014).

Moreover, a weak or negative relationship with an HCP has been noted as a reason for why patients may consider traditional, complementary, or alternative systems of medicine (TCAM) as an appealing option for health care (Faith, Thorburn, & Kimberly, 2015). In fact, numerous studies have demonstrated that the use of TCAM practitioners was associated with previous discriminatory experiences in mainstream health care settings (Matthews, Hughes, Osterman, & Kodl, 2005; Smith et al., 2010; Thorburn, Faith, Keon, & Tippens, 2013), as well as with having unmet health needs (Mao et al., 2008; Su & Li, 2011; Thorburn et al., 2013; Williams, Kitchen, & Eby, 2011). Patients have also noted that they value TCAM given that non-mainstream systems of care typically make less of a distinction between mind and body, and seek to attend to psychological, social, emotional, and spiritual aspects of wellbeing (Gureje et al., 2015). Several studies have provided evidence that TCAM approaches are more likely to be utilised by members of certain ethno-cultural groups, females, individuals with higher incomes and education, and/or individuals that come from certain geographical regions (McFarland, Bigelow, Zani, Newsom, & Kaplan, 2002; Thomson, Jones, Browne, & Leslie, 2014; Villa-Caballero et al., 2010; Wu et al., 2007). Despite limited research, preliminary evidence suggests increased use of TCAM by lesbians (Matthews et al., 2005; McNair & Bush, 2016; Smith et al., 2010), but it is unknown if other members of the LGBTQ+ community may also be more likely to seek out care from outside of the mainstream health care system.

To date, there is no data regarding the percent of LGBTQ+ adults living in the Halifax regional municipality (HRM) and little is known about their health and experiences in seeking mental health care in this diverse population. More importantly, despite the high prevalence of mental health problems in this community, research has not explored how LGBTQ+ peoples, who are living with symptoms of psychological distress, experience mental health stigma. Like

other types of stigma in relation to sexual, gender, and ethno-racial identities, mental health stigma has been shown to predict increased symptoms of psychological distress over time (Hatzenbuehler, Phelan, & Link, 2013) and has been associated with reduced help-seeking (Clement et al., 2015). This study was specifically interested in two types of stigma, enacted stigma and internalized stigma. Enacted stigma, or experienced stigma, is the personal experience of being treated or perceived unfairly, whereas, internalized stigma is the process of holding stigmatizing views about ones-self (Clement et al., 2015). A 2015 systematic review of the literature from around the world reported that between enacted and internalized stigma, only the latter was associated with reduced help-seeking behaviours (Clement et al., 2015). There were, however, only two studies that explored the relationship between enacted stigma and help-seeking; therefore, this study sought to explore that relationship further.

This study also sought to understand the relationship with between one's general tendency to talk about or disclose their symptoms of distress to others in relation to their help-seeking behaviours with various practitioners. Previous literature has demonstrated that increased distress disclosure was associated with an increased help-seeking behaviour (Nam & Choi, 2013), while other literature has demonstrated no such association (Li, Dorstyn, Denson, 2014). One study found that distress disclosure predicted help-seeking behaviours for Whites and Asian subgroups, but not for African American peoples in their study (Saykeo & Lawrence, 2019).

This study also sought to explore the relationship between having a mental health diagnosis and help-seeking. One study found that having a diagnosis of depression was associated with help-seeking for females, but not males (Angst et al., 2010). Similarly, an earlier study found that having a diagnosis of an affective disorder or anxiety disorder was significantly

4

predictive of seeking help from a general practitioner (GP) in Australia (Parslow, & Jorm, 2000).

Lastly, a 2014 study explored the help-seeking behaviours of individuals from a Swiss general

population sample who have had an exceptional experience, which are experiences that deviate

from ordinary experiences, including precognition, supernatural appearances, or déjà vues

(Landolt et al., 2014). The findings demonstrated that those with an official mental health

diagnosis sought help more often than those with a self-reported mental disorder (Landolt et al.,

2014).

Finally, this study was interested in the relationship between a patient's health insurance

and one's willingness to seek help. One study revealed that among the most common barrier to

treatment for anxiety disorder in Quebec, Canada was a lack of health insurance coverage

(Chartier-Otis, Perreault, & Bélanger, 2010). Another study conducted in Quebec revealed that

almost two-thirds (63%) of their sample who sought help from a psychologist had private health

insurance (Fleury, Grenier, Bamvita, & Perreault, 2012). Several other studies around the world

have found an association between having insurance and increased mental health service

utilization (Lindamer et al., 2012; McAlpine, Mechanic, 2000; Rocha, Rodriguez-Sanz, Pérez,

Obiols, Borrell, 2013b), while other studies did not demonstrate such a relationship (Fasoli,

Glickman, Eisen, 2010; Lewis, 2013; Rocha et al., 2013a).

Using a mixed-methods design, this study aimed to achieve the following objectives:

- Explore how various aspects of mental health stigma are associated with psychological

  distress in a sample of LGBTQ+ adults who identify as living with symptoms of anxiety

  and/or depression. It was expected that internalized stigma would be positively associated

  with psychological distress and that enacted stigma will not be related to psychological

  distress.

- Explore how help-seeking behaviours and treatment preferences among LGBTQ+ adults living with psychological distress are associated with experienced and internalized mental health stigma, distress disclosure, gender and sexual identity, mental health diagnosis, and insurance coverage. It was expected that enacted stigma, internalized stigma, and distress disclosure would be positively associated with help-seeking behaviours. Moreover, it was expected that members of the LGBTQ+ community would have sought help from a greater number of different health care practitioners as compared to their cisgender and heterosexual counterparts. It was also expected that having a mental health diagnosis would be associated with seeking help from any and all health care practitioners. Finally, it was expected that individuals with extended insurance coverage would have accessed health care practitioners not covered by provincial insurance (psychologists and TCAM practitioners) more so than individuals without extended coverage.

- Explore the experiences and views of adults from the LGBTQ+ community who are living with psychological distress in relation to mental health help-seeking within and outside of the mainstream health care system. It was expected that participants' lived experiences will be consistent with the predicted findings of the quantitative analyses.

**Chapter 2**

**LITERATURE REVIEW**

**Mental Health and Help-Seeking In LGBTQ+ Peoples**

The following chapter reviews the pertinent literature to date regarding mental health in the LGBTQ+ community, first by describing the history of LGBTQ+ psychiatry, then by summarizing the literature in relation to the current state of mental well-being and health care use in the LGBTQ+ community.

**The History of LGBTQ+ Psychiatry**

Although variations in sexual behavior and attraction are ubiquitous throughout human history, societal notions of homosexuality and heterosexuality are a relatively new construct. They first emerged in the nineteenth century and are attributed to Karl Bennkert's use of "homosexuality" in 1868 in a German-language pamphlet (Dynes, 2016; Katz, 1995). At the time, homosexuality meant same-sex attraction and heterosexuality meant attraction to both sexes, what is known today as bisexuality (Katz, 1995). Modern notions of sexual orientation became a dominant part of the psychiatric discourse in the mid-twentieth century through Freud's conceptualization of homosexuality in his Three Essays on the Theory of Sexuality (Chauncey, 1982; Freud, 1953). He remarked that "[homosexuality] is nothing to be ashamed of …, it cannot be classified as an illness" (Freud, 1951, p. 786). Nevertheless, it became commonplace in psychiatry, as in society, to define homosexuality as non-normative (Herek & Garnets, 2007). Traditionally, societies around the world have condemned LGBTQ+ identities, and the primary reason in Western Liberal Democracies has been attributed to religious teachings such as the Bible (Gallup, 2015). The historic rejection of LGBTQ+ peoples by the medical

community helped perpetuate the stigmatization of homosexuality and the conceptualization of homosexuality as pathological (von Krafft-Ebing, 2011).

The emerging view of homosexuality as an illness resulted in numerous theories about homosexuality's etiology that reinforced the associations between homosexuality and pathology. By many, deviations from heterosexuality were understood as a "reparative" attempt to achieve sexual pleasure when "normal" heterosexual outlets prove too threatening (Rado 1940, 1949; Bieber & Dain, 1962; Socarides 1968). Psychoanalysis, the dominant perspective in psychiatry during the mid-twentieth century, also upheld the view of homosexuality as a pathology, and this had ramifications for LGBTQ+ peoples throughout North America (Bayer, 1987; Silverstein, 1991). For example, during World War II, when the United States military began to use psychiatric screening in its induction process, it became procedural to reject LGBTQ+ recruits (Bérubé, 2010). Following the war, the first DSM was released and listed homosexuality as a sociopathic personality disturbance (American Psychiatric Association, 1952). The response from the medical community was to find a potential "cure" to homosexuality and resulted in LGBTQ+ people undergoing psychotherapy, which was an ineffective and harmful attempt to change an individual's sexual orientation (Haldeman, 1991). In turn, many resorted to more severe methods such as aversive conditioning, lobotomy, electroshock therapy, and castration (Katz, 1976).

Challenges to the illness model began to emerge around the same time the DSM was released. For example, Kinsey demonstrated that homosexual behavior and attractions were common, contrary to widespread assumptions of the time (Kinsey et al., 1948; Kinsey et al., 1953). Similarly, Ford and Beach (1951) documented homosexual behavior in nonhuman species and its acceptance in numerous human cultures. In turn, Hooker (1957) sought to investigate the

relationship between sexual orientation and mental health systematically. In her ground-breaking study, Hooker compared a nonclinical sample of homosexuals and matched heterosexuals, relying on evaluations of projective test protocols by experts who were made unaware of each subject's sexual orientation. When experts were unable to identify a subject's sexual orientation at a level better than chance, Hooker concluded that homosexuality was not inherently associated with clinical pathology (Hooker, 1957). This growing body of research alone was insufficient to convince the medical community to renounce the illness model of homosexuality. In fact, homosexuality continued to be listed as a pathology in the DSM as a "sexual deviation" (American Psychiatric Association, 1968). Nevertheless, growing pressure from civil right movements led by the LGBTQ+ community in the United States prompted society to reconsider their ingrained and ill-informed assumptions (Adam, 1995). Together, the increasingly changing cultural views about homosexuality and the lack of empirical evidence supporting the illness model encouraged the American Psychiatric Association to pass a vote to remove homosexuality from the DSM in 1973 (Herek & Garnets, 2007).

Nevertheless, homosexuality was included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) as 'ego-dystonic homosexuality' and classified as a mental disorder along with fetishism and pedophilia until 1986 (Rutherford, McIntyre, Daley, & Ross, 2012). In fact, gender identity disorder was listed in the DSM-IV until 2013 (American Psychiatric Association, 2013). It is important to recognize that homosexuality and gender non-conformity were presented as a form of pathology, with members of the LGBTQ+ community characterized as the products of disturbed upbringings (Rosario, 1997; Sennott, 2010). Despite this no longer being the case for over 30 years, this history continues to complicate the discussion around the mental well-being of sexual and gender minorities (Herek

& Garnets, 2007). For example, sexual orientation and gender identity can be incorrectly identified as the cause of, or a source of, an LGBTQ+ patients' mental illness even though said identities are not inherently the cause or source of one's illness; such an association is rarely, if at all, made between mental illness and cisgender or heterosexual identities. Despite consensus among mainstream professionals, many in society still regard homosexuality as pathological and believe that the LGBTQ+ should conform to heteronormativity and the gender binary; these attitudes inform how LGBTQ+ experiences and health needs come to inform, or not inform, health policy and health services, as well as university curricula and clinical training (Enson, 2015; Röndahl, 2011). Consequently, any discussion about the mental health of LGBTQ+ peoples must be understood in the context of sexual stigma, the stigma that is historically attached by society to the LGBTQ+ community, as well as cis-normativity (Baril and Trevenen, 2014; Herek, 2004). According to Herek and Garnets (2007), sexual stigma has long been expressed by cultural institutions such as religion and the law, and its legitimacy is derived from homosexuality's status as a psychopathology for much of the twentieth century. It is crucial to discuss LGBTQ+ health disparities without upholding heterosexuality as the gold standard, and conversely, it is also essential not to pathologize the sexual and gender minority as a whole, as has been previously done.

Although homosexuality is no longer considered a mental illness in the medical community, it has been commonplace for the medical community to conflate symptoms of psychological distress with transgender and non-binary identities (Veltman & Chaimowitz, 2014). This has been a point of controversy as some groups have argued that that inclusion of gender dysphoria in the DSM-V further pathologizes transgender identities (De Cuypere, Knudson, & Bockting, 2010; Drescher, 2014; Veltman & Chaimowitz, 2014). Transgender

advocacy groups have long identified such a classification as transphobic and harmful to the LGBTQ+ community (Whalen, 2012). Particularly because some governments around the world have used the classification as the basis for discriminatory policies, and numerous governments require an official diagnosis of gender dysphoria in order for transgender people's names and gender markers on official documents (Power, 2019). The requirement of such a diagnosis, advocates suggest, impedes fundamental rights like work, education, and travel. Conversely, others believe that the gender dysphoria diagnosis should remain to ensure continued access to appropriate medical treatment and gender-confirming surgeries (Veltman & Chaimowitz, 2014). Nevertheless, the World Health Organization voted on May 25th, 2019 in favour of adopting the revisions proposed in the International Statistical Classification of Diseases and Related Health Problems (ICD-11), including the elimination of gender dysphoria from its list of mental disorders; the change will take effect in 2022 (Power, 2019; World Health Organization, 2019)

**Mental Health and Well-Being In The LGBTQ+ Community**

**Depression, anxiety, and general psychological distress.** Despite recognition that homosexuality and variations in sexual behaviours are natural rather than pathological, continued societal stigma can increase the risk of psychological distress, as well as reduce help-seeking and access to appropriate care for LGBTQ+ individuals, resulting in overall diminished health. There is strong evidence in the literature that demonstrates elevated rates of mental health disorders among homosexual individuals relative to heterosexuals, particularly in relation to depression and anxiety (Burgess, Lee, Tran, & Van Ryn, 2008; Cochran, Sullivan, & Mays, 2003; Kidd et al., 2016; Ross et al., 2018; Sandfort, de Graaf, & Schnabel, 2001). Increased rates of depression and anxiety have been observed for both homosexual men and women (Cochran & Mays, 2000; Case et al., 2004; Gilman et al., 2001).

Bostwick et al. (2010) confirmed using nationally representative data in the United States that LGB (excluding transsexual and queer+) individuals experience a greater lifetime prevalence of mood disorders, as compared to heterosexual Americans. The authors reported that gay and bisexual men demonstrated a higher prevalence of mood disorders; alternatively, bisexual women reported highest rates of mood disorders, more so than heterosexual women, with lesbians demonstrating the lowest rates. The authors explained the gender disparity between non-heterosexual men and non-heterosexual women to be in large part due to the more extreme stigma associated with male homosexuality in the United States. Notably, the authors reported that same-sex attraction or behaviour might confer protective mental health benefits for women, and therefore, the discussion regarding the health of sexual minorities must move beyond the current "repathologizing" view (Bostwick et al., 2010). These findings are supported by other literature, including a recent meta-analysis, which demonstrated that both bisexual men and women experienced the greatest risk for mood disorders as compared to gay, lesbian, and heterosexual counterparts (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Ross et al., 2018). Increased psychological distress has been reported in the homosexual population, even after controlling for variables such as age, race, educational background, and marital status (King et al., 2003).

Burgess et al. (2008) conducted nearly 8,000 interviews with individuals with various sexual and gender identities in Minnesota. The authors compared their sample of LGBT adults (n = 472) as one group relative to heterosexual and cisgender adults (n = 7412). They found that LGBT peoples were 1.68 times more likely to have a diagnosis of depression, 1.56 times more likely to have a diagnosis of anxiety, and 1.52 times more likely to report needing mental health care in the past year. The authors found that perceived discrimination was associated with

increased psychological distress experienced by LGB participants. However, the authors note that their measure of perceived discrimination did not capture other stressors, including heterosexist and heteronormative stressors, which likely also contribute to poorer mental health outcomes for LGB peoples (Burgess et al., 2008). Similarly, a meta-analysis by King et al. (2008) pooled findings from 25 studies that included nearly 12,000 LGB individuals. They found that, compared to heterosexuals, LGB individuals were at least 1.5 times more likely to have a diagnosis of depression and/or anxiety. Similarly, the authors note that the higher rates of psychological morbidity in LGB peoples do not imply that LGB identities are themselves a disorder, but rather, are likely the result of the constant social hostility, stigma, and discrimination experienced by most LGB people (King et al., 2008).

Compared to the literature on sexual minorities, there is relatively little literature that has explored disparities in mental illness for transgender and other gender minorities, specifically. Generally, studies include non-cisgender identities within a larger LGBTQ+ study group, making it difficult to differentiate the experiences of sexual minorities from gender minorities. Despite there being a limited number of studies that have focused on transgender populations individually, research does suggest similar trends in health disparities (Burgess et al., 2008; Clements-Nolle, Marx, Guzman, & Katz, 2001). The 2013 Australian National Trans study revealed that 43.7% of transgender people had clinically relevant psychological distress symptoms, which included 28.8% with major depressive disorder and 16.9% with anxiety disorder (Hyde et al., 2013).

Similarly, studies have consistently demonstrated that in comparison to cisgender heterosexual youth, LGBTQ+ youth and adolescents experience elevated rates of psychological distress, emotional distress, and self-harm (Clements-Nolle et al., 2006; D'Augelli et al., 2005;

13

Eskin et al., 2005; Fergusson, Horwood, Ridder, & Beautrais, 2005; Fleming, Merry, Robinson, Denny, & Watson, 2007; Friedman, Koeske, Silvestre, Korr, & Sites, 2006; Marshal et al., 2011; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007). A 2016 review of the literature demonstrated that LGBTQ+ youth are at greater risk for mood disorders, particularly depression and anxiety (Russell & Fish, 2016). Notably, numerous studies have demonstrated that the health disparities of LGBTQ+ youth exist prior to, and persist into, adulthood (Fish & Pasley 2015, Needham 2012, Ueno 2010). Nevertheless, Russel and Fish (2016) note that despite well-established disparities in symptoms and distress among LGBTQ+ youth, relatively few studies have explored the prevalence of mental health disorders and diagnoses among this population.

**Suicidal ideation and behaviour.** Many findings have been reported in LGBTQ+ adults, which demonstrate that members of the LGBTQ+ are at a greater risk for suicidal ideation and behaviours (Haas et al., 2010; King et al., 2008; Ross et al., 2018; Warner et al., 2004). A co-twin control study found a significant association between homosexuality and suicidal ideation (Herrell et al., 1999). Similarly, King et al. (2008) found that gay/lesbians were 2.5 times more likely to have attempted suicide compared to heterosexual adults. Moreover, the lifetime prevalence of suicide attempts in gay and bisexual men was reported to be four times greater than heterosexual males (King et al., 2008). Similarly, Warner et al. (2004) reported that homosexual and bisexual men and women are more likely to have planned or actually inflicted self-harm and/or have higher levels of psychiatric morbidity. The proportion of self-harm or psychiatric morbidity were 42% of gay men, 43% of lesbian women, and 49% of bisexual men and women, as compared to previous studies reporting prevalence rates of 12% in men and 20% in women in the general population (Meltzer et al., 1995; Singleton et al., 2003).

Pompili et al. (2014) conducted a systematic review of the literature specifically examining the risk of suicidal behaviour among bisexual persons. They found that bisexual persons were more likely to attempt suicide in comparison to both heterosexual and homosexual people (Pompili et al., 2014). Notably, several studies have reported that tendency toward suicidal ideation and attempts differ by gender; the risk of suicidal ideation is higher among lesbian and bisexual women, whereas the risk of suicidal attempts is higher among gay and bisexual men (Haas et al., 2010). Furthermore, it has been estimated that between 26% and 43% of transgender individuals have attempted suicide at least once in their life (Grant et al., 2011; Grossman & D'Augelli, 2007; Haas et al., 2010; Scanlon, Travers, Coleman, Bauer, & Boyce, 2010).

Compromised wellness is a significant predictor of several behavioural disparities among LGBTQ+ youth, such as substance use, and a predictor of suicidal ideation (Fergusson, Horwood, Beautrais, 1999; Marshal et al., 2008; Marshall et al., 2011; Russell & Fish, 2016). In fact, suicide is the third leading cause of death of LGBTQ+ youth in the United States between the ages of 10 to 14, and the second leading cause of death for those ages 15 to 24 (CDC, 2011). A 2010 study in Chicago, United States, found that 31% of their LGBTQ+ sample reported suicidal behaviour at some point in their life (Mustanski, Garofalo, & Emerson, 2010). While not explicitly measured in all studies, the literature demonstrates that bisexual youth exhibit higher suicidality and alcohol use as compared to heterosexual or solely homosexual youth (Marshal et al., 2011; Saewyc et al., 2007; Talley, Hughes, Aranda, Birkett, & Marshal, 2014). Disparities in suicidality have been attributed to negative experiences, including discrimination and victimization (Marshal et al., 2011).

**Other health and social outcomes.** Although not the main aim of the following

literature review and study, there is significant evidence that LGBTQ+ peoples experience poorer overall health and worse social outcomes in comparison to the cisgender and heterosexual population. One study reported that adults who have had a same-sex partner at some point in their life have an increased risk of childhood maltreatment, interpersonal violence, and the unexpected death of someone close to them (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010). The same study also reported that adults from a sexual minority were more likely to experience post-traumatic stress disorder (PTSD) as compared to their heterosexual counterparts (Roberts et al., 2010). LGBTQ+ peoples have also been found to be more likely to smoke and use illicit substances or alcohol (Gruskin, Hart, Fordon, & Ackerson, 2001; Keuroghlian, Reisner, White, & Weiss, 2015; King et al., 2003; Rimes, Goodship, Ussher, Baker, & West, 2017; Tang et al., 2004), and to have a higher prevalence of eating and body image disorders, namely among non-heterosexual men (Kaminski, Chapman, Haynes, & Own, 2005). A 2009 study in Massachusetts, United States, reported that in general, LGBTQ+ individuals are less likely than their cisgender and heterosexual counterparts to report "excellent" overall health (Landers & Gilsanz, 2009).

**Risk Factors and Pathways to Health Disparities Faced by LGBTQ+ People**

The mental health disparities faced by LGBTQ+ populations are not inherent to gender and sexual identities, rather, they are the product of societal stigma and discrimination that put members of this group risk for a variety of stressful experiences that in turn negatively impact health and that contribute to disparities. Indeed, ongoing health disparities experienced by the LGBTQ+ community have often been explained by the minority stress model (Meyer, 2003) that emphasizes the unique chronic stressors that members of stigmatized minority groups face on top of routine stressors encountered by all people. Meyer's (2003) model outlines three predominant

stressor classifications: (i) stressors at the level of the individual (self-stigma), which include felt stigma and internalized stigma; (ii) stressors at an interpersonal level (interpersonal-stigma), often including the manifestation of discrimination and violence; (iii) stressors at a structural and societal level (structural stigma). Research supporting this framework in the context of the LGBTQ+ population has shown that discriminatory experiences and everyday micro-aggressions are common stressors, which can also be accompanied by ongoing state of hypervigilance and/or self-stigma, are significant factors contributing to the ongoing health disparities faced by LGBTQ+ peoples (Anderson, 2018; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Hatzenbuehler & Pachankis, 2016; Mogul-Adlin, 2015).

**Self-stigma: felt stigma.** Meyer's (2003) postulates that members of the LGBTQ+ community do not need to be the direct victim of enacted stigma to be affected by it. "Felt stigma" is the attitudes and beliefs of an individual associated with their subjective experience of stigma against the LGBTQ+ community, including the awareness that stigma is prevalent and an understanding of how it manifests (Scambler & Hopkins, 1986). That is, felt stigma reflects the LGBTQ+ person's expectations of being rejected or discriminated against because of their identity. Felt stigma is believed to be heightened by salient anti-gay sentiments in one's community or larger society, such as visible anti-gay violence (Bosson, Haymovitz, & Pinel, 2004; Noelle, 2002) and homophobic political campaigns (Russell, 2000; Russell & Richards, 2003). LGBTQ+ peoples are exposed to high levels of harassment and discrimination, both directly and through portrayals in the media and arts (Herek et al., 1999). In a world dominated by heteronormativity and binary gender norms, LGBTQ+ peoples continuously experience felt stigma.

17

Felt stigma often plays a central role in an LGBTQ+ individual's decision to come out, or disclose their sexual or gender identity to others (Herek, 1996). LGBTQ+ individuals make such decisions logically by weighing the relative costs and benefits. A significant factor that influences one's decision to come out is others' response and the impact of a prejudiced reaction to the persons own subjective well-being (Cole, 2006; Herek, 1996). LGBTQ+ peoples are usually torn between concealing a portion of their identity to avoid incurring enacted stigma, and on the other hand, requiring to be constantly vigilant about the personal information that is shared with people who are unaware about the LGBTQ+ person's sexual or gender identity. Most often, a strategy of "rational outness" is adopted, in which a person is as out as possible about their sexual and gender identity while remaining as closed as necessary to protect themselves from discrimination (Bradford & Ryan, 1994). The degree to which a person feels that they can express their sexual and gender identity depends on numerous personal circumstances and factors. Numerous studies have demonstrated a positive correlation between being out and positive psychological well-being (Jordan & Deluty, 1998; Ullrich, Lutgendorf, Stapleton, & Horowitz, 2004), but this pattern has not been continuously observed (Frable, Wortman, & Joseph, 1997). Despite general greater acceptance of LGBTQ+ peoples today, which has contributed to more adolescents and young adults having an easier time coming out, LGBTQ+ youth are still at a greater risk for mental health problems (Russell & Fish, 2016).

The decision to disclose one's sexual orientation or gender identity represents a strategy to manage stigma, but these decisions often result in further exposure to stressful experiences. While concealment of one's LGBTQ+ identity can reduce an individual's risk of overt discrimination and violence, it often leads to significant disruption of everyday life, limiting behavioural options, reducing opportunities to seek support, and increasing risk of psychological

and physical illness (Cole, 2006; Herek, 1996; Herek, 2007; Lewis, Derlega, Griffin, &

Krowinski, 2003; Reisner et al., 2014; Reisner, Greytak, Parsons, & Ybarra 2015).

Hatzenbuehler and Pachankis (2016) have reported that concealment behaviour is associated

with long term psychological consequences, including depressive symptoms, anxiety, poor self-

esteem, and elevated psychiatric symptoms/distress.

A review of the literature on transgender stigma and health by Hughto et al. (2015)

revealed that transgender individuals who are visually conforming as cisgender may choose to

conceal their identity in health care settings, allowing them to avoid mistreatment (Mizock &

Mueser, 2014; Sevelius, 2013). However, such concealment often imparts profound stress on

individuals, particularly in fear that their identities will be discovered or questioned, leading to

poor health outcomes (Hughto, Reisner, & Pachankis, 2015). Moreover, transsexual individuals

who do not undergo gender-affirming treatment as a result of concealment may be at greater risk

of stigma given their gender nonconformity (Cohen-Kettenis & Van Goozen, 2002;

Hatzenbuehler & Pachankis 2016; Hughto et al., 2015), as well as poorer mental and physical

health outcomes (Gagné & Tewksbury, 1998). Concealing one's identity as a pre-transition

transsexual adult leads to restricted access to transition-related medical services, whereas

concealment as a post-transition transsexual adult can lead to inappropriate medical care for

relevant anatomy (Algeria, 2011; Samuel & Zaritsky, 2008). Importantly, non-binary and

transgender patients with a lack of access to both hormonal and surgical treatment (i.e., gender-

affirming treatments) can result in poorer mental health outcomes (Coleman et al., 2012). In turn,

access to services is imperative for transgender peoples' overall well-being. Similarly, sexual

minority patients have special medical needs that likely go unmet if they conceal their identity

from the health care practitioner, resulting in poorer outcomes and inadequate provision of care (Cochran, 2001; Hatzenbuehler & Pachankis 2016; Petroll & Mosack, 2011).

**Self-stigma: internalized stigma.** An individual's internalized notions of stigma and self-stigmatization are another type of self-stigma that can affect the decisions and well-being of a person. Internalized stigma or homophobia is a consequence of an individual accepting society's negative attitudes towards non-heterosexuals. This state of self-stigmatization has been labeled internalized homophobia, internalized heterosexism, and internalized homonegativity (Herek & Garnets, 2007). There is consensus among HCPs that having negative affect about one's LGBTQ+ desires lead to diminished well-being, including poor self-esteem, depression, increased substance use, and relationship instability (DiPlacido, 1998; Hughto et al., 2015; Szymanski & Chung, 2002; Williamson, 2000). High levels of internalized transgender stigma have been associated with increased probability of attempted suicide (Perez-Brumer, Hatzenbuehler, Oldenburg, & Bockting, 2015). Moreover, high levels of internalized stigma may lead to reduced help-seeking for symptoms of mental illness (Hughto et al., 2015). In fact, transsexual individuals who internalize stigma may be unable to cope with external stressors and inability to be resilient in the face of negative events (Hendricks & Testa, 2012).

The internalization of homonegativity has been implicated in higher rates of body dissatisfaction and lower self-esteem in gay men (Williamson, 1999). Internalized homonegativity is widespread in the gay and bisexual community, for example, the want to conform to masculine norms (Kimmel & Mahalik, 2005), which has been identified as inherently heterosexist and homophobic (Amola & Grimmett, 2015). Furthermore, high levels of internalized homophobia among sexual minorities has been positively associated with substance use, HIV risk behaviours, and sexual risk-taking (Hatzenbuehler & Pachankis, 2016).

**Interpersonal stigma: enacted stigma and other external stressors.** Because of the pervasive social stigma that continues to exist in our society, there are numerous objectively stressful experiences that LGBTQ+ peoples face on a chronic basis that cisgender heterosexual people do not, which is a major factor that contributes to health disparities. In this regard, "enacted stigma" is when the stigma results in negative actions towards members of a given group (Clement et al., 2015; Scambler & Hopkins, 1986), including discrimination, rejection, ostracism, and violence (Herek, Gillis, & Cogan, 1999; Herek & Sims, 2008; Mays & Chochran, 2001). While there are many unique experiences that different LGBTQ+ individuals face depending on their identities, LGBTQ+ people share remarkably similar experiences related to stigma, discrimination, rejection, and violence across cultures and worldwide (Bockting, Miner, Swinburne, Hamilton, Coleman, 2013; Diaz, Ayala, Bein, Jenne, & Marin, 2001; Fullilove & Fullilove, 1999; Grant et al., 2011; Herek, 2000; Herek 2007; Reisner et al., 2015). In addition to personal experiences of discrimination, societal stigma also results in discrimination at the institutional levels, both of which negatively impact the health and well-being of LGBTQ+ individuals.

In one study, two-thirds of homosexual individuals who experienced an act of discrimination such as damage to property, personal attacks, insults, or bullying believed it to have been motivated by their sexual orientation (Warner et al., 2004). Likewise, Burgess et al. (2008) reported that one-half of gays and lesbians in their study attributed experiences of discrimination to their sexual orientation as compared to 2% of heterosexual participants. A 2009 national study in the United States revealed that 21% of LGB (not including transsexual and queer+) adults reported experiencing violence or property crime based on their sexual orientation at least once during their adult life (Herek, 2009). The same study revealed that other forms of

anti-gay abuse and harassment are common for sexual minorities than heterosexual people, which included 13% reporting objects thrown at them, 23% reporting threats, and 49% reporting verbal abuse (Herek, 2009). Notably, a higher proportion of gay men (38%) experienced anti-gay violence or property crimes as compared to lesbians and bisexual persons (11-13%) (Herek, 2009). In a 2013 study in California, United States, 76% of gay or bisexual respondents experienced discrimination, and this was also true for 21.4% of lesbians (Choi, Ayala, Boylan, & Gregorich, 2013). Similarly, a National study of nearly 3000 individuals in the United States found that gender minorities were more likely to report experiencing discrimination across several domains, relative to cisgender heterosexuals (Mays & Cochran, 2001). Bockting et al. (2013) found that 56% of transgender respondents in the United States experienced verbal harassment, 37% experienced employment discrimination, and 19% were victims of physical violence because of their gender identity at some point in their life.

Experiencing hate crimes, such as anti-gay violence, has been associated with heightened levels of depressive symptoms, anxiety, and symptoms of posttraumatic distress compared to violence that is not fueled by bigotry or discriminatory intentions (Herek et al., 1999; Huebner, Rebchook, & Kegeles, 2004; Mills et al., 2004; Hughto, Reisner, & Pachankis, 2015). Moreover, experiences of perceived discrimination have also been determined to be associated with higher rates of depressive symptoms in a sample of Asian and Pacific Islander homosexual men (Yoshikawa, Wilson, Chae, & Cheng, 2004). Similarly, studies have demonstrated a relationship between mental distress and discrimination in gay and bisexual Latino men (Diaz, Ayala, & Bein, 2004; Diaz et al., 2001). Other studies found that perceived discrimination was associated with risky behavior in homosexual men, including engaging in unsafe sex (Wong & Tang, 2004; Yoshikawa et al., 2004). LGBTQ+ individuals may also cope with stress of discrimination

through the use of substances such as alcohol and cigarettes, given that consumption of such substances is higher in individuals who have experienced discrimination (Keuroghlian, Reisner., White, & Weiss, 2015; McCann, Sharek, Higgins, Sheerin& Glacken 2013; Weber, 2008; Williams, Neighbors, & Jackson, 2003).

It has been well noted in the literature that LGTBQ+ children and youth are also at greater risk of discrimination in the form of bullying relative to their peers (Eisenberg et al., 2017; Kosciw, 2004; Toomey & Russell, 2016). One study reported that 94% of young men who have sex with men experienced victimization fueled by their sexual orientation (Mustanski et al., 2011). In fact, LGBTQ+ youth are bullied more than their heterosexual peers in a number of settings including middle school, high school, child welfare institutions, and within religious communities (Clements-Nolle, 2006; Poteat & Espelage, 2005; Ryan & Rivers, 2003; Wyss, 2004). Importantly, the type of bullying experienced by LGBTQ+ youth has been recognized as different in nature than the bullying experienced by other youth; LGBTQ+ youth experience bullying targeted explicitly at their identity, including homophobic remarks, bullying that simulates gay sex, and even "mock" or real rape (D'Augelli, Grossman & Starks, 2006; Elze, 2003; Herek, 2009; Klein, 2012; Russell, Franz, Driscoll, 2001; Wyss, 2004). These experiences faced by LGBTQ+ youth have been shown to be able to leave lasting psychological wounds that persist into adulthood, and has been linked with social anxiety disorder, phobia, and post-traumatic stress disorder in adulthood (Carlisle & Rofes, 2007; D'Augelli, 2002; D'Augelli, Pilkington, & Herschberger, 2002; Hartung, Little, Allen, & Page, 2011; Mustanski, Newcomb, & Clerkin, 2011; Rosario, Schrimshaw, Hunter, & Gwadz, 2002).

**Structural stigma.** Another significant source of stress is institutionalized stigma and discrimination, which further contributes to the systemic oppression and poor health outcomes of

LGBTQ+ peoples. The LGBTQ+ community faces numerous inequities in society, including legal discrimination, barriers to employment, housing, adoption, and access to health care and health insurance (Torres et al., 2015). An example of institutionalized discrimination is that LGBTQ+ individuals around the world have been, and continue to be, denied the right to marry. Same-sex marriage was legalized relatively recently in western nations: 2005 in Canada (*Civil Marriage Act*, 2005), 2016 in the United States (*Obergefell v. Hodges*, 2015), and 2017 in Australia (*Australian Marriage Law*, 2017). Being denied fundamental human rights causes LGBTQ+ couples more stress than the general population. This has negative consequences for well-being and contributes to more challenges that create obstacles in same-sex relationships, which do not exist in heterosexual couples (Herek, 2006). LGBTQ+ men also earn significantly less than heterosexual men, and socio-economic status is often related to overall well-being (Badgett, 2003; Herek, Chopp, & Strohl, 2007).

LGBTQ+ are often disenfranchised from religious and spiritual resources, which are at time crucial to cultural and community affiliations, as many religious denominations condemn homosexual relationships (Herek et al., 2007). Religious establishments have historically played a large role in the laws and policies of nations, and as such, the marginalization of LGBTQ+ peoples has been further perpetuated by the beliefs of religious institutions such as the Catholic Church.  For example, in the United States, unlike other disadvantaged groups, LGBTQ+ peoples have fewer protections under the law, with only 22 states outlawing discrimination based on sexual orientation and 20 states protecting gender identity or expression (Task Force, 2008). Gender identity and expression were also unprotected under the law in Canada until 2017 (LEGISinfo, 2017). The lack of protections, disenfranchisement, economic disparities, and denial

of fundamental human rights are often the basis for harassment and discrimination experienced by LGBTQ+ peoples (Meyer, 2001).

Studies have also demonstrated that structural stigma can diminish transgender health through policies and practices that restrict access to health care. For example, many people from gender minorities lack access to adequate insurance, which can be in part due to the high unemployment among transgender peoples (Conron et al., 2012; Grant et al., 2011). Even with insurance or capacity to afford treatment, transgender patients experience barriers to accessing gender affirming care as a result of policies that deem such interventions as "pre-existing," "cosmetic," or "medically unnecessary" (Khan, 2011). Structural stigma also permeates in other forms, for example, where social systems favour masculinity over femininity (Schilt, 2010), male-to-female transgender persons often experience greater discrimination in employment and subsequent economic disparities. The effects and inequities caused by structural stigma have been linked to increased depression, suicidal ideation, and self-harm for transsexual individuals (Huft, 2008; Hughto et al., 2015; Spicer, 2010).

Heteronormativity, a form of structural stigma, is the presumption that heterosexuality is the default sexual orientation, and this often leads to discrimination against LGB populations (Utamsingh, Richman, Martin, Lattanner, & Chaikind, 2016). Existing policies and attitudes are often informed by heteronormativity, ultimately affecting the wellbeing of LGB peoples (Röndahl, 2011). Many health care practitioners have heteronormative attitudes, which can manifest in many different ways, including assumptions that one's partner is always the opposite sex or disregarding bisexuality as a sexual orientation (Habarth, 2008). Such assumptions affect the provision of adequate care for LGBTQ+ patients. A lack of adequate LGBTQ+ diversity clinical training in medical schools across Canada and the United States has been attributed, in

part, for heteronormative attitudes held by health care practitioners (Obedin-Maliver et al., 2011; Utamsingh et al., 2016). Utamsingh et al. (2016) found that participants who were exposed to heteronormative assumptions during a practitioner-patient interaction were less likely to feel comfortable disclosing health information to their doctor and has less trust in their doctor as compared to patients with non-heteronormative interactions. The authors ultimately concluded that experiencing heteronormative interactions in health care settings may be contributing to health disparities among sexual minorities (Utamsingh et al., 2016). Cisnormativity, similar to heteronormativity, is the assumption that being cisgender is the default gender identity. The two concepts are closely related, and a recent term Hetero-cis-normativity has been coined to represent a hierarchical system of prejudice and discrimination which may be directed at anyone who is non-cisgender and/or non-heterosexual (Worthen, 2016). These attitudes continue to inform health policies, health curricula, and the provision of health care in a manner that disenfranchises LGBTQ+ peoples and hinders access to quality care.

*Discrimination in the health care system.* In considering systemic discrimination in the health care system, recently conducted systematic reviews have shown that LGBTQ peoples are often less likely to seek care when needed and are also less likely to receive quality care (Clement et al., 2015; Hughto et al., 2015), which has been linked with their past discriminatory encounters (Trivedi & Ayanian, 2006; Van Houtven et al., 2005). The stressful experiences of gay and bisexual men in relation to the human immunodeficiency virus (HIV) epidemic provides a blatant example of how institutionalized discrimination can contribute to increased stress for a given stigmatized group, and in turn contribute to health disparities (Hamel et al., 2014). Individuals with the disease often suffer from the stress of having HIV, and healthy individuals are constantly faced with the possibility of contraction or the loss of a partner to HIV. In fact, the

loss of entire communities has been documented throughout the 1980s and 1990s as a result of the epidemic (Hamel et al., 2014), and such disproportionate experiences of disease and loss are another pathway leading to disparities in psychological distress (Folkman, Chensey, Collette, Boccelari, & Cooke, 1996; Martin, 1988). Reflecting how stigma influences institutional responses to health crises, the initial response to address the HIV epidemic by government and health care system was meager, and consequently, much of the care provided to those affected at the time had to be spearheaded mostly through grass-roots efforts by the LGBTQ+ community (Greene, 2007). This absent sense of urgency was in part due to inaccurate beliefs that relate homosexuality with illness, which further contributed to the struggles experienced by an already marginalized community (Greene, 2007). Health policies based on falsehoods and stigma continue to exist today and represent a form of institutional discrimination. In this regard, men who have sex with men are denied the right to donate blood in Canada unless they refrain from doing so for one year (*About Men Who*, 2017), despite accurate and reliable measures to detect HIV (Ablin, 1993; Shyamala, 2014).

Despite mixed evidence about whether LGBTQ+ peoples seek mental health care more than the general population, consensus is that LGBTQ+ individuals' experiences with health care are more negative than cisgender heterosexuals (Herek & Garnets, 2007). Optimal health care for LGBTQ+ communities requires access to competent personnel and sensitive prevention services. However, the current health care system, having been founded in the historical pathologization of LGBTQ+ peoples and preference, comprises of numerous barriers to access. Given the aforementioned evidence that LGBTQ+ peoples suffer from more health issues, it is expected that they need more health care. In one study that demonstrated higher service utilization by LGBTQ+ individuals than the general population, LGBTQ+ minorities also reported higher rates

of dissatisfaction with mental health services (Avery, Hellman, & Sudderth, 2001). These are best understood as the result of discrimination in the context of care (Beehler, 1996; Beehler, 2001). The following section will discuss barriers to health care access through discrimination on the level of the LGBTQ+ individual, the health care practitioner, and the health care system as a whole.

*Barriers at the individual level.* Quality care can be first compromised when an individual who accesses health services chooses not to disclose their sexual and gender identity to their health care provider. LGBTQ+ participants have multiple reasons for concealing their identity, and they usually result from sexual stigma (Mayer, 2008). When an individual has a heightened sense of felt stigma or internalized stigma, they are less likely to reveal their sexual and gender identity to anyone else, including their health care provider. They do this for fear of being ostracized or being stigmatized by the medical community. Moreover, there may be confidentiality concerns, in which an LGBTQ+ individual may be uncomfortable entrusting their sexual and gender identity to a health care professional, lest that information becomes known to others. Given the niche health needs of LGBTQ+ individuals, concealing one's sexual and gender identity can hinder the quality of care that an individual receives.

Research demonstrates that LGBTQ+ individuals need to access the mental health care system more than the general population, but help-seeking behaviours are often discouraged by negative experiences (Bakker, Sandfort, Vanwesenbeeck, van Lindert, & Westert, 2006; Burgess et al., 2008; Cochran et al., 2003; King et al., 2003; White & Dull, 1997). In general, LGBTQ+ populations are more likely to report unmet health care needs as compared to cisgender heterosexuals, which is troublesome particularly given the higher prevalence of mental health disorders experienced by LGBTQ+ populations (Burgess et al., 2008). Poor health care outcomes

have implications for how LGBTQ+ peoples interact with the health care system. Studies have

demonstrated that because of the discomfort with the medical community, LGBTQ+ females are

discouraged from seeking routine breast and cervical cancer screening, as compared to

heterosexual women (Matthews, Bradenburg, Johnson, & Hughes, 2004; Powers, Bowen, &

White 2001). Importantly, despite recognition by the wider medical community that LGBTQ+

identities are not inherently pathological, this may not be the case for individual doctors and

practitioners who may hold opposing beliefs. Such pervasive attitudes may continue to hinder

LGBTQ+ patients' wellbeing (Clement et al., 2015; Munson & Cook, 2016).

However, utilizing health care services and disclosing one's sexual or gender identity will

only begin to close the gap in health care disparities if the provider offers competent and well-

informed services in return. In fact, LGBTQ+ populations may be reluctant to disclose their

sexual and gender identity to health care professionals whom they view as unsympathetic or

ignorant (Bernstein et al., 2008; Elford, Bolding, Maguire, & Sherr, 2000; Jackson, Johnson, &

Roberts, 2008). This would require that the health care provider is aware of the unique health

concerns of LGBTQ+ populations and can take into consideration an individual's partnership

status and sexual behavior without assumptions or judgement.

*Barriers at the level of the health care practitioner.* Although attitudes are changing, and

LGBTQ+ populations are becoming more accepted by society (Smith & Mathews, 2007),

societal misconceptions and discomfort about non-heterosexual behavior and identities persist,

even among health care personnel (O'Hanlan, Cabaj, Schatz, Lock, & Nemrow, 1997; Schatz &

O'Hanlan, 1994; Smith & Mathews, 2007). One of the ways in which health care professionals

may hinder access to quality care for LGBTQ+ peoples is through enacted stigma. That is,

discrimination from health care professionals can negatively affect the way LGBTQ+

populations interact with the health care system (Institute of Medicine, 2011).

LGBTQ+ peoples throughout North America report negative experiences when they disclose their sexual and gender identities to their health care professionals and/or support staff, including verbal abuse, disrespectful behavior, and even denial of care (Eliason & Schope, 2001; James et al., 2016; Hollenbach, Eckstrand, & Dreger, 2014; Sears, 2009; Scherzer, 2000). Although rare in general, negative patient experiences are substantially higher for LGBTQ+ patients. One study reported 1.5 times more negative experiences for non-heterosexual patients, relative to cisgender heterosexuals, and gay men experienced the highest prevalence of negative encounters (Elliott et al., 2014). Moreover, transgender and gender-queer individuals are often stigmatized, discriminated against, and ridiculed in encounters with their HCPs (Meyer, 2001). One study of nearly 7,000 transgender individuals reported that roughly 30% had experienced verbal harassment in a medical professional's office, and nearly 20% were refused medical care altogether as a result of their gender identity (Grant et al., 2011). LGBTQ+ peoples have reported changes in the quality of care provided to them after disclosing their sexual orientation to their HCP. The changes in provider interactions include the emergence of unconscious biases, overt mistreatment, and refusal of care (Zestcott, Blair, & Stone, 2016).

Conversation therapy, a method of attempting to change an individual's sexual orientation, has been proven both ineffective and harmful and has been condemned by national health care organizations, including the Canadian Psychiatric Association (Veltman & Chaimowitz, 2014). Nevertheless, some HCPs who believe that homosexuality is fundamentally wrong continue to encourage the use of conversion therapy to impose societal norms (Human Rights Campaign, 2017). A recent report by the Williams Institute in the United States estimates that 20,000 LGBTQ+ youth between the ages of 13 and 17 will receive conversion therapy from

a licensed HCP in one of the 41 states that do not ban the practice (Mallory, Brown, & Conron, 2018). In Canada, the federal government rejected a plea for a nation-wide ban of conversion therapy in 2019, and only four provinces have legal restrictions on conversion therapy; in fact, Ottawa is the only province with an outright ban (Stroh, 2019). These experiences further contribute to the lingering stigma and increased mistrust of the health care system by LGBTQ+ (Hollenbach et al., 2014).

In addition to hostile experiences in the context of medical care, LGBTQ+ individuals often report significant gaps in the knowledge of their HCPs. That is, even if a health care professional is accepting of an LGBTQ+ patient's identity, they are unfamiliar with the specific health needs of LGBTQ+ individuals (Grant et al., 2011). HCPs may also be uncomfortable discussing the specific needs of LGBTQ+ peoples or be insensitive to their needs (Hinchliff, Gott, & Galena, 2005; Herek, 1999; Khan, Plummer, Hussain, Minichiello, 2008). Studies suggest that mental health providers do not receive adequate training in LGBTQ+ health as part of their formal education. Medical and psychiatric HCPs, in particular, reported insufficient curricular content pertaining to LGBTQ+ health care (Rutherford et al., 2012). Seventy percent of participants from a North America wide survey of 3,500 medical students reported gaps in the medical curriculum at their various institutions (White & Wells, 2010). LGBTQ+-related curriculum was rated 'fair' by one-third of the respondents and 'poor' or 'very poor' by another third.

Ultimately, studies have demonstrated that as much as 40% of LGBTQ+ patients cite the lack of provider education as a barrier to care, and similar numbers report refusal of care, poor treatment, and verbal abuse from HCPs (Graham et al., 2011; Legal, 2014; US Department, 2011). In turn, many patients avoid medical treatment, including mental health care and

emergency treatment (Moll et al., 2014). Therefore, medical professionals and service providers need to be sensitive to the experiences of LGBTQ+ peoples, understand their health care needs, and should be prepared to answer their questions and make referrals.

*Systemic barriers to health care.* Many of the systemic barriers experienced by LGBTQ+ in health care are invisible and more pervasive. They include inadequate attention to health care concerns of LGBTQ+ people as a result of stigma and stereotypes, insufficient concern for LGBTQ+ health issues because they affect a small number of people, or due to a lack of knowledge, general insensitivity towards the concerns of LGBTQ+ people (Meyer, 2001). Many of the variables associated with health risks among LGBTQ+ populations are unique to these communities, and therefore, require specifically tailored prevention services (Stall et al., 2001). However, due to pervasive stigma and lack of urgency, LGBTQ+ communities experience barriers related to poor or inadequate education available to health care professionals and students, a lack of resources available for LGBTQ+ health care needs, and poor policies that further perpetuate these health care disparities. These barriers are interrelated and need to be addressed together in order to arrive at a solution.

The provision of adequate care requires that health care professionals be sensitive to the needs of LGBTQ+ populations. Particularly, LGBTQ+ patients require safe clinical environments that allow for good communication and provide comfort, such that individuals feel capable of discussing matters of their gender and sexual identities (Makadon, Mayer, & Garofalo, 2006). It is imperative that providers speak to LGBTQ+ patients in a non-judgemental manner (Mayer et al., 2008). Moreover, clinical intake forms should ask about gender identity and same-sex partnerships, and visual cues in waiting rooms be present that signal acceptance (e.g., pamphlets that discuss LGBTQ+ health promotion) (GLMA, 2006; Mogul-Adlin, 2015).

Otherwise insensitive or hostile care is believed to lead to inappropriate interventions, failure to effect change, and the mistrust of authority of public health and policies (Clark, Landers, Linde, & Sperber, 2001). Nevertheless, both professional schools and continuing education programs fail to provide the sufficient training needed to improve the attitudes, knowledge, and skills of practitioners in the care of LGBTQ+ patients in the United States and Canada (Makadon, 2006; White et al., 2015). As a result, there is a shortage of skilled and competent HCPs who are able to provide proper care to LGBTQ+ patients. Without explicit teaching of LGBTQ+ issues, HCPs and medical students often reflect the level of homophobia and heterosexism of the society at large (American Medical Association, 2010). Integrating LGBTQ+ health competency in the curricula of schools has demonstrated increased willingness of medical students to care for LGBTQ+ issues (Kelley, Chou, Dibble, & Robertson, 2008; Wallick, Cambre, & Townsend, 1995). Yet, schools have been slow to incorporate teaching and research into LGBTQ+ health issues, which is partly stunted by the lack of resources and empirical research on this topic (Corliss, Shankle, & Moyer, 2007; Kelley et al., 2008; White & Wells, 2010).

In regard to issues facing women and ethnic minorities, recent researchers and policymakers have become aware of the role of inequalities in health and public health has begun to implement strategies to circumvent these issues (Meyer, 2001). However, LGBTQ+ peoples continue to be stigmatized, and the disregard of LGBTQ+ issues continues to be justified by political, moral, or religious beliefs. The call for programs and intervention services for non-HIV-related LGBTQ+ issues has been rare, and research on these topics is limited (Herek & Garnets, 2007). Albeit exceedingly uncommon for any group, there are currently few mental health prevention services that are specific to LGBTQ+ concerns, and most of the existing services have not been as thoroughly evaluated as HIV prevention services specific to non-

heterosexual men (Human Services, 2001). Moreover, transgender health has been further excluded from mental health care because of a greater lack of data and resources (Mayer et al., 2008). Notably, the very same social forces, including homophobia and heterosexism, that have previously led to the exclusion of LGBTQ+ populations currently lead to inappropriate or even damaging programs. It has been cautioned that placing sexuality, sexual orientation, and gender under the public health lens may lead to pathologizing and further institutionalizing of negative attitudes (Meyer, 2001), as has been done in the past.

A study by Rutherford et al. (2012) interviewed eight practicing mental health care professionals who were identified with the aid of the Rainbow Health Ontario service provider database. All of the interviewed HCPs were members of the LGBTQ+ community. However, it was clear that providers do not need to be a member of the community to provide adequate care. Rutherford et al. (2012) also noted that all of the interviewed HCPs emphasized the lack of available resources and professional training opportunities, and any opportunities available had to be actively sought out. Currently, resources available to health care professionals regarding LGBTQ+ related health care are scarce, and without making LGBTQ+ mental health a priority, it is unlikely that resources will become more readily available.

### Traditional, Complementary, and Alternative Medicine

Traditional, complementary, and alternative medicines (TCAM) are a class of diverse wellness systems, practices, and products that are typically considered outside of the realm of mainstream biomedicines (National Center for Research Resources, 2008). These include practitioners such as traditional (cultural) healers, naturopathic doctors, herbalists, and self-directed approaches (Freeman, 2009; Gureje et al., 2015; Solomon & Adams, 2015). Typically, TCAM use differs based on race, socioeconomic status, and insurance coverage; however,

differences according to gender and sexual orientation have also been reported (Barnes, Bloom, & Nahin, 2008; Matthews et al., 2005; Smith et al., 2010). Usually, higher levels of unmet health needs are correlated with increased use of TCAM, suggesting that patients turn to TCAM when faced with barriers to accessing conventional care, in the persistence of symptoms despite biomedical treatment, and/or as a result of dissatisfaction with the care they are receiving (Freeman, 2009; Su & Li, 2011). In turn, it expected the patients from medically marginalized populations are likely to seek TCAM as an alternative to conventional care.

Previous studies show trends that people with mental health concerns in Canada and other western countries have been increasingly turning to TCAM, with some estimates reporting as much as 40% of all adults having utilized such services (Barnes et al., 2008; Solomon & Adams, 2015). Among other reasons, TCAM approaches are appealing to patients as TCAM regiments offer more personal autonomy and control over health care decision (Solomon & Adams, 2015). Importantly, patients that exercise control over their health care decision are said to experience improved outcomes, which can be in part attributed to factors such as better engagement, increased therapeutic alliance, greater adherence, and reduction of attrition (Geers et al., 2013; Winter & Barber, 2013). Several studies have also uncovered an association between discriminatory experiences in health care and increased use of TCAM (Matthews et al., 2005; Shippee, Schafer, & Ferraro, 2012; Smith et al., 2010). Moreover, LGBTQ+ women are more likely than heterosexual women to access TCAM services, and this was true even after controlling for age, education, race, and health status (Bowen, Anderson, White, Powers, & Greenlee, 2002; Matthews et al., 2005; Smith et al., 2010). Similarly, women access TCAM services more often than men (Barnes et al., 2008); in fact, women between the ages of 30 and 69 have been identified as the primary consumers of TCAM (Barnes, Powell-Griner, McFann, &

Nahin, 2002; Drivdahl & Miser, 1998; Lloyd, Lupton, Wiesner & Hasleton, 1993). Notably, much of the TCAM literature regarding LGBTQ+ patients, albeit minimal, has focused on lesbian women; little is known about TCAM preferences of other LGBTQ+ groups.

Despite the established widespread use of TCAM services among patients, mainstream HCPs do not routinely ask about such practices (Flannery, Love, Pearce, Luan, & Elder, 2006; Robinson & McGrail, 2004). HCPs typically dismiss TCAM as beyond their scope and/or avoid discussing it with patients due to their limited knowledge, and these behaviours contribute to the silence of TCAM use (Flannery et al., 2006; Milden & Stokols, 2004; Robinson & McGrail, 2004). Moreover, nearly 75% of patients do not report using TCAM services to their mainstream HCPs. Patients have reported that one of the reasons for non-disclosure is a fear that doing so would have a negative impact on their relationship with HCP (Sirois, 2014). The silence around TCAM use may have significant negative consequence for patients, including interactions with conventional care (antagonistic or synergistic) and preventable adverse effects (Mehta, Gardiner, Phillips, & McCarthy, 2008). Ultimately, there is a clear need to better understand the help-seeking practices and experiences of LGBTQ+ Canadians in order to improve the provision of mental health care.

# CHAPTER 3

## METHODS

In the last decade, the health care system has begun to recognize the importance of engaging patients in research and treatment that is relevant to their well-being. In fact, current guidelines highlight the importance of incorporating patient preferences for treatment (Clark, 2011), and patient participation in clinical decision making has been identified as an important factor for improving treatment adherence and clinical outcomes (Loh, Leonhart, Wills, Simon, Härter, 2007). Moreover, the Canadian Institutes of Health Research (CIHR) initiated a Strategy for Patient-Oriented Research (SPOR) to engage patients in the governance, priority setting, and conduct of research, as well as in summarizing, distributing, sharing, and applying its resulting knowledge (Canadian Institutes of Health Research, 2013). Similarly, the Canadian Depression Research & Intervention Network (CDRIN) is a collaborative cross-Canada network with the mission to create and share knowledge that leads to more effective prevention, early diagnosis, and treatment of depression (Canadian Depression Research & Intervention Network, 2015).

Community-based participatory research (CBPR) is a widely utilized approach to engaging in research by collaborating with all important stakeholders throughout the research process to better understand and protect public health (Jagosh et al., 2012; Israel, Schulz, Parker, & Becker, 1998). CBPR engages people with lived experiences (PLEs) of mental illness as co-investigators, working together with academic researchers, HCPs, and policymakers (Jagosh et al., 2012; Israel et al., 1998). Recognizing the importance of such collaborations and the benefits of such participatory approaches (Michalak et al., 2015; Tapp, White, Steuerwald, & Dulin, 2013), our research team comprised of individuals with lived experience of mental illness. In addition to the primary researchers (Dr. Amy Bombay, Dr. Ingrid Waldron, and Dr. Zenovia

Ursuliak) we put together a cultural, sexual, and gender diverse research team that consists of community members in HRM with experiences of living with symptoms of anxiety, depression, and psychological distress; researchers from Dalhousie University; and representatives from various community groups and stakeholders. From the outset, feedback was provided by white, Indigenous, African Canadian, and African NS persons with lived experience (PLE), as well as individuals from sexual and gender minorities. The team worked together to develop our research questions, populations of interest, research methodologies, and research tools.

Mixed methods are used in research to answer complex questions by incorporating different types of information produced by quantitative and qualitative methodologies (Clark & Ivankova, 2015). The following study utilized an exploratory sequential mixed methods design, with a cross-sectional sample, to understand the help-seeking behaviours and preferences of adults from sexual and gender minorities. The first phase of the study deployed a quantitative survey to explore help-seeking behaviours of individuals with symptoms of psychological distress and to establish widespread use of TCAM in the HRM. The second phase of the study comprised of a focus group, as qualitative methodologies allow for a complex articulation of the human experience and validate the knowledge that emerges from personal frames of references (Kitzinger, 1995). The study received ethics approval from the Nova Scotia Health Authority Ethics Board (NSHA REB Romeo #1021960).

## Phase 1: Online Survey

## Participants and Eligibility

Participants were eligible to partake in the study if they were above the age of 18 years, have lived in the HRM for at least one year, and identify as living with experiences of psychological distress, depression, and/or anxiety; eligibility was not contingent on whether or

not participants had a diagnosis of mental illness. Recruitment was open to people from all genders, sexual orientations, and ethno-racial backgrounds. In line with the research aims of the greater project (not this specific study), targeted recruitment was conducted for Indigenous and African NS peoples through advertising in cultural/community centres (e.g., Mi'kmaq Native Friendship Centre), and through the connections and relationships of Indigenous and African NS investigators on the team (Watters & Biernacki, 1989). Advertisements were also posted in local community hubs (e.g., café's and libraries), on posts near busy streets in the HRM (e.g., Spring Garden Road), and online using targeting advertising on Facebook. This allowed for the recruitment of white Canadians, people from other ethno-racial groups, and individuals from sexual and gender minorities. To ensure that adults who are currently seeking mainstream HCP and TCAM practitioners regarding their symptoms of psychological distress, advertisements were placed in mainstream and TCAM clinics, respectively.

**Procedure**

A convenience sample of 512 adults living in the HRM completed the quantitative survey. The survey was housed on Qualtrics, an online survey platform, and participants accessed the survey anonymously through a URL provided on advertisements. A participant-specific code was generated to maintain confidentiality and allowed participants to complete the survey in more than one sitting. A physical copy of the survey was available to interested participants; however, none requested this option. Notably, web surveys yield comparable data to that obtained by a physical survey and tend to have increased sampling coverage in hard-to-reach groups (Trau et al., 2013). Online research is preferred over other methods as it can empower stigmatized populations by giving them "a means to come forward" and the opportunity to "voice their experience" (Miller & Sonderlund, 2010; Trau et al., 2013). On average, it took

participants one hour to complete the survey in one sitting. Note, some participants took up to 10 days to complete the survey from start to finish, making it difficult to assess precisely how much time was spent on the survey. Participants had the option to skip any questions that they did not wish to answer. Upon completion, each participant was mailed a $10 gift card of their choice as compensation for their time.

**Measures**

The overall survey included 52 sections, each with a separate questionnaire, to address the overall research questions of the project. Note that the survey included substantial branching, such that participants only answered sections relevant to them (e.g., participants did not answer the sections pertaining to seeking help from a Psychiatrist if they did not do so). The following paper only reports on a subset of the analyses, and therefore, only the relevant measures are included below; the questionnaires utilized in this study are listed in Appendix D. Measures were calculated if participants completed every item pertaining to the scale.

**Demographic information.** Participants reported various demographic information, including their age, gender orientation, sexual orientation, ethno-racial identity, the duration in years that they lived in the HRM, and their insurance coverage. Gender and sexual orientation were open-ended questions to allow participants to express their identities in a manner that was not constrained by a cisgender and heteronormative framework.

**Diagnosis of mental illness.** Participants were asked to report whether or not they had a diagnosis of mental illness by selecting from a list of options.

**Health care practitioners.** Participants reported the HCPs that they sought directly in relation to their symptoms of psychological distress by selecting from a list of practitioners. The list included both mainstream HCP and TCAM practitioners.

**Distress disclosure.** Participants' likelihood to discuss their symptoms of psychological distress with friends and family in various context was measured using the Distress Disclosure Index (DDI; Kahn, Achter, & Shamaugh, 2001). The DDI is a 12-item questionnaire that uses a 7-point Likert scale from strongly disagree to strongly agree. It has been demonstrated to have a test-retest correlation equal to 0.80, an internal consistency of roughly 0.93 (Kahn & Hessling, 2001), and Cronbach's alpha of 0.94 (Kahn, Achter, & Shamaugh, 2001). In the current study, the Cronbach alpha was 0.95. In addition to being widely used, the DDI has also been used in research pertaining to help-seeking attitudes and behaviours (Kahn, Hucke, Bradley, Glinski, & Malak, 2012), making it particularly well suited to help uncover the aim of this study.

A confirmatory principal component analysis (PCA) was conducted to determine if all of the measurements factor loaded on one component (Appendix E). All of the items had a correlation greater than |0.4| and were included in the analyses. Six items were reverse-scored, and the sum of the 12 items was used to calculate a distress disclosure score for each participant. Scores can range from 12 to 60, with greater score was associated with greater tendencies to disclose distress to one's next of kin.

**Mental health stigma.** Various measures related to participants' mental health stigma were assessed using the Stigma Scale (SS; King et al., 2007). The SS was used to measure perceived mental health stigma regarding an individual's symptoms of psychological distress; the measure was non-specific to a single type of diagnosis. This was effective for our population of interest, which comprised of individuals who may not have a diagnosis of mental illness. Therefore, a scale that was developed uniquely for one mental health stigma would be insufficient for our sample.

The scale comprises of 28-items and is rated on a 7-point Likert scale from strongly

disagree to strongly agree and has a demonstrated a Cronbach's alpha equal to 0.87 (King et al., 2007). Cronbach's alpha was 0.90 in the current study. Compared to other survey measures in the literature, the SS has been demonstrated to excel in content validity, internal consistency, construct validity, and test-retest reliability (Brohan et al., 2010). One other survey, the Internalized Stigma of Mental Illness (ISMI; Ritsher et al., 2003) was comparable to the SS and could have been used instead. However, unlike the ISMI, the SS measures positive perceptions of mental illness, which was identified as particularly important to PLEs on the research team.

The three subscales of the SS are discrimination, disclosure, and positive aspects (King et al., 2007). A confirmatory PCA revealed that 26-items factor loaded on four main components, and two items did not correlate with any subscale (Appendix E). The four components of the PCA were defined as the following subscales: discrimination/enacted stigma (e.g., "I have been discriminated against in educational settings because of my mental health issues"; "Sometimes I feel that I am being talked down to because of my mental health issues"), positive perceptions of mental illness (PPMI) (e.g., "Having had mental health issues has made me a more understanding person", "Having had mental health issues has made me a stronger person"), negative perceptions of mental illness (NPMI) (e.g., "Having had mental health issues makes me feel life is unfair"; "I would have had better chances in life if I had not had mental health issues"), and disclosure (e.g., "I worry about telling people that I take medicines/pills for mental health issues"; "People's reactions to my mental health issues make me keep them to myself"). Disclosure was not included in any of the analyses as it was not a measure of interest and was likely to be highly correlated with a measure of distress disclosure from the DDI. The average of 10 items, with two reverse-scored, was calculated to generate a score for discrimination; higher scores indicated that a participant experienced more mental health discrimination. The average of

42

three items, each, were taken to calculate positive and negative perceptions of one's mental illness; higher scores demonstrated more positive perceptions and more negative perceptions, respectively.

**Psychological distress.** Symptoms of non-specific psychological distress were measured using the Kessler Psychological Distress scale (K10; Kessler et al., 2002). The K10 was useful in detecting distress in a population that self-identified as suffering from depression and/or anxiety but may not meet diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V; American Psychiatric Association, 2013).

The questionnaire comprised of 10 items that were rated on a 5-point Likert scale from none of the time to all of the time and measured how often participants experienced symptoms of psychological distress within the past 30 days. Estimates of internal reliability (Cronbach's alpha) for the K10 has been found to be around 0.85 (Kessler et al., 2002). The Cronbach's alpha was 0.92 in the current study. The K10 was validated as having a two-component factor structure that consisted of depression and anxiety (Brooks et al., 2006; Chinneck et al., 2018). The depression and anxiety subscales were confirmed following a PCA (Appendix E). However, the following study was not interested in examining symptoms of depression and anxiety separately. Therefore, a second PCA was conducted to measure the correlation of the 10 items when loaded on one factor. All of the items had a correlation greater than |0.4|, and the sum of the items was calculated as a score of psychological distress. Higher scores indicated greater symptoms of psychological distress.

## Data Analysis

All of the data analyses were conducted using SPSS (version 25). The demographic information provided by participants were coded into categorical variables in preparation for

regression analyses. Gender identity was coded into three categories, which were woman, man, and trans/non-binary/other. Sexual orientation was coded into four categories, which were straight, lesbian/gay, bisexual, and queer. Ethno-racial identity was coded into four categories, which were Euro-Canadian (white), Indigenous, Black, and other. Insurance coverage was also coded into four categories; they were, provincial insurance only, extended insurance, other insurance, and no insurance coverage. Mental health diagnosis status was a binary variable indicating if a participant did or did not have a diagnosis. Finally, five binary variables were coded for whether participant sought any HCP, a general practitioner (GP), a psychiatrist, a psychologist, and a TCAM practitioner in relation to their symptoms of psychological distress.

First, a multiple linear regression was conducted to determine which variables were associated with psychological distress. The predictor variables included in the model were gender identity, sexual orientation, distress disclosure, mental health diagnosis, mental health discrimination, PPMI, and NPMI. Gender identity and sexual orientation were dummy coded; the categories trans/non-binary/other and queer were comparison groups. The assumptions of multiple linear regression were met, and no outliers were identified (Osborne & Waters, 2002). Post hoc tests, without adjustments, were conducted with significant categorical variables.

Second, five hierarchical binary logistic regression were conducted to determine which variables were associated with participants help-seeking any HCP, a GP, a psychiatrist, a psychologist, and any TCAM. Figure 1 depicts a visual representation of the analysis. Psychological distress was included as a covariate, and the other predictor variables were distress disclosure, discrimination, PPMI, NPMI, insurance coverage, gender identity, sexual orientation, and mental health diagnoses. In addition to assessing their main effects, the potential moderating effects of gender identity, sexual orientation, and mental health diagnoses were also assessed.

The analyses were conducted in two steps, first where all of the variables were entered into the model, and second by including the interaction between the moderators and all of the predictor variables, with the exception of insurance coverage. The interaction model was selected for interpretation if there was a significant ($p < 0.05$) decrease in deviance ($-2LL$). Otherwise, the first step of the model was used to interpret the association between variables. The assumptions of binary logistic regression were met, and no outliers were identified (Menard, 2002).

## Phase 2: Focus Group

### Instrument

A semi-structured interview guide was developed by the research team and was informed by the findings of the quantitative results (see interview guide in Appendix F). The interview guide was semi-structured for flexibility and provided meaningful and comprehensive data (Berg & Lune, 2007). In order to investigate the help-seeking experiences of the LGBTQ+ community, the interview guide asked general questions about help-seeking behaviours and experiences. Then the guide asked specifically about participant experiences as LGBTQ+ members. Open-ended questions were asked to allow participants to describe their experiences in-depth (Berg & Lune, 2007). Finally, results from the quantitative survey were shown to participants, who were asked to contextualize and interpret findings.

### Sample

A single focus group was conducted, which was comprised of six individuals from diverse ethno-racial, gender, and sexual backgrounds. Participant demographic information, including gender and sexual orientation, is listed in Table A *2*. One participant was unable to attend the focus group due to extreme anxiety and social phobia; he (P7) was interviewed separately.

There are numerous definitions and models of saturation in qualitative research, however, they all agree that saturation is a criterion to determine adequate sampling (Ajmal, Almatrooshi, & Hussain, 2018). Typically, two-to-three focus groups must be conducted in order for a researcher to determine if saturation has been achieved (Guest, Namey, & McKenna, 2017). Given that we conducted one focus group, we were unable to assess if saturation was reached. However, the aim of phase 2 of the study was to pilot a qualitative component of this research, and more focus groups are being conducted by the research team. Moreover, as a focus group was being used to enlighten and further elaborate on the results of the quantitative phase of the study; a single focus group was deemed sufficient to serve this purpose.

**Recruitment**

Individuals who completed the online survey (Phase 1: Online Survey) had the option to leave their contact information and express interest in partaking in focus groups. Ten randomly selected participants who expressed interest in being interviewed and were a member of the LGBTQ+ community were invited to attend the focus group. Six participants were recruited through this method. One participant (P5) heard about the focus group through word-of-mouth. He was above the age of 18, lived in the HRM for at least one year, and expressed living with symptoms of depression, anxiety, or psychological distress, and therefore, was also invited to partake in the focus group.

**Procedure**

The focus group took place in a private room booked on campus, and the interview was conducted in P7's home due to his social anxiety. Upon arrival, participants reviewed and signed a consent form. The focus group and interview were audio-recorded and transcribed verbatim. Participants were offered $40 as compensation for their time and were provided with a list of

queer-friendly mental health services and resources. Recordings were then transcribed, verbatim, and all identifying information was removed.

**Data Analysis**

Both the focus group and the interview were analyzed using Braun and Clarke's (2006) six-phase process of thematic analysis. Transcripts were coded using NVivo, a qualitative software. The four steps in the data analysis process are outlined below.

**Familiarization.** Familiarization was achieved by reading each transcript twice. The primary researcher also conducted both the focus group and interview, as well as transcribed the audio recording, which promoted familiarity with the data (Johnson & Turner, 2003; Braun & Clarke, 2006).

**Generation of codes.** Initial codes were produced by summarizing important concepts from the focus group into brief descriptions. These codes emerged through an inductive (bottom-up) process, in that they were based on the researcher's interpretation of the data rather than a pre-existing theoretical framework (Braun & Clarke, 2006).

**Searching for themes.** Once both the focus group and interview were coded the list of codes and their associated quotes were organized into meaningful clusters (themes) and rearranged in Nvivo.

**Reviewing themes/defining and naming themes.** Internal homogeneity was achieved by the primary researcher reviewing the coded data to ensure that they were consistent with the thematic category that they were assigned to. A second researcher was present at the focus group and also reviewed the transcripts; external homogeneity was achieved by the second researcher reviewing the themes and codes to ensure that they were representative of the whole dataset. The themes that were most important were identified and named. Each was given a brief description

to outline main findings and significance (Braun & Clarke, 2006).

**Trustworthiness**

In order to confirm the rigour of the study, qualitative research must outline the ways in which trustworthiness was ensured (Thomas & Magilvy, 2011). The following study accepted the approach to trustworthiness by Lincoln and Guba (1985). The four criteria to trustworthiness are outlined below.

**Credibility.** The completeness and accuracy of the data are known as its credibility. It is an incredibly important factor in establishing trustworthiness by ensuring that the study findings are consistent with the reality of the phenomena under exploration (Lincoln & Guba, 1985). Credibility was ensured by note-taking during the data collection and data analysis process, and by also ensuring that a second researcher was present at all times, including during the taping of the focus group.

**Transferability.** Transferability refers to the degree to which the findings can be applied in other settings (Lincoln & Guba, 1985). Since the findings of this study were specific to a subset of LGBTQ+ peoples, it is not possible to demonstrate that these findings are generalizable to a broader population. However, the focus group comprised of a diverse group of individuals from varying gender and sexual backgrounds, which were made note of in this study, to allow future researchers to determine the applicability of the current findings to a wider LGBTQ+ population.

**Dependability.** If a study is repeated in a similar context with similar participants and methods, it is considered dependable if similar results are achieved (Lincoln & Guba, 1985). In turn, the research process and methods of this study were recorded at every step of the process. There is enough detail available such that a future researcher would be able to replicate the

findings. Although the study is replicable, it is likely that the findings will differ as the preferences and practices of LGBTQ+ peoples' regarding their mental illness and help-seeking behavior will for different participants and different experiences.

**Confirmability.** Confirmability pertains to the degree to which the research findings are informed by participants' experiences rather than the researcher's bias (Lincoln & Guba, 1985). To achieve confirmability, the primary researcher was aware of their own biases, interests, and motivations regarding the subject matter. As an LGBTQ+ person, the researcher acknowledged their experiences engaging with the health care system. In advance of the focus group, the primary researcher, who facilitated the focus group, journaled their answers to the interview guide and therefore did not feel the need to inject their own experiences or opinions into the conversation.

# CHAPTER 4

## RESULTS

### Phase 1: Quantitative Findings

**Descriptive Statistics**

A total of 512 adults above the age of 18 responded to the online questionnaire. Table A 2 summarizes the participant's gender identity, sexual orientation, and ethno-racial identity. Roughly three-quarters (73.24%) identified as women, one-sixth identified as men (16.80%) and the remainder (9.96%) identified as trans, non-binary, or other. Similarly, around 70 percent (69.34%) identified their sexual orientation as straight, and the remaining participants identified as lesbian or gay (8.79%), bisexual (12.89%), and queer (9.57%). Regarding ethno-racial identity, most participants were Caucasian or white (64.84%). Other prominent ethno-racial identities were Indigenous (18.55%) and Black (11.33%), and the remaining participants (5.27%) identified with another ethno-racial group. On average, participants were 32.58 years old ($sd =$ 11.61; Table A 3), and the age range was from 19 to 72.

A summary of participants' health care coverage, mental health diagnoses, and help-seeking history are listed in Table A 2. The majority of participants (62.70%) reported having extended health benefits or insurance coverage in addition to provincial NS insurance. Conversely, one-third (31.25%) reported only having provincial insurance, and a few participants (3.32%) reported having no insurance (Table A 2). A minor subset (2.73%; Table A 2) noted that they had a different type of insurance coverage, such as disability insurance (see Appendix D). Although all of the participants reported experiencing significant symptoms of psychological distress, just over one-quarter (27.54%) did not have an official diagnosis of mental illness, and roughly one-sixth (16.41%) had never spoken to any HCP regarding their symptoms. Of the

participants who did speak to HCPs, most (64.45%) sought a GP, and roughly one-half (48.63%) spoke to a psychologist. Similar proportions, roughly one-third, spoke to a psychiatrist (30.86%) and a TCAM practitioner (30.47%).

The mean scores of the participants who answered the various scales in the online survey are listed in Table A 3. On average, the study population had a K10 psychological distress score of 30.09 ($sd = 8.38$), which is indicative of a moderate-to-high level of clinical distress (Andrew & Slade, 2001). The mean DDI score was 48.61 ($sd = 16.62$) indicating that on average, the sample had a greater tendency to disclosure distress. The mean score on the of PPMI was 5.30 ($sd = 1.16$), suggesting that participants generally agreed with statements about positive self-perceptions of one's mental illness. The mean score for NPMI was just above the midpoint ($m = 4.72$; $sd = 1.44$), suggesting that participants were on average pretty neutral about negative self-perceptions of one's own mental illness. The mean score on the enacted/experienced mental health discrimination subscale was just below the mid-point ($m =$, 3.64; $sd = 1.24$), meaning that on average, participants disagreed with statements indicating that they experienced/perceived mental health discrimination enacted toward themselves.

**Predicting Psychological Distress**

The results of the multiple linear regression ($R^2 = 0.39$) predicting psychological distress are presented in Table A 4. Regarding participant identities, only gender identity of men compared to trans, non-binary, or other gender identities was significant ($B = 3.01$; $p < 0.05$). Figure 2 depicts the results of a post hoc pairwise comparison between the three categories of gender identity (woman, man, trans/non-binary/other). The findings demonstrate that men ($m = 28.39$) had significantly lower K10 psychological distress scores than both women ($m = 30.16$; $|\Delta m| = 1.77$; $p < 0.05$) and trans, non-binary, or other gender identities ($m = 31.40$; $|\Delta m| = 3.01$; $p$

< 0.05). The difference between women and other gender identities was non-significant ($|\Delta m|$ = 1.24; $p > 0.05$). Additionally, a participant's diagnosis status was also significantly related to their K10 psychological distress score (Table A 4; Figure 3). Participants without a mental health diagnosis had a lower K10 score compared to participants with a diagnosed mental illness ($|\Delta m|$ = 1.66; $p > 0.05$). However, the partial-eta squared ($\eta_p^2$) revealed that the differences related to gender and diagnosis status had small effect sizes ($\eta_p^2 = 0.01$; Lakens, 2013). For example, the mean K10 score of participants with a diagnosed mental illness was 30.81, whereas, the mean K10 score for the undiagnosed group was 29.16; these scores suggest that both groups have K10 scores indicative of high clinical distress.

Psychological distress was also associated with three other variables in the regression model (Table A 4). In this regard, distress disclosure was negatively predicted distress such that individuals who reported being less likely to disclose their distress were at an increased risk ($B$ = -0.05; $p < 0.05$; $\eta_p^2 = 0.01$). Experiences of mental health discrimination were also significantly predictive of distress ($B$ = 1.11; $p < 0.01$; $\eta_p^2 = 0.03$), with higher levels of discrimination being associated with greater distress. The greatest predictor of distress was NPMI ($B$ = 2.47; $p < 0.01$). As a participant's negative perception of their own mental illness increased, so did their distress scores; this relationship demonstrated a medium effect size ($\eta_p^2 = 0.03$; Lakens, 2013).

**Mental Health Help-Seeking**

Given that the participants who engaged in this study self-reported as experiencing high levels of psychological distress, K10 scores were included as a covariate in the five binary logistic regressions predicting whether participants sought care from any type of health care provider and in predicting help-seeking for each specific HCPs. As reported again in each of the sub-sections below, psychological distress was a non-significant ($p > 0.05$) predictor of whether

participants sought any health care practitioner (Table A 6), a GP (Table A 7), a psychiatrist (Table A 8), a psychologist (Table A 9), and any TCAM practitioner (Table A 10).

**Seeking any health care practitioner.** A hierarchical logistic regression revealed that incorporating interaction terms between gender identity, sexual orientation, and mental health diagnosis with all of the other variables in the model did not significantly decrease the deviance (or variance accounted for) by the model ($\Delta$ -2$LL$, $\chi^2(24) = 28.03$; $p > 0.05$; Table A 5). Therefore, moderation did not take place in predicting participants seeking any health care practitioner. The following results report on the first model of binary logistic regression (Figure 1). The variance ($R^2$) accounted for by this model was 0.31 (Cox & Snell), 0.41 (Hosmer & Lemeshow), and 0.52 (Nagelkerke).

The overall logistic regression was significant ($\chi^2(14) = 184.72$; $p < 0.01$; Table A 6); however, only four coefficients in the model were significant and accounted for unique variance in the dependent variable. In this regard, both distress disclosure ($B = -0.02$; $p < 0.05$; $OR = 0.98$) and PPMI ($B = -0.32$; $p < 0.05$; $OR = 0.73$) were negatively associated with mental health help-seeking. That is, as tendencies toward distress disclosure decreased, participants were less likely to seek help from any HCP. Similarly, as positive perceptions of one's own mental illness decreased, so did likelihood to have sought any help from any HCP.

Participants who had extended health benefits were less likely to seek help from any HCP, as compared to individuals with just provincial health benefits ($B = -1.03$; $p < 0.01$; $OR = 0.36$). This relationship demonstrated a small ($OR < 0.60$) to medium effect size ($OR < 0.29$; Chen, Cohen, & Chen, 2010). Perhaps unsurprisingly, participants with a mental health diagnosis were significantly more likely to have sought help from any HCP ($B = 3.22$; $p < 0.05$; $OR = 25.11$) regarding their symptoms of psychological distress. The odds ratio associated with mental

health diagnosis represents a very large effect size ($OR > 6.71$; Chen et al., 2010). None of the other variables in the model were predictive of whether a participant sought any HCP.

**Seeking a GP.** The hierarchical logistic regression revealed that no moderation took place in predicting whether a participant sought help from a GP ($\Delta$ -2$LL$, $\chi^2(24) = 32.14$; $p > 0.05$; Table A 5). In turn, the following results discuss the outcome of the first model in the binary logistic regression (Figure 1). The variance ($R^2$) accounted for by this model was 0.23 (Hosmer & Lemeshow), 0.26 (Cox & Snell), and 0.35 (Nagelkerke).

There were three variables that were significantly associated with help-seeking behaviours regarding GPs, and the overall logistic regression was significant ($\chi^2(14) = 150.62$; p $< 0.01$; Table A 7). The association between variables was similar to that with seeking any HCP. That is, distress disclosure was negatively associate with having sought a GP ($B = -0.02$; $p < 0.01$; $OR = 0.98$). Individuals with extended health benefits were less likely than individuals with provincial insurance to have sought a GP ($B = -0.79$; $p < 0.01$; $OR = 0.46$). Lastly, individuals with a mental health diagnoses were more likely to have seen a GP ($B = 1.97$; $p < 0.05$; $OR = 7.16$).

**Seeking a psychiatrist.** The hierarchical logistic regression revealed that model 2 (Figure 1) demonstrated a significant reduction in deviance ($\Delta$ -2$LL$, $\chi^2(24) = 41.31$; $p < 0.05$; Table A 5); this indicated that model two accounted for significantly more variance. Therefore, moderation did take place, and these results are outlined below (Figure 1). The following proportion of variance was accounted for by model 2: 0.27 (Hosmer & Lemeshow), 0.29 (Cox & Snell), 0.40 (Nagelkerke).

The overall logistic regression was significant ($\chi^2(39) = 170.23$; $p < 0.01$; Table A 8); however, only two coefficients were associated with having sought a psychiatrist. First, as PPMI

increased, likelihood to have seen a psychiatrist decreased ($B = -0.42$; $p < 0.05$; $OR = 0.66$).

Similar to previously, participants with extended health benefits were less likely to have sought

help from a psychiatrist ($B = -0.54$; $p < 0.05$; $OR = 0.59$). None of the other variables had a

significant association with participant help-seeking behaviour regarding psychiatrists.

Only one interaction coefficient was significant in the model, which was discrimination

moderated by sexual orientation ($B = -2.09$; $p < 0.05$; $OR = 0.12$); specifically, lesbian and gays

as compared to straight participants. Depicted in Figure 4, the interaction reveals that lesbian and

gay participants were less likely to seek help from a psychiatrist as compared to straight

participants, particularly among those who experienced greater levels of discrimination.

Conversely, the likelihood that straight participant sought help from a psychiatrist was unaffected

by their experiences with mental health discrimination.

**Seeking a psychologist.** The change in variance when including interaction terms into

the logistic regression model was non-significant ($\Delta$ -$2LL$, $\chi^2(24) = 29.10$; $p > 0.05$; Table A 5),

indicating that moderation did not take place. As such, the following results pertain to the first

binary logistic model (Figure 1). The variance accounted for by model 1 was 0.15 (Hosmer &

Lemeshow), 0.19 (Cox & Snell), 0.25 (Nagelkerke).

The binary logistic regression predicting if participants sought help from a psychologist

was significant ($\chi^2(14) = 184.72$; $p < 0.01$; Table A 9). There were four coefficients, not

including the constant, that were significantly associated with seeking help from a psychologist.

Both PPMI ($B = -0.26$; $p < 0.01$; $OR = 0.78$) and NPMI ($B = -0.19$; $p < 0.05$; $OR = 0.83$) were

negatively associated with help-seeking. That is, lower PPMI and NPMI scores were associated

with a greater likelihood that a participant spoke to a psychologist regarding their symptoms of

psychological distress. However, these relationships had a relatively small effect size (Chen et

al., 2010). On the other hand, there was a significant relationship between gender and seeking help from a psychologist; specifically, trans, non-binary, and queer participants were less likely than women to seek help from a psychologist ($B = -1.16$; $p < 0.01$; $OR = 0.31$). The effect size associated with this relationship was of medium strength (Chen et al., 2010). Mental health diagnosis was the final predictor of having sought a psychologist. Participants with a diagnosed mental illness were more likely to have seen a psychologist than participants without a diagnosis ($B = 1.56$; $p < 0.01$; $OR = 4.76$).

**Seeking any TCAM practitioner.** The hierarchical logistic regression demonstrated a significant decrease in deviance when interaction terms were included into the second step of the model ($\Delta$ -$2LL$, $\chi^2(24) = 68.26$; $p < 0.01$; Table A 5). The following results are interpreted from the second model in the regression, which includes moderation analysis (Figure 1). The variance accounted for by this model was 0.21 (Hosmer & Lemeshow), 0.23 (Cox & Snell), 0.32 (Nagelkerke).

The overall binary logistic regression was significant ($\chi^2(38) = 129.73$; $p < 0.01$; Table A 10). There were three variables, excluding interaction terms, that were significant predictors of whether a participant sought help from a TCAM practitioner. First, lesbian and gays were more likely than women to have sought help from a TCAM practitioner ($B = 9.63$; $p < 0.05$; $OR > 500$). Second, individuals with extended insurance coverage were less likely than those solely with provincial coverage to have spoken to a TCAM practitioner regarding their mental health symptoms ($B = -0.78$; $p < 0.01$; $OR = 0.46$). Lastly, individuals with a mental health diagnosis were more likely to have sought help from a TCAM practitioner than those without a diagnosed mental illness ($B = 8.10$; $p < 0.01$; $OR > 500$).

Gender only moderated one of the relationships associated with help-seeking. There was a significant effect of discrimination predicting if participants sought help from a TCAM practitioner that was moderated by gender ($B = 0.95$; $p < 0.05$; $OR = 2.58$). Figure 5 reveals that men were more likely to seek help from a TCAM practitioner if they had higher experiences of discrimination, whereas, women's help-seeking behaviour was unaffected by variations in discrimination.

There were four significant interaction terms associated with sexual orientation and various predictors of help-seeking behaviour (Table A 10). As a result of dummy coding, the lesbian/gay, bisexual, and queer groups were compared to the behaviours of straight participants. One interaction was between sexual orientation and distress disclosure ($B = -0.13$; $p < 0.01$; $OR = 0.88$), two interactions with discrimination ($B = -0.89$; $p < 0.0;5$ $OR = 0.41$; $B = -1.94$; $p < 0.01$; $OR = 14$), and a final interaction with NPMI ($B = -1.40$; $p < 0.07$; $OR = 0.25$). First, lesbian and gays with lower tendencies to disclose distress were more likely to seek help as compared to those with high distress disclosure (Figure 6). Regarding experiences of discrimination, both bisexual (Figure 7) and queer (Figure 8) participants were less likely to seek help from a TCAM practitioner if they had high experiences of mental health discrimination. Lastly, lesbian and gay participants were less likely to seek help from a TCAM practitioner if they had high NPMI (Figure 9). Straight people's help-seeking behaviour did not differ for any of the three aforementioned variables.

The final significant term in the logistic regression model was the interaction between mental health diagnosis and PPMI ($B = -0.83$, $OR = 0.43$, $p = 0.01$). Figure 10 revealed that individuals without a mental health diagnosis were less likely to seek help from a TCAM

practitioner if they had a higher PPMI score. Conversely, the help-seeking behaviour of adults in with a diagnosed mental illness was unaffected by changes in PPMI scores.

**Phase 2: Qualitative Findings**

A total of eight themes were identified following thematic analysis of the focus group (and interview) transcription. Following the conversation regarding living with symptoms of psychological distress, which was asked by the facilitator, the following themes emerged: (1) negative perceptions of mental illness, (2) positive perceptions of mental illness, and (3) persistence of mental health social stigma. A second cohort of themes emerged when participants were asked about their experience navigating the mental health care system in the HRM; the themes were (4) reasons for help-seeking, (5) factors that influence help-seeking, (6) experiences with mainstream health care system, (7) experiences with complementary health care, and (8) unique experiences as LGBTQ+ persons. The following quotes have been altered to exclude fillers (e.g., Uhm) to improve readability and at times shortened for succinctness. Ellipses in the text are indicated by the use of three dots. Where noted, I (primary investigator) refers to the moderator and interviewer.

Notably, the participants who were from diverse ethno-racial backgrounds (P1, P4, P6, P7) often referred back to their ethno-racial identity during the focus group and interview. This was especially true for P1, who felt a strong connection between their LGBTQ+ identity, ethno-racial identity, and mental wellness. The codes regarding race are not reported on in the following results section, but their presence emphasizes the importance of considering the intersectional identity of LGBTQ+ patients.

**Negative Perceptions of Mental Illness**

At the beginning of the focus group, participants were asked to express their feelings regarding symptoms of psychological distress (see Appendix F). Despite a wide range of experiences, participants shared an overwhelming negative sentiment. Amidst the discussion, one participant said, "I feel a lot of shame, all the time" (P6). The conversation came to a still hush as the other participants nodded both somberly and sympathetically. Despite the presence of non-verbal cues of agreement and/or empathy, none of the other participants verbally echoed this sentiment of self-stigma. Nevertheless, a conversation was sparked following the comment by P6 regarding negative components of their symptoms, which mostly attributed to the effect that mental illness had on daily life. Participants expressed that living with depression and anxiety can be "very debilitating" (P3), and often can hinder their capacity to accomplish tasks. This was true for both at home and at work, where their ability to succeed or be productive was often diminished. One participant stated that they viewed their symptoms of anxiety "negatively [because] it's barriers to employment- I can't work- and barriers to socializing" (P7). He continued:

> P7: It [social anxiety] really restricts my freedom of movement. I don't like urban living. I like rural living. … I find winter is better because I can go outside more easily when it's dark, 'cause I feel more hidden. So, I rarely go out in the daytime.

This conversation demonstrated that participants were readily able to recall how their symptoms impede everyday function. Nevertheless, it was unclear if participants felt negatively about these symptoms, for example, a sense of shame, which would have been indicative of mental health self-stigma.

**Positive Perceptions of Mental Illness**

Participants struggled to describe positive aspects of living with mental illness. Only after the moderator probed for a positive remark, one participant said:

P2: I feel [that] my experiences of depression and anxiety and other kinds of issues … could be positive 'cause it makes me more aware or cog- or like empathetic to people who are struggling with those situations, but in the long term, I feel like there's still a big stigma.

However, none of the other participants in the focus group engaged with this comment, perhaps indicating that they were unable to identify positive aspects of their distress symptoms any further. During the independent interview, P7 also said, "I think I have a broader world view- being able to empathize more", when asked if he could identify any positive elements of his mental illness. Much like the participants in the focus group, P7 struggled to identify any further positive aspects of his symptoms. He did, however, recall later on in the conversation that his symptoms allow him to "dissociate" from his emotions, such that he could "[engage in] certain interactions without any emotion involved." P7 felt that his capacity to distance himself from his emotions was positive because he "can navigate a system and leave my emotions somewhere else entirely … so that actually kind of helps in a way". Ultimately, it was apparent that participants struggled to identify positive aspects of their mental illness, which suggests that participants' negative perceptions of their mental illness are more salient than positive perceptions.

**Persistence of Social Stigma**

All of the participants felt that there was a pervasive social stigma regarding mental illness. Many recalled experiences with friends and family that participants considered mental health discrimination; as is illustrated by the following interaction between two participants:

P6: I feel like it's some of my closest friends who are kind of radical mental health enthusiasts have even turned around and said you know go do yoga and all these kind of-

P3: and everything will be fine.

P6: Cis-white people recommendations (laughs) that are useless.

Participants described these experiences as harmful, leaving them with a sense of shame. These experiences were so ubiquitous in participants' lives and are a regular occurrence. So much so that they were referred to throughout the focus group discussion. One participant remarked:

P2: In the long term, I feel like there's still a big stigma, …[in that] people do kind of try to solve your issues by saying that you should exercise, or you should – eat  in a more healthy way, when in reality that's not accessible to everyone given their circumstances.

Participants indicated that social stigma came from people in all aspects of their lives, both at work and at home. These prejudiced experiences were described as ineffective, unhelpful, and implied that they discounted the realities and struggles of living with mental illness.

**Reasons for Help-Seeking**

There were a number of reasons that participants identified regarding why they sought HCPs in general. The ultimate aim was to address their symptoms and associated hindrance to daily function. Generally, the types of HCPs that participants sought did not happen to be a very purposeful decision. Many participants remarked that they sought help from mainstream HCPs as they were prescribed medication and that it was a part of a routine. It was apparent from the

tone of the discussion that seeking help from mainstream HCPs was an obvious resource to address health concerns, and all of the participants did speak to a mainstream HCP regarding their mental illness. One reason to seek help that was repeatedly identified was desperation. Participants discussed that many of them had sought help in hopes of finding something that would be helpful. As one participant said, "I'm trying anything. I'm like, somebody heal me. … Throw some money … down that hole, maybe it'll work" (P2). Often times, when a participant remarked that they would access a service hoping that it would work, other participants nodded and hummed in agreement, as is illustrated by the following exchange:

> P3: None of … the other ones, seem to help, you know? Let's see if this will help, let's see if that will help, let's see if this will help.
>
> I: So, it's like pulling straws?
>
> P3: Yeah.
>
> I: Trying to find, you know-
>
> P2: well, you get really desperate sometimes, when your back is against the wall, and you'll try anything you can to feel better and be better, I think. Sometimes people think people with mental illness are copping out, or it's, they have some sort of choice, but I feel like people do, will try to get better, and that's why you see people do like so many different things that they can access.
>
> P4: And sometimes trying anything or sometimes trying everything, to find the best fit.
>
> P2: Yes! yeah, exactly. That's why you do a lot of-
>
> P4: Yeah, yeah, juggling around and going from one place to another-
>
> P2: Until you don't want to try anymore.

Participants explained that they were trying different services and seeking various HCPs in order to find something that would be useful or ideal for them. Generally, participants were willing to try a number of different regiments. However, they would only do so if they were capable of affording the treatments.

**Factors that Affect Help-Seeking**

Even though participants had different reasons for help-seeking, they identified factors that affected their capacity to seek help. A primary reason to speak to a certain HCP was affordability. Participants noted that being able to pay for services was crucial if they were to seek help from a certain practitioner. As one participant said:

P7: My benefits cover- they don't cover psychologists, but they do cover naturopath, osteopath, that stuff.

I: And do you feel that encourages you to speak to them?

P7: Oh, I wouldn't- I couldn't otherwise

In fact, participants noted that their capacity to seek help from certain HCPs was constrained by their health benefits (insurance coverage). One participant explained:

P6: My coverage- I have $1500 a year to a lot to whoever, [for example] to see a psychiatrist. That is like three sessions.

I: Right.

P6: If I had more coverage, I obviously would be more likely to do it. Because I know now [that] I am only going to get three sessions, I didn't, I don't, I haven't bothered to use it.

It was important to participants that they would be able to afford a service such that they receive a complete treatment regime. Even if they had extended health benefits, they were not inclined to use it if it was limited.

**Experiences with Mainstream Health Care**

As participants discussed their experiences entering and navigating the mainstream health care system, numerous struggles were identified. It was evident that participants valued a healthy and respectful relationship with their HCP. In fact, all of the participants indicated that it was difficult to find an HCP whom you have a positive rapport with. As one participant explained:

P7: I have a good psychiatrist, which I realize now is not that common. Because it's far away I've tried to, you know- I've seen a few people more locally, and, just not had a good experience.

Participants struggled to articulate exactly what was necessary to build good rapport with an HCP. However, a few noted that being able to trust an HCP and feel comfortable with them influenced whether a participant continued to visit said practitioner. The following quote reveals the struggle to explain what was necessary to allow for proper rapport, but how lacking rapport deters help-seeking:

I: What do you think contributed to that [poor rapport], was it just the person's [HCP] personality?

P5: I guess maybe the personality or just, the way, I don't know maybe the way the questions were asked, and the- I just didn't feel comfortable I guess it's kind of a hard thing to explain but, it just eventually didn't go anywhere so then didn't see the point of continuing it.

The consensus was that rapport was earned and can easily be tarnished if a participant felt off-put by their HCP. Moreover, participants were quick to lose faith in their HCP if they felt unwelcome, unimportant, rushed, or that the discussions were not helpful.

In trying to find an HCP to share a positive relationship with, participants noted that navigating the health care system was difficult and inaccessible. In general, participants explained that it could be hard to access the health care system, request to see a provider, and even more difficult to switch HCPs if they felt that they could not build rapport with said HCP. One participant described the process of entering the health care system accordingly:

> P6: I find the mental health system here is kind of hard to get into and stay in. … I was like on a waitlist for so long before I got in [with] the first person and then, you know? That was because I went to the hospital and said I'm going to kill myself, [they said] "you're going to be with someone now" and then, you know, the next day they sent me to Abbey Lane and then after that they referred me to someone else and so forth until I finally had a steady counselor.

Fostering a positive relationship with an HCP could take time, but once it was there, it was incredibly valuable and important to hold on to. For example, one participant said:

> P7: I don't remember how long it took to trust her [psychiatrist], but now I trust her more than any other human. It probably took a few years. but it's the longest-term relationship that I've ever had.

Demonstrating that participants regarded their relationships with their HCPs highly. It was important for their treatment adherence and outcomes.

Although participants explained they could build a positive relationship with their HCP, most of the experiences that they recalled were negative. Participants felt that the health care

system was overwhelmingly rushed, unwelcoming, and a "cookie-cutter solution" (P6), where one size fits all. Participants stated that they were quick to be "labeled with like multiple labels" (P2) and that doing so was unhelpful. Particularly because participants felt that they were left without follow-up and resources to manage their symptoms. As one participant explained:

> P2: It was just kind of like you are labeled and sent out of the door without any treatment or referral to services that might help support you with these big labels that were placed on you, so, I kind of developed aversion to psychiatry.

Furthermore, participants explained that their experiences within the mainstream HCP were very much a process of trial-and-error that was meant to address simple cases of mental illness. All of the participants agreed that they needed customized treatments but were not provided with a personalized regime to suit their specific needs. One participant recalled his experiences with group therapy in the following way:

> P3: I found the system was kind of a set up to be an assembly line. … [They would] throw you into a group, "oh, this is the group you want to be in," and to see if that worked and when it didn't address your problems they would just throw you into another group to see if that works and they were all just, like, groups. And all of them are based on the same cognitive behaviour therapy, and- so, it was just this like [an] endless cycle.

Participants remarked that the mainstream HCP was overburdened with "so many different people [with] so many different problems" (P6). They understood that this was a limitation of the HCP, nevertheless, felt that personalization was important.

As previously mentioned, participants were repeatedly exposed to stigma from various aspects of their personal lives. However, many mentioned that they also experienced mental health stigma from the HCPs that they sought for help. One participant said:

P4: I think the biggest stigma towards mental health is in the field of the mental health itself because people [who] work in mental health and mental health services day in and day out, they see people struggling and living with different symptoms, so they almost build this wall, and they have different mechanisms and negative outlooks towards others.

This experience was shared by a few of the participants, where they felt stigmatized by individuals in the health care system.

**Experiences with Complementary Health Care**

There was a wider range of experiences regarding seeking help outside of the mainstream health care system. Some participants did not think to seek help beyond mainstream HCP because they were not aware that it was an option. Others felt that perhaps it might not be suited to their needs or even unhelpful. Participants did identify benefits from seeking TCAM because the support that they receive was described as being different from that of mainstream HCPs. Roughly one-half of the participants described their experiences engaging with TCAM as wonderful and communal. This was particularly relevant when a ethno-racial/cultural or spiritual component was involved. In fact, a sense of diversity and community was identified as "healing" (P1) and helped with managing their symptoms.

There was a discussion between a few participants about a TCAM service available in the HRM known as Saturday Clinic. This service was no longer available, and participants speculated that it was a result of insufficient funds or the lack of proven efficacy of the treatment. Nevertheless, participants remarked the benefits of the Saturday Clinic were not contingent on the efficacy of TCAM as a treatment for mental illness, but rather, the type of environment that it fostered. The following dialogue describes the experience in the Saturday Clinic:

P1: I think it was one of the best programs this city had. It was a really, really welcoming and enjoyable and I don't know why the hell they cut it. And really diverse, you know, people who would show up there.

P2: But then they did like research into the results of the study like, you know using like evidence-based whatever and they found it was not technically like that effective. But people talk about how much they loved going, and people went there, and people were using the services and getting connected to other things [other health services], so they got buy-in in that way, but then they cut because it was like "not clinically effective." I think it cost too much money or something. I don't know

P1: It was a great community-building thing. …

I: Right, and so, was it like- did you find the fact that there was a lot of community there and that diversity helped the treatment?

P1: Yup, absolutely.

Although a few participants reminisced the positive experiences of the Saturday Clinic, others noted that they felt impatient with TCAM techniques that were not grounded in evidence-based research. One participant said the following regarding his experience with naturopaths:

P7: I find with the naturopath, and I've seen a few, that their strengths are not in mental health. … Like I'll see someone for about 6 months and then I just kind of- its - they don't seem to quite get it. Or I'm not able to quite explain it, whichever way you want to look at it.

**Unique Experiences as LGBTQ+ Persons**

When navigating through the health care system, participants explained that there were a number of special considerations that they had to account for as individuals from sexual and

gender minorities. Participants had different perspectives regarding whether they needed to disclose their identities (come out) to their HCP. For some, there was no question about disclosing their identity, as this was a part of who they were, and they sought an HCP who would be accepting of that. Some participants noted that they did not have a choice in disclosing their identity to their HCP. For example, they might be a transgender person, and their identification documents (ID cards/birth certificates) may contradict their presenting and preferred gender orientation. Such was the experience of one participant, who said:

> P6: not passing [as cisgender] has caused a lot of issues for me in the health care community. I've gone to do things so simple as blood work, and you know my name didn't match my identity the way it should, and I've had people walk out of the room like, we're not doing this because you're not you and I'm like, the fucking picture, look at the picture! My name is a shortening of my legal name; there's no way you have no idea that's not me, right?

Similarly, a patient may be biologically female but has no chance of becoming pregnant as their sexual orientation may be lesbian, or the patient themselves are asexual. In turn, they may feel obliged to come out to their HCP.

For other participants, disclosing their identity to an HCP was unthinkable. They did not feel like knowledge of their gender/sexual identity was necessary to their mental health treatment outcomes and feared that they would be treated differently or stereotyped by their provider. Regardless, participants felt that queer-friendly health services were important and helpful. As one participant explained:

> P1: Well, I immediately contacted Pride Health, this group organization, to find out what services were available and assuming that the people in their loop would either be queer

or queer-friendly or whatever. And, that turned out to be the case … and that was very

helpful.

It became apparent from the discussion that being able to feel safe about being a member of the

LGBTQ+ community was imperative to lasting rapport with a provider.

Participants had varying experiences seeking help from HCPs who are queer themselves.

Some participants felt that if their HCP was a member of the LGBTQ+ community, the mutual

experience would foster a better doctor-patient relationship. On the other hand, some participants

felt that their HCP might over-identify with them, ultimately discounting the participant's unique

experiences. One participant explained that they would avoid seeking help from a queer HCP:

P4: I would think before going to that medical practitioner or doctor [who is queer]

because I don't want … them to look at me the way they look at themselves …, like, "…

because I may be gay, and I may have all these things you being my patient, you also

have the same symptoms." And sometimes I find that non-queer or the straight

community to be pretty helpful. Sometimes almost more helpful than the gay or queer

community. … when it comes to … [queer] medical professions and things like that, it's

like, why label me and do things the way you would do it with yourself? I want to be

treated like anyone else.

The discussion established that LGBTQ+ persons are likely to experience discrimination from

individuals within the system; this was true from both queer and non-queer HCPs.

Due to the diversity within the LGBTQ+ community, experiences of discrimination are

also diverse. A unique experience faced by transgender and non-binary peoples was the

conflation of symptoms of mental illness and transgender identities. Participants described these

experiences as ultimately detrimental, and further perpetuated long-lasting stereotypes that being

queer is a mental illness. As one participant described their transphobic experience with an HCP, the other participants displayed sympathy and understanding:

> P6: Being trans, sometimes anxiety and depression is wrapped into that. To get permission from doctors or psychiatrists to get surgery or start hormones you kind of have to prove that you're very uncomfortable in your body. What they want to hear is that you need to change it [gender]. Otherwise, you know, if I walk in, I'm like, "well, I don't know. I think I'm trans, but I feel fine. I'm great. I'm happy in my body." They're going to be like, "why are we going to send you for surgery?" So … that's reinforcing some mental health stigmas, where … being trans isn't a mental health thing at all, right?

Even though they each have their own struggles as queer people, there was a clear display of mutual experience and struggle.

**Chapter 5**

**Discussion**

**Psychological Distress in a Clinical Sample**

In our self-selected sample of adults in the HRM who identify as living with symptoms of depression, anxiety, or general psychological distress, men had the lowest psychological distress scores, which was significantly less than both women and transgender/non-binary participants. Our study also revealed that transgender/non-binary participants did not have a significantly different psychological distress score than women. To our knowledge, there is no previous research that has compared the severity of psychological distress in a clinical sample of transgender and queer adults to cisgender controls. Our findings also revealed that there were no significant differences across sexual orientation in predicting psychological distress. This is consistent with previous literature, which compared a sample of LGBT adults with major mental illness to cisgender and heterosexual controls (Hellman, Sudderth, & Avery, 2002); the authors did not find any differences in the rates of mood disorders between LGBT adults and controls, however, the age of onset of symptoms was significantly lower (Hellman et al., 2002). The Hellman et al. (2002) article primarily focused on sexual minorities, with only 4.8% of their sample (~3 people) identifying as transgender, which is insufficient to draw any conclusions. Moreover, the same article did not comment on the severity of psychological distress (or mood disorders), and our study did not explore rates of mood disorders.

Importantly, our sampling strategy, which primarily relied on online advertisements, may have limited our findings as the sample may not be a representative sample of adults from the HRM. Therefore, it would be difficult to generalize our findings to all LGBTQ+ adults in the HRM. Furthermore, some groups who experience high self-stigma may not be able to

acknowledge that they are experiencing symptoms of depression and/or anxiety. Therefore, these individuals may not have opted to complete our survey, even if they saw the advertisement. In turn, our findings pertain to a clinical sample of adults who have acknowledged that they suffer from symptoms of psychological distress, which may have different needs and help-seeking than individuals who do not recognize their symptoms.

Importantly, we found that participants without a diagnosis of mental illness had an overall statistically significantly smaller psychological distress score than participants with a diagnosis. While possible that some participants without a diagnosis may not meet the clinical diagnosis of depression and/or anxiety, it is more likely that other factors have deterred these individuals from accessing mental health care services. Among many other access issues associated with the health care system, a patient may be deterred from seeking help in regard to their symptoms of mental illness if they are "high functioning." The focus group revealed that the mental health care system is hard to access and hard to remain in. Moreover, participants revealed that in order to access mental health care services in the HRM, they needed to plead and display a sense of urgency and distress. These findings from our focus group indicate that the presumption that an individual living with significant symptoms of depression and/or anxiety cannot also a productive member of society may deter patients in need of support from help-seeking. Numerous studies in various contexts across the globe have revealed that individuals with ongoing unmet need and living with symptoms of mental illness have overall worse outcomes (Ngui, Khasakhala, Ndetei, & Roberts, 2010). Moreover, our study found that increased mental health discrimination is significantly predictive of psychological distress, which was consistent with our first hypothesis. This finding is inconsistent with previous literature, which found that stereotype endorsement and discrimination experiences were unrelated to

psychological distress over time (Lysaker et al., 2012). The focus group revealed that if participants feel that their symptoms of depression or anxiety are discounted by others, particularly service providers, they are discouraged from seeking help; we believe that this may further exacerbate their distress by leaving them with more unmet health needs. As participants from the focus group mentioned, a number of them felt that mental health care services providers could be very stigmatizing toward individuals living with mental illness. Whether or not it is true that health care providers are in fact stigmatizing, patients with this perception may be discouraged from seeking help; onus is on the mental health care system in the HRM to allow for better access and easier access to services without stigma or feeling of shame if participants are not "ill enough". Future research should explore how patients living with symptoms of mental illness feel stigmatized by different health care and service providers.

**LGBTQ+ Help-Seeking**

In general, the existing literature on the help-seeking behaviours of LGBTQ+ peoples demonstrate that LGBTQ+ individuals seek help for mental health symptoms more than cisgender and heteronormative counterparts (Dunbar, Sontag-Padilla, Ramchand, Seelam, & Stein, 2017; Grella, Cochran, Greenwell, & Mays, 2011), but report more unmet health needs than said counterparts (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Meyer, Teylan, & Schwartz, 2015; Steele et al., 2017). Increased service utilization by LGBTQ+ peoples may be attributed to several factors. For example, coming out may be distressing and therefore encourage help-seeking (Dunbar et al., 2017). LGBTQ+ individuals may also have better access to mental health resources through engagement with LGBTQ+ organizations (Dunbar et al., 2017). In the current study, the quantitative and qualitative findings revealed that experiences of and factors affecting mental health help-seeking among LGBTQ+ adults in this sample are

different from cisgender and heterosexual patients in regard to some HCPs and not others. Specifically, transgender adults were less likely to seek help from a psychologist than cisgender participants, and lesbian/gay participants were less likely to seek help from TCAM as compared to straight participants. It is unclear why LGBTQ+ help-seeking behaviours may differ for different HCPs, and future studies should explore these nuisances in more detail.

**Mental Health Stigma and Help-Seeking**

Participants in the focus group emphasized that mental health stigma continues to pervade society, both on an individual and interpersonal level. This is particularly concerning because our study revealed that greater mental health self-stigma was associated with increased psychological distress, and also with reduced help-seeking at the same time for certain groups. In this regard, self-stigma (as NPMI) was the strongest predictor of psychological distress. Moreover, as NPMI increased, participants were less likely to seek help from psychologists. Importantly, lesbian and gay participants were less likely to seek help from TCAM practitioners when they demonstrated high NPMI, but straight participants appeared unaffected by self-stigma. Regarding our study revealed that an increase in PPMI was associated with increased help-seeking from any HCP, psychiatrists, and psychologist. The less patients felt positively about their mental illness, the more likely they were to seek help. In the focus groups, participants struggled to identify positive aspects of their mental illness and were more likely to perceive their mental illness negatively. It is difficult to parse out why PPMI and NPMI are associated with help-seeking behaviours for different HCPs differently. However, a 2015 systematic review of the literature identified that self-stigma and treatment stigma were the only forms of stigma that influenced help-seeking (Clement et al., 2015), and our findings also demonstrate that self-stigma influence help-seeking. Future studies should explore more specifically the relationship

between mental health self-stigma and help-seeking, particularly in the LGBTQ+ community, especially because our study has demonstrated that mental health self-stigma may influence LGBTQ+ patients differently than cisgender and heteronormative counterparts.

Interpersonal mental health stigma, specifically, enacted stigma, affected various help-seeking behaviours only in relation to gender or sexual identity. A 2015 systemic review reported that experienced mental health stigma did not affect help-seeking behaviours; however, the studies in question did not extensively account for differences across gender and sexuality (Clement et al., 2015). Our study revealed that lesbian and gays who experience mental health discrimination were less likely to seek help from a psychiatrist. Regarding seeking TCAM practitioners, bisexual and queer people were less likely than straight people to seek help with increasing experiences of mental health discrimination. Moreover, men who experience discrimination were also less likely than women to seek help from TCAM practitioners. We demonstrated that experiences of mental health discrimination do affect help-seeking behaviours for different gender and sexual orientations. Future studies should explore these processes in more detail to better uncover how mental health discrimination affects different people from gender identities and sexual orientations, and why discrimination may affect different people differently.

**Diagnosis of Mental Illness and Help-Seeking**

Our study revealed that having a diagnosis of mental illness was a significant predictor of help-seeking, which was consistent with previous literature (Angst et al., 2010; Parslow & Jorm, 2000). The relationship between mental health diagnosis and help-seeking was significant for all types of health care providers that we assessed (all health care providers, GP, psychiatrist, psychologist, and TCAM). While our studies do not assess causality, it is likely that patients who

seek help will probably receive an official diagnosis of mental illness. This indicates that there is a subset of the population in the HRM who meet diagnostic criteria for depression, anxiety, and/or other mental illness but remain undiagnosed. Having a diagnosis allows patients to access services that they otherwise would be denied. Official mental health diagnoses serve numerous purposes, such as providing clinicians with an effective means of identifying their patients' symptoms, expected course, and prognosis. Notably, there are a number of disadvantages associated with diagnoses of mental illness (Corrigan, 2007). For example, our focus group revealed that some patients felt labelled, then left without follow-up or continued support. In turn, it is necessary for future studies to explore ways to make the mental health care system more accessible for patients to continue to be supported in meaningful ways, in addition to making prospective patients feel welcome to initiate help-seeking.

Interestingly, participants with a mental health diagnosis were also more likely to seek help from a TCAM practitioner. One explanation is that participants who are likely to seek help from a mainstream HCP would also be more likely to seek help from a TCAM HCP. However, the qualitative component of the study revealed that participants often seek help from various outlets through a process of trial and error, as well as out of desperation. This was especially true if participants felt that treatment was ineffective and not personalized. Participants remarked that these "one-size-fits-all" treatment programs felt disconnected from their specific needs as patients living with symptoms of mental illness. Therefore, it is not unexpected that participants may have sought help from TCAM as an alternative to mainstream services, in search for treatments that are more personalized (Solomon & Adams, 2015). This is consistent with previous literature that demonstrates that patients utilize TCAM services often to supplement mainstream health care practice (Solomon & Adams, 2015).

**Health Care Access and Extended Benefit**

Counterintuitively, participants with extended health coverage were less likely than participants with provincial coverage regarding seeking help from any HCP, a GP, and any TCAM practitioner. However, during the focus groups, participants discussed that cost was a great factor that influenced their abilities to seek help. Some participants remarked that they were unable to seek help unless they had health benefits that could cover the cost of treatment. In turn, it would be expected that participants with extended health benefits would be more likely to seek help from practitioners that are not covered by provincial health benefits. GPs are covered by provincial health benefits, so the relationship that we uncovered is puzzling at first. However, the qualitative component of the study revealed that participants are unwilling to seek help from all professionals if their extended health benefits are not extensive. That is, if a participant's health insurance only covers the cost of a few sessions with an HCP, they are unlikely to seek help. Similarly, if the insurance only covers the initial costs of a treatment regime, but not over the long term, patients are reluctant to begin seeking help. In fact, it is clear that participant may fear seeking help from a practitioner, lest they feel obliged to opt into a treatment regime that is too costly or inaccessible. In turn, our study revealed that extended health insurance policies that provide minimal health coverage do not encourage help-seeking from patients experiencing significant symptoms of psychological distress. Further, patients who do not have extensive coverage are also reluctant to seek help from practitioners who are covered by provincial care, in fear of being prescribed a treatment regime that will become a financial burden. These findings are consistent with previous literature that demonstrate that cost and insurance coverage are primary factors that influence help-seeking behaviours, particularly for transgender patients (Shipherd, Green, & Abramovitz, 2010; Snowden, 2001).

Notably, there may be other confounding variables that have not been accounted for in the following study, such as socioeconomic status, education, and ethno-racial group, which are known to influence help-seeking behaviour (Blumenthal & Endicott, 1996; Nam et al., 2010; Slaunwhite, 2015). It is also possible that these other confounding variables have influenced the relationship that we have uncovered between insurance coverage and help-seeking behaviours. This may explain why we did not find an effect of insurance coverage associated with seeking help from a psychologist. It is often the case that seeking help from a psychologist or psychiatrist is recommended by another health professional, therefore, individuals may have to pay for costs out of pocket. In turn, wealth and capacity may very well play a role that is not accounted for in our insurance variable. Another confounding variable that may help to explain the relationship between insurance coverage and help-seeking is education and profession. Typically, extended health insurance is offered as job benefits, and usually associated with higher qualifying jobs for those with a more advanced western education. Higher socioeconomic status is also associated with less psychological distress (Hackman, Farah, Meaney, 2010). Therefore, individuals with extended health benefits may have greater wealth, overall greater health, and better access to services that they can afford.

**Therapeutic Alliance and Rapport**

Participants had mixed experiences in both the mainstream and TCAM health care systems. However, one component that was of primary importance for patients was a good rapport with their HCP, regardless of mainstream or TCAM practice. Evidently, good rapport was difficult to foster between patients and their practitioners. There were numerous reasons attributed to this difficulty; for example, participants feeling rushed or discounted by their HCP. Nevertheless, participants struggled to identify ways to foster meaningful and healthy

relationships with their HCP. There is, however, literature that demonstrates that therapeutic alliance (TA) between patient and provider is important for overall wellbeing and treatment outcome (Arnow et al., 2013). Therefore, it is important to understand the variables that contribute to a positive therapeutic alliance and better understand the preferences of various groups of people. For example, the focus group revealed that some participants valued a mental HCP who was queer-friendly and who knew about the patient's LGBTQ+ identity. Alternatively, other LGBTQ+ patients felt that this knowledge was unnecessary information for the provider to have. It is important for the health care system in the HRM to measure therapeutic alliance ratings and collect participant demographic information to understand patient preferences better. Despite having the capacity and tools to canvass this information, the Nova Scotia Health Authority (NSHA) does not collect information regarding sexual orientation, ethnicity, or therapeutic alliance. Furthermore, the NSHA collects information regarding gender identity in a binary and non-LGBTQ+ inclusive manner (i.e., male/female). There is an option that allows patients to disclosure a "preferred pronoun," but this is ultimately mute given that it is preceded by a binary marker of gender. It is, therefore, our recommendation that the NSHA utilize more inclusive language on their intake forms, as well as, provide anonymized therapeutic alliance scales to patients following sessions with various HCPs. These therapeutic alliance ratings should measure general rapport between patient-provider. Moreover, therapeutic alliance ratings specific to the relationship between LGBTQ+ patients and providers should also be used to better understand the unique health care needs of non-cisgender and non-heterosexual patients. To our knowledge, there is no validated measure of LGBTQ+ therapeutic alliance to date. We recommend future research to focus on the development of a measure that can be utilized to better understand the TA of patients in mental health care. This measure ought to be developed in

80

collaboration with the LGBTQ+ community so that it takes into account experiences that may be deemed important for LGBTQ+ patients.

Perhaps one of the most prevailing criticisms of the mainstream mental health care system that were identified by participants in the focus group was regarding a lack of patient-specific treatments. TA and rapport between patients and their providers are negatively affected by the aforementioned "one-size-fits-all" model of treatment by trial-and-error. However, this need not be the case. The biopsychosocial model of psychiatry takes into account the biological, psychological, and social dimensions of health, which is not the case for the biomedical model (Engel, 1980). There have been many proponents and critics of the biopsychosocial model of psychiatry (Ghaemi, 2009). However, the process entails understanding the biological, psychological, and social determinants of health that contribute to a patients' overall health and treatment outcomes. HCPs will need to request this information from their patients and will have to learn about their patients in a more personal and intimate manner. We postulate that this will help overcome feelings over being rushed and dismissed by their HCPs, ultimately improving overall health care experiences. Notably, the biopsychosocial model is being taught to medical students and psychiatry residents at Dalhousie University with the intention of providing an integrative, non-reductionist approach to understanding and caring for patients with mental health concerns; however there is no evaluation of whether it this model is actually utilized in mental health services in the HRM (personal communication, Ursuliak). It may be useful for HRM mental health services review their model of care in consultation with important stakeholders, namely the patients they serve, including people from the LGTBQ+ community, to determine if the current model of care is meeting the needs of the people they serve.

**Distress Disclosure and Peer Support**

Quantitative analyses of the survey data revealed that distress disclosure was negatively associated with psychological distress, which was consistent with our hypothesis. As distress disclosure decreased, participants' psychological distress increased. Furthermore, we uncovered a negative relationship between distress disclosure and seeking help from any HCP as well as a GP. Perhaps these relationships indicate that distress disclosure and peer support is of particular importance for patient psychological wellbeing.

Importantly, the relationship between distress disclosure and seeking TCAM was moderated by sexual orientation; lesbian and gays were less likely to seek help when they had higher distress disclosure scores. This may indicate that LGBTQ+ patients can rely on their queer-friendly and queer-sensitive friends and family to disclose their distress and decrease their symptoms of psychological distress. In turn, the NSHA would benefit from piloting and establishing an LGBTQ+ peer support program, where patients are able to foster relationships with other LGBTQ+ patients who have had similar experiences to them. Previous peer support programs have been demonstrated to provide patients with empowerment, empathy and acceptance, reduced stigma, and hope (Repper & Carter, 2011). Although a 2011 review of the literature revealed that peer support programs have no effect of patient outcome, they do foster a sense of community and belonging, which were identified as important by some of our participants in the focus group (Repper & Carter, 2011). To our knowledge, no LGBTQ+ mental health peer support programs have been developed or assessed. Therefore, we recommend that future research focus on developing an LGBTQ+ specific peer support program and assess effectiveness in relation to mental health outcomes.

**TCAM Services in the HRM**

Although there were different perspectives regarding the effectiveness of TCAM services in relation to mental health outcomes, there were clear benefits identified regarding the diversity and inclusion that TCAM services provide. Specifically, patients discussed the Aural Acupuncture program that was provided by the Capital Health department of Addiction Prevention and Treatment Services in Nova Scotia. This program was praised by our participants and lauded for providing an atmosphere of diversity, inclusion, and healing that they identified as having helped their symptoms. The Aural Acupuncture program was discontinued due to a lack of evidence-based research for treatment effectiveness during the merger of the Addiction Prevention and Treatment Services and Mental Health Services into the new Mental Health and Addictions Department. Notably, there was a lack of evidence against the effectiveness of this program. It is, therefore, our recommendation that the NSHA's Mental Health and Addictions Department explore the benefits and disadvantages of this program, in consultation with patients, to assess efficacy. Importantly, the NSHA should also explore other positive effects such as community building and creating an inclusive space.

**Recommendations for an LGBTQ+ Inclusive Health Care System**

LGBTQ+ patients identified a number of unique experiences in the mainstream and TCAM health care systems, particularly relating to their identities and experiencing LGBTQ+ stigma. There are numerous complex identities that comprise of the LGBTQ+ community, including numerous intersecting identities, therefore, their preferences cannot be assumed to be unanimous. It is important for HCPs to recognize that members of the LGBTQ+ can be a visible minority, or non-visible (passing as straight or cisgender). Importantly, HCPs should not assume a patient's gender identity or sexual orientation based on appearance, as it may be dismissive,

offensive, and/or triggering. HCPs should provide outlets and opportunities for patients to disclose their identity. It is important that HCPs use inclusive language when first meeting a patient, such as not assuming gender through language (use they/them, rather than he/him and she/her) and sexual orientation based on appearance (patients may be gay, lesbian, bisexual, asexual, among other identities). Without outing patients, HCPs should indicate to patients that it is safe to disclose sexual and gender identity by providing LGBTQ+ positive and inclusive cues around clinics, including brochures, pamphlets, intake forms, and decorations (e.g., LGBTQ+ flags). Importantly, individuals are diverse and have diverse wants/needs. Therefore, HCPs should not assume patient preferences based on their gender or sexual identities or any other identity. It is our recommendation that HCPs have an open and non-judgemental conversation with their patients about their unique preferences, needs, and wants. To do so, LGBTQ+ health organizations, such as Pride Health, ought to offer sensitivity training to HCPs in the HRM.

Transgender patients, in particular, identified the harms associated with the diagnostic classification of gender dysphoria in the DSM-V. They mentioned that needing to demonstrate distress about one's transgender identity in order to receive gender-affirming services reinforced longstanding notions that LGBTQ+ identities are illnesses. It is our belief that general citizens will not pursue gender-affirming treatments and surgeries for cosmetic purposes. Society is overwhelmingly heteronormative and cis-normative; therefore, it is difficult to believe that cisgender patients would opt for gender-affirming treatments, ultimately exposing themselves to stigma and discrimination. It is important for health care services in HRM and around the world to follow the direction of the ICD-11 and omit dysphoria from the list of mental illness (Power, 2019; World Health Organization, 2019).

**Limitations and Considerations**

One limitation of this study was that the focus group interview guide and the interviewer did not differentiate between self-stigma and general negative perceptions of mental illness. It was difficult to parse out if patients in the focus group were discussing the realities of living with mental illness simply as facts, or if they were discussing them in a manner that was indicative of internalized stigma. Similarly, during the quantitative phase of the survey, the 28-item microaggressions scale did not mimic the same subscale structure as in the literature (King et al., 2007). The new items that we identified may not have differentiated between self-stigma and general negative perceptions of one's own mental illness. Once again, there may be a difference between if a patient is able to identify negative aspects of their illness and if a patient internalizes negative attitudes regarding their mental illness.

Another pertinent limitation of this study is the over-representation of straight women. The following study found difficulty recruiting a large sample of men and LGBTQ+ participants. This was in part due to the aims of the overall study, which hoped to recruit members from diverse ethno-racial groups. However, due to the small number of LGBTQ+ patients, the following study lacked enough power to explore the interaction between gender and sexual orientation. That is, LGBTQ+ individuals can have complex identities where they are a member of either a gender minority, a sexual minority, or both – for example, straight trans-men versus gay trans-men. The following study did not allow to comment on how lesbians may behave differently than gays or how bisexual men differently than bisexual women. Future studies should explore the mental health care experiences of LGBTQ+ people in a more comprehensive manner.

**Conclusion**

The following study was the first of its kind the HRM to explore the experiences of LGBTQ+ peoples living with psychological distress in relation to help-seeking and its association with mental health discrimination and stigma. We identified a number of differences across gender and sexual orientation, highlighting the need for future research exploring these issues in more detail. Therapeutic alliance and rapport were identified as one of the most significant outcomes associated with health outcomes and overall wellbeing. This was true for patients who access services in the mainstream health care system as well as TCAM system. Moreover, the use of TCAM practitioners is seemingly ubiquitous in the HRM. It would behoove mainstream HCPs in the HRM to ask patients about their treatment preferences and practices, particularly in relation to TCAM use. The mental health care system in the HRM must work to be more inclusive of LGBTQ+ identities; doing so will be the first step in bridging the current inequities and barriers to adequate care experienced by LGBTQ+ patients. Different LGBTQ+ people have different help-seeking experiences and preferences. Understanding the complexities of these identities will begin to inform ways that the health care system can be more inclusive of LGBTQ+ people.

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Appendix A

Tables

Table A 1

*Focus Group Sample Demographics*

| Participant | Age | Gender Identity | Sexual Orientation | Diagnosed Mental Illnesses |
|---|---|---|---|---|
| P1 | 63 | Woman | Lesbian | Depression |
| P2 | 32 | Woman | Pansexual | Anxiety, BPD, Depression, PTSD, SUD |
| P3 | 46 | Man | Asexual | Depression |
| P4 | 33 | Man | Gay | Depression |
| P5[†] | - | Man | Gay | - |
| P6 | 31 | Trans-Man | Straight | Anxiety, ADD/ADHD, Depression, OCD |
| P7[*] | 40 | Trans-Man | Bisexual | Anxiety, Depression, SUD, PTSD |

*Notes:* [†]Missing demographic information as participant did not complete the online survey.

[*]P7 was unable to attend the focus group and was interviewed individually.

ADD/ADHD, attention deficit disorder/attention deficit hyperactivity disorder; BPD, body personality disorder; OCT; obsessive compulsive disorder; SUD; substance use disorder; PTSD, post-traumatic stress disorder.

Table A 2

*Descriptive Statistics of Categorical Variables*

| Variable | *n* (%) |
|---|---|
| Woman | 375 (73.24) |
| Man | 86 (16.80) |
| Trans/Non-binary/other | 51 (9.96) |
| Straight | 355 (69.34) |
| Lesbian/Gay | 45 (8.79) |
| Bisexual | 66 (12.89) |
| Queer | 49 (9.57) |
| Caucasian (white) | 332 (64.84) |
| Indigenous | 95 (18.55) |
| Black | 58 (11.33) |
| Other | 27 (5.27) |
| Provincial Insurance | 160 (31.25) |
| Extended Insurance | 321 (62.70) |
| Other Insurance | 14 (2.73) |
| No Insurance | 17 (3.32) |
| Mental Health Diagnosis | 371 (72.46) |
| Seen Any HCP | 428 (83.59) |
| Seen GP | 330 (64.45) |
| Seen Psychiatrist | 158 (30.86) |
| Seen Psychologist | 249 (48.63) |
| Seen TCAM practitioner | 156 (30.47) |

*Note*: *N* = 512.

Table A 3

*Descriptive Statistics of Continuous Variables*

| Variable | *n* (%) | *M* | *sd* |
|---|---|---|---|
| Age | 512 (100) | 32.58 | 11.61 |
| Psychological Distress | 511 (99.8) | 30.09 | 8.38 |
| Distress Disclosure | 512 (100) | 48.61 | 16.62 |
| PPMI | 509 (99.4) | 5.30 | 1.16 |
| NPMI | 511 (99.8) | 4.72 | 1.44 |
| Discrimination | 512 (100) | 3.64 | 1.24 |

*Note: N* = 512.

Table A 4

*Coefficients for Multiple Linear Regression Predicting Psychological Distress*

| Coefficient | $B$ | 95% $CI$ | $\eta_p^2$ |
|---|---|---|---|
| Gender (women) | -1.24 | [-3.53, 1.05] | 0.00 |
| **Gender (men)** | **-3.01*** | **[-5.71, -0.32]** | **0.01** |
| Sexual Orientation (straight) | -0.55 | [-2.94, 1.84] | 0.00 |
| Sexual Orientation (lesbian/gay) | -0.81 | [-3.73, 2.10] | 0.00 |
| Sexual Orientation (bisexual) | 1.10 | [-1.48, 3.68] | 0.00 |
| **Mental Health Diagnosis** | **1.66*** | **[0.26, 3.05]** | **0.01** |
| **Distress Disclosure** | **-0.05*** | **[-0.08, -0.01]** | **0.01** |
| **Discrimination** | **1.11**** | **[0.53, 1.70]** | **0.03** |
| PPMI | -0.09 | [-0.61, 0.44] | 0.00 |
| **NPMI** | **2.47**** | **[1.97, 2.98]** | **0.16** |
| **Constant** | **17.59** | **[12.81, 22.37]** | **0.10** |

*Note:* Dependent variable is psychological distress (K10) score. Gender is dummy coded so that trans/non-binary/other is comparison group. Sexual orientation is dummy coded so that queer is comparison group. Overall $R^2$ = 0.39. ($N$ = 508; 4 missing cases).

$B$, unstandardized beta; $CI$, confidence interval; $\eta_p^2$ partial eta squared; * p < 0.05; ** p < 0.01.

Table A 5

*Hierarchical Logistic Regression – Summary of Change in Deviance.*

| Dependent Variable | -2*LL* (Model 2) | *Δ* -2*LL* |
|---|---|---|
| Seek any HCP | 239.26 | 28.03 |
| Seek GP | 473.51 | 32.14 |
| **Seek Psychiatrist** | **455.45** | **41.31[*]** |
| Seek Psychologist | 568.64 | 29.10 |
| **Seek any TCAM practitioner** | **494.43** | **68.26[**]** |

*Note:* ($N = 507$; 5 missing cases). The following table represents the results in the hierarchical logistic regression model for five independent logistic regressions, each predicting a binary dependent variable. Model 1 includes gender, sexual orientation, insurance coverage, mental health diagnosis status, distress disclosure, discrimination, positive stigma, negative stigma, and psychological distress (K10). Model 2 includes the addition of interaction terms between gender, sexual orientation, and mental health diagnosis with distress disclosure, discrimination, PPMI, and NPMI. $Δ$ -2*LL* ~ $\chi^2(24)$ and demonstrates the decrease in deviance from model 1 to model 2. -2*LL*, deviance; * $p < 0.05$; ** $p < 0.01$.

Table A 6

*Coefficients for Model 1 Predicting if Participants Sought Help from any HCP*

| Coefficient | B | 95% *CI* for *OR* | | |
|---|---|---|---|---|
| | | Lower | *OR* | Upper |
| **Distress Disclosure** | **-0.02*** | **0.96** | **0.98** | **1.00** |
| Discrimination | 0.00 | 0.69 | 1.00 | 1.45 |
| **PPMI** | **-0.32*** | **0.55** | **0.73** | **0.97** |
| NPMI | -0.21 | 0.60 | 0.81 | 1.09 |
| Gender (men) | 0.29 | 0.60 | 1.33 | 2.98 |
| Gender (non-binary) | -19.02 | 0.00 | 0.00 | . |
| Sexual Orientation (lesbian/gay) | -0.21 | 0.19 | 0.81 | 3.47 |
| Sexual Orientation (bisexual) | -0.09 | 0.28 | 0.92 | 2.98 |
| Sexual Orientation (queer) | 0.22 | 0.21 | 1.25 | 7.54 |
| **Insurance Coverage (extended)** | **-1.03**** | **0.17** | **0.36** | **0.75** |
| Insurance Coverage (other) | -0.53 | 0.07 | 0.59 | 5.09 |
| Insurance Coverage (none) | 0.35 | 0.29 | 1.42 | 6.81 |
| **Mental Health Diagnosis (has diagnosis)** | **3.22**** | **12.01** | **25.11** | **52.49** |
| Psychological Distress | -0.02 | 0.94 | 0.98 | 1.03 |
| Constant | 1.43 | | 4.20 | |

*Note:* Dependent variable is a binary variable measuring if participants sought help from any HCP (0) versus has not (1). Comparison group for categorical variables are women (gender), straight (sexual orientation), provincial coverage (insurance), and has a diagnosis (mental health diagnosis). $R^2$ = 0.31 (Cox & Snell), 0.41 (Hosmer & Lemeshow), 0.52 (Nagelkerke). $\chi^2(14)$ = 184.72, p < 0.01. (*N* = 507; 5 missing cases).

*B*, unstandardized beta; *CI*, confidence interval; *OR*, odds ratio; * p < 0.05; ** p < 0.01.

Table A 7

*Coefficients for Model 1 Predicting if Participants Sought Help from a GP*

| Coefficient | *B* | 95% *CI* for *OR* | | |
| --- | --- | --- | --- | --- |
| | | Lower | *OR* | Upper |
| **Distress Disclosure** | **-0.02**\*\* | **0.97** | **0.98** | **0.99** |
| Discrimination | -0.17 | 0.68 | 0.85 | 1.06 |
| PPMI | -0.11 | 0.73 | 0.89 | 1.08 |
| NPMI | -0.14 | 0.71 | 0.87 | 1.07 |
| Gender (men) | 0.35 | 0.77 | 1.41 | 2.60 |
| Gender (non-binary) | -1.06 | 0.11 | 0.35 | 1.11 |
| Sexual Orientation (lesbian/gay) | -0.64 | 0.21 | 0.53 | 1.31 |
| Sexual Orientation (bisexual) | -0.40 | 0.32 | 0.67 | 1.40 |
| Sexual Orientation (queer) | -0.06 | 0.35 | 0.94 | 2.53 |
| **Insurance Coverage (extended)** | **-0.79**\*\* | **0.28** | **0.46** | **0.74** |
| Insurance Coverage (other) | 0.19 | 0.33 | 1.21 | 4.43 |
| Insurance Coverage (none) | 0.89 | 0.71 | 2.43 | 8.30 |
| **Mental Health Diagnosis (has diagnosis)** | **1.97**\*\* | **4.37** | **7.16** | **11.73** |
| Psychological Distress | 0.01 | 0.97 | 1.01 | 1.04 |
| **Constant** | **1.98**\* | | **7.27** | |

*Note:* Dependent variable is a binary variable measuring if participants sought help from a GP (0) versus has not (1). Comparison group for categorical variables are women (gender), straight (sexual orientation), provincial coverage (insurance), and no diagnosis (mental health diagnosis). $R^2 = 0.23$ (Hosmer & Lemeshow), 0.26 (Cox & Snell), 0.35 (Nagelkerke). $\chi^2(14) = 150.62$, $p < 0.01$. ($N = 507$; 5 missing cases).

*B*, unstandardized beta; *CI*, confidence interval; *OR*, odds ratio; \* $p < 0.05$; \*\* $p < 0.01$.

Table A 8

*Coefficients for Model 2 Predicting if Participants Sought Help from a Psychiatrist*

| Coefficient | B | 95% *CI* for OR | | |
| --- | --- | --- | --- | --- |
| | | Lower | *OR* | Upper |
| Distress Disclosure | 0.00 | 0.98 | 1.00 | 1.02 |
| Discrimination | -0.21 | 0.61 | 0.81 | 1.08 |
| **PPMI** | **-0.42*** | **0.48** | **0.66** | **0.90** |
| NPMI | -0.13 | 0.68 | 0.88 | 1.13 |
| Gender (men) | 1.88 | 0.04 | 6.55 | a |
| Gender (non-binary) | 0.99 | 0.00 | 2.70 | a |
| Sexual Orientation (lesbian/gay) | 0.42 | 0.00 | 1.52 | a |
| Sexual Orientation (bisexual) | -0.07 | 0.00 | 0.93 | a |
| Sexual Orientation (queer) | 7.13 | 0.09 | a | a |
| **Insurance Coverage (extended)** | **-0.54*** | **0.34** | **0.59** | **0.99** |
| Insurance Coverage (other) | 0.95 | 0.38 | 2.59 | 17.78 |
| Insurance Coverage (none) | -0.42 | 0.15 | 0.66 | 2.93 |
| Mental Health Diagnosis (has diagnosis) | 0.89 | 0.01 | 2.43 | a |
| Psychological Distress | 0.01 | 0.98 | 1.01 | 1.05 |
| Gender (men) by Distress Disclosure | 0.04 | 0.99 | 1.04 | 1.09 |
| Gender (non-binary) by Distress Disclosure | -0.01 | 0.93 | 0.99 | 1.07 |
| Gender (men) by Discrimination | 0.03 | 0.54 | 1.03 | 1.98 |
| Gender (non-binary) Discrimination | -0.85 | 0.17 | 0.43 | 1.08 |
| Gender (men) by PPMI | -0.37 | 0.34 | 0.69 | 1.40 |
| Gender (non-binary) by PPMI | 0.50 | 0.58 | 1.65 | 4.71 |
| Gender (men) by NPMI | -0.56 | 0.31 | 0.57 | 1.04 |
| Gender (non-binary) by NPMI | -0.14 | 0.28 | 0.87 | 2.76 |
| Sexual Orientation (lesbian/gay) by Distress Disclosure | 0.00 | 0.94 | 1.00 | 1.07 |
| Sexual Orientation (bisexual) by Distress Disclosure | -0.03 | 0.92 | 0.97 | 1.03 |
| Sexual Orientation (queer) by Distress Disclosure | -0.01 | 0.92 | 0.99 | 1.07 |
| Sexual Orientation (lesbian/gay) by PPMI | 0.41 | 0.57 | 1.50 | 3.93 |
| Sexual Orientation (bisexual) by PPMI | -0.07 | 0.45 | 0.93 | 1.94 |
| Sexual Orientation (queer) by PPMI | -1.03 | 0.12 | 0.36 | 1.06 |
| **Sexual Orientation (lesbian/gay) by Discrimination** | **-2.09*** | **0.02** | **0.12** | **0.76** |
| Sexual Orientation (bisexual) by Discrimination | -0.13 | 0.45 | 0.88 | 1.71 |
| Sexual Orientation (queer) by Discrimination | 0.16 | 0.49 | 1.18 | 2.86 |
| Sexual Orientation (lesbian/gay) by NPMI | 1.31 | 0.72 | 3.69 | 18.99 |
| Sexual Orientation (bisexual) by NPMI | 0.53 | 0.84 | 1.70 | 3.44 |
| Sexual Orientation (queer) by NPMI | -0.37 | 0.23 | 0.69 | 2.10 |

| Coefficient | $B$ | | 95% $CI$ for OR | |
|---|---|---|---|---|
| Diagnosis (has diagnosis) by Distress Disclosure | 0.02 | 0.97 | 1.02 | 1.07 |
| Diagnosis (has diagnosis) by Discrimination | 0.50 | 0.63 | 1.65 | 4.27 |
| Diagnosis (has diagnosis) by PPMI | -0.28 | 0.33 | 0.76 | 1.76 |
| Diagnosis (has diagnosis) by NPMI | 0.08 | 0.58 | 1.09 | 2.02 |
| **Constant** | **4.46**[**] | | **86.62** | |

*Note:* Dependent variable is a binary variable measuring if participants sought help from a

psychiatrist (0) versus has not (1). Comparison group for categorical variables are women

(gender), straight (sexual orientation), provincial coverage (insurance), and no diagnosis (mental

health diagnosis). $R^2 = 0.27$ (Hosmer & Lemeshow), 0.29 (Cox & Snell), 0.40 (Nagelkerke).

$\chi^2(38) = 170.23$, p < 0.01. ($N = 507$; 5 missing cases).

*B*, unstandardized beta; *CI*, confidence interval; *OR*, odds ratio.

[a]Values larger than 500; * p < 0.05; ** p < 0.01.

Table A 9

*Coefficients for Model 1 Predicting if Participants Sought Help from a Psychologist*

| Coefficient | B | 95% CI for OR | | |
| --- | --- | --- | --- | --- |
| | | Lower | OR | Upper |
| Distress Disclosure | -0.01 | 0.98 | 0.99 | 1.00 |
| Discrimination | -0.11 | 0.74 | 0.90 | 1.09 |
| **PPMI** | **-0.26**** | **0.65** | **0.78** | **0.93** |
| **NPMI** | **-0.19*** | **0.69** | **0.83** | **1.00** |
| Gender (men) | 0.04 | 0.59 | 1.04 | 1.84 |
| **Gender (non-binary)** | **-1.16**** | **0.14** | **0.31** | **0.72** |
| Sexual Orientation (lesbian/gay) | -0.02 | 0.48 | 0.98 | 2.00 |
| Sexual Orientation (bisexual) | 0.12 | 0.61 | 1.13 | 2.09 |
| Sexual Orientation (queer) | 0.35 | 0.64 | 1.42 | 3.17 |
| Insurance Coverage (extended) | -0.27 | 0.50 | 0.76 | 1.18 |
| Insurance Coverage (other) | 0.04 | 0.29 | 1.04 | 3.69 |
| Insurance Coverage (none) | 0.19 | 0.37 | 1.21 | 3.92 |
| **Mental Health Diagnosis (has diagnosis)** | **1.56**** | **2.87** | **4.76** | **7.90** |
| Psychological Distress | 0.00 | 0.97 | 1.00 | 1.03 |
| **Constant** | **2.85**** | | **17.35** | |

*Note:* Dependent variable is a binary variable measuring if participants sought help from a psychologist (0) versus has not (1). Comparison group for categorical variables are women (gender), straight (sexual orientation), provincial coverage (insurance), and no diagnosis (mental health diagnosis). $R^2 = 0.15$ (Hosmer & Lemeshow), 0.19 (Cox & Snell), 0.25 (Nagelkerke). $\chi^2(14) = 104.65$, $p < 0.01$. ($N = 507$; 5 missing cases).

*B*, unstandardized beta; *CI*, confidence interval; *OR*, odds ratio; * p < 0.05; ** p < 0.01.

Table A 10

*Coefficients for Model 2 Predicting if Participants Sought Help from any TCAM Practitioner*

| Coefficient | *B* | 95% *CI* for OR | | |
| --- | --- | --- | --- | --- |
| | | Lower | *OR* | Upper |
| Distress Disclosure | -0.01 | 0.97 | 0.99 | 1.01 |
| Discrimination | -0.11 | 0.68 | 0.90 | 1.19 |
| PPMI | -0.20 | 0.61 | 0.82 | 1.09 |
| NPMI | 0.09 | 0.85 | 1.09 | 1.40 |
| Gender (men) | -0.97 | 0.00 | 0.38 | 93.44 |
| Gender (non-binary) | 0.51 | 0.00 | 1.66 | a |
| **Sexual Orientation (lesbian/gay)** | **9.63**[*] | **1.31** | a | a |
| Sexual Orientation (bisexual) | 1.94 | 0.01 | 6.97 | a |
| Sexual Orientation (queer) | 4.01 | 0.00 | 55.18 | a |
| **Insurance Coverage (extended)** | **-0.78**[**] | **0.27** | **0.46** | **0.77** |
| Insurance Coverage (other) | -0.81 | 0.12 | 0.45 | 1.65 |
| Insurance Coverage (none) | 1.08 | 0.51 | 2.93 | 16.90 |
| **Mental Health Diagnosis (has diagnosis)** | **8.10**[**] | **22.26** | a | a |
| Psychological Distress | 0.01 | 0.98 | 1.01 | 1.05 |
| Gender (men) by Distress Disclosure | 0.05 | 1.00 | 1.05 | 1.11 |
| Gender (non-binary) by Distress Disclosure | 0.04 | 0.97 | 1.04 | 1.11 |
| **Gender (men) by Discrimination** | **0.95**[*] | **1.15** | **2.58** | **5.77** |
| Gender (non-binary) Discrimination | 0.15 | 0.32 | 1.16 | 4.28 |
| Gender (men) by PPMI | -0.02 | 0.46 | 0.98 | 2.09 |
| Gender (non-binary) by PPMI | -0.05 | 0.35 | 0.95 | 2.57 |
| Gender (men) by NPMI | -0.67 | 0.26 | 0.51 | 1.03 |
| Gender (non-binary) by NPMI | -0.43 | 0.16 | 0.65 | 2.76 |
| **Sexual Orientation (lesbian/gay) by Distress Disclosure** | **-0.13**[**] | **0.81** | **0.88** | **0.96** |
| Sexual Orientation (bisexual) by Distress Disclosure | 0.04 | 0.98 | 1.04 | 1.11 |
| Sexual Orientation (queer) by Distress Disclosure | 0.03 | 0.96 | 1.03 | 1.11 |
| Sexual Orientation (lesbian/gay) by PPMI | 0.05 | 0.42 | 1.05 | 2.62 |
| Sexual Orientation (bisexual) by PPMI | -0.49 | 0.30 | 0.61 | 1.26 |
| Sexual Orientation (queer) by PPMI | -0.23 | 0.25 | 0.80 | 2.57 |
| Sexual Orientation (lesbian/gay) by Discrimination | 1.01 | 0.83 | 2.73 | 9.02 |
| **Sexual Orientation (bisexual) by Discrimination** | **-0.89**[*] | **0.19** | **0.41** | **0.89** |
| **Sexual Orientation (queer) by Discrimination** | **-1.94**[**] | **0.03** | **0.14** | **0.61** |
| **Sexual Orientation (lesbian/gay) by NPMI** | **-1.40**[*] | **0.07** | **0.25** | **0.83** |
| Sexual Orientation (bisexual) by NPMI | 0.58 | 0.81 | 1.79 | 3.96 |
| Sexual Orientation (queer) by NPMI | 0.82 | 0.49 | 2.27 | 10.55 |

| Coefficient | $B$ | 95% $CI$ for OR | | |
|---|---|---|---|---|
| Diagnosis (has diagnosis) by Distress Disclosure | -0.03 | 0.93 | 0.97 | 1.00 |
| Diagnosis (has diagnosis) by Discrimination | 0.05 | 0.49 | 1.05 | 2.28 |
| **Diagnosis (has diagnosis) by PPMI** | **-0.85**\*\* | **0.22** | **0.43** | **0.81** |
| Diagnosis (has diagnosis) by NPMI | -0.28 | 0.46 | 0.76 | 1.26 |
| Constant | 2.31 | | 10.05 | |

*Note:* Dependent variable is a binary variable measuring if participants sought help from any

TCAM practitioner (0) versus has not (1). Comparison group for categorical variables are

women (gender), straight (sexual orientation), provincial coverage (insurance), and no diagnosis

(mental health diagnosis). $R^2 = 0.21$ (Hosmer & Lemeshow), 0.23 (Cox & Snell), 0.32

(Nagelkerke). $\chi^2(38) = 129.73$, $p < 0.01$. ($N = 507$; 5 missing cases).

*B*, unstandardized beta; *CI*, confidence interval; *OR*, odds ratio.

[a]Values larger than 500; \* $p < 0.05$; \*\* $p < 0.01$.

Figures

| | |
|---|---|
| 1. **Distress Disclosure** *A*<br>2. **Discrimination**<br>3. **PPMI**<br>4. **NPMI**<br>5. **Insurance Coverage**†<br><br>**Psychological Distress\*** | 1. **Has seen any HCP** *B*<br>2. **Has seen a GP**<br>3. **Has seen a Psychiatrist**<br>4. **Has seen a Psychologist**<br>5. **Has seen any TCAM** |

1. **Gender Identity** *C*
2. **Sexual Orientation**
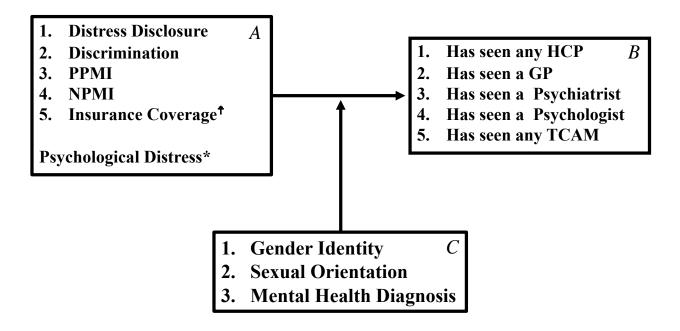3. **Mental Health Diagnosis**

*Figure 1*. Visual representation of binary logistic regression analyses. Box A represents the predictor variables, box B represents the outcome variables, and box C represents the moderators. The first model of the logistic regression included all items in box A and C predicting B. The second model added interaction terms between all items in box C with items in box A, unless otherwise noted.

†Insurance coverage was not included in moderation analysis.

\*psychological distress was a covariate, and also not included in moderation analysis.

*Figure 2.* Estimated marginal means of gender predicting psychological distress. Post-hoc

pairwise comparison following linear regression where gender is significant ($F(2, 497) = 3.03$, $p$

$= 0.04$). No adjustment for multiple comparisons. ($N = 508$; 4 missing cases). Covariates

appearing in the model are evaluated at the following values: Distress Disclosure $= 48.63$,

Discrimination $= 3.64$, PPMI $= 5.30$, and NPMI $= 4.72$.
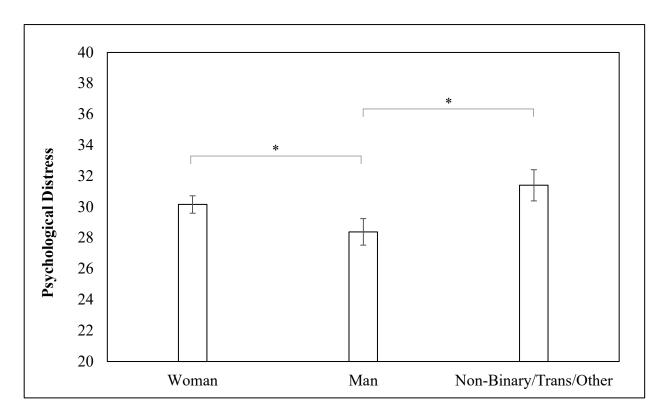
Error bars $= SE$; * $p < 0.05$.

*Figure 3.* Estimated marginal means of diagnosis status predicting psychological distress. Post-hoc pairwise comparison following linear regression where diagnosis status is significant ($F(1, 497) = 5.41$, $p = 0.02$). No adjustment for multiple comparisons. ($N = 508$; 4 missing cases). Covariates appearing in the model are evaluated at the following values: Distress Disclosure = 48.63, Discrimination = 3.64, PPMI = 5.30, and NPMI = 4.72.
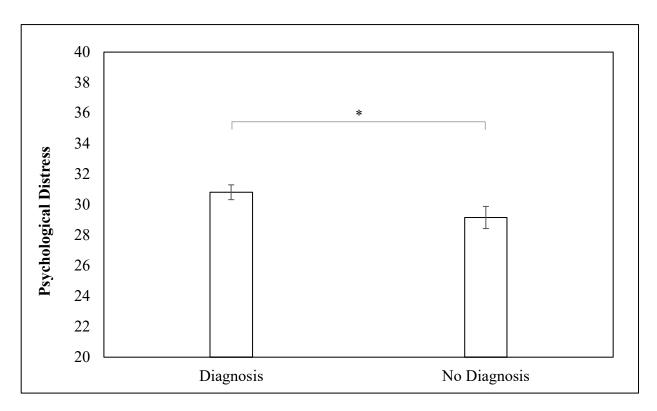
Error bars = *SE*; * $p < 0.05$.

*Figure 4*. Interaction term between sexual orientation (Lesbian/Gay = 1; Straight = 0) and discrimination predicting seeking a psychiatrist in logistic regression. Interaction is significant where $B = -2.09$, $OR = 0.12$, $p = 0.02$, indicating that as experiences of discrimination increased, lesbian/gay participants were less likely than straight participants to seek a psychiatrist. Help-seeking is a binary dependent variable, where 0 means participant has not seen a psychiatrist and 1 means that they have. ($N = 508$; 4 missing cases).

*Figure 5.* Interaction term between gender (Man = 1; Woman = 0) and discrimination predicting seeking any TCAM practitioner in logistic regression. Interaction is significant where *B* = 0.95, *OR* = 2.58, *p* = 0.02, indicating that as experiences of discrimination increased, men were more likely than women to seek help from a TCAM practitioner. Help-seeking is a binary dependent variable, where 0 means participant has not seen a TCAM practitioner and 1 means that they have. (*N* = 508; 4 missing cases).

*Figure 6.* Interaction term between sexual orientation (Lesbian/Gay = 1; Straight = 0) and distress disclosure predicting seeking any TCAM practitioner in logistic regression. Interaction is significant where $B = -0.12$, $OR = 0.89$, $p < 0.01$, indicating that as distress disclosure increased, Lesbian/gay participants were less likely to seek help from a TCAM practitioner than straight participants. Help-seeking is a binary dependent variable, where 0 means participant has not seen a TCAM practitioner and 1 means that they have. ($N = 508$; 4 missing cases).
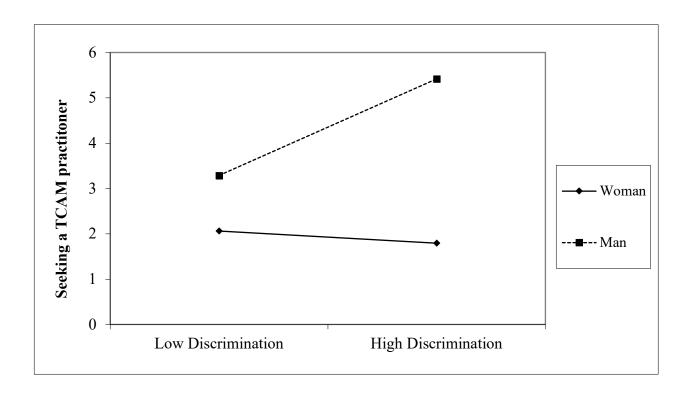
*Figure 7.* Interaction term between sexual orientation (Bisexual = 1; Straight = 0) and discrimination predicting seeking any TCAM practitioner in logistic regression. Interaction is significant where $B = -0.87$, $OR = 0.42$, $p = 0.03$, indicating that as discrimination increased, bisexual participants were less likely to seek help from a TCAM practitioner than straight participants. Help-seeking is a binary dependent variable, where 0 means participant has not seen a TCAM practitioner and 1 means that they have. ($N = 508$; 4 missing cases).

*Figure 8.* Interaction term between sexual orientation (Queer = 1; Straight = 0) and discrimination predicting seeking any TCAM practitioner in logistic regression. Interaction is significant where $B = -2.00$, $OR = 0.14$, $p < 0.01$, indicating that as discrimination increased, queer participants were less likely to seek help from a TCAM practitioner than straight participants. Help-seeking is a binary dependent variable, where 0 means participant has not seen a TCAM practitioner and 1 means that they have. ($N = 508$; 4 missing cases).
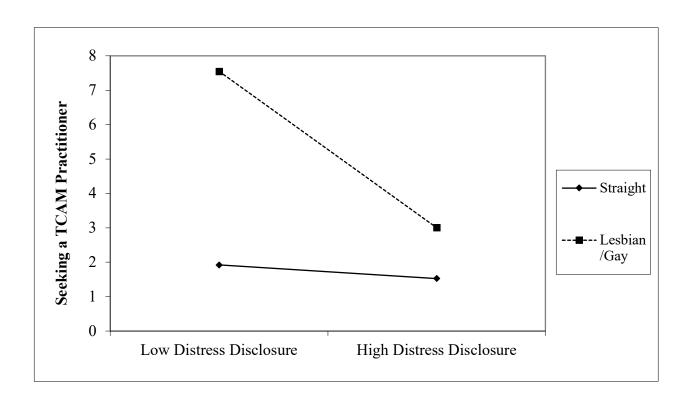
*Figure 9.* Interaction term between sexual orientation (Lesbian/Gay = 1; Straight = 0) and

negative perceptions of mental illness (NPMI) predicting seeking any TCAM practitioner in

logistic regression. Interaction is significant where $B = -1.40$, $OR = 0.25$, $p = 0.03$, indicating that

as negative perceptions of mental illness increased, lesbian and gay participants were less likely

to seek help from a TCAM practitioner than straight participants. Help-seeking is a binary

dependent variable, where 0 means participant has not seen a TCAM practitioner and 1 means
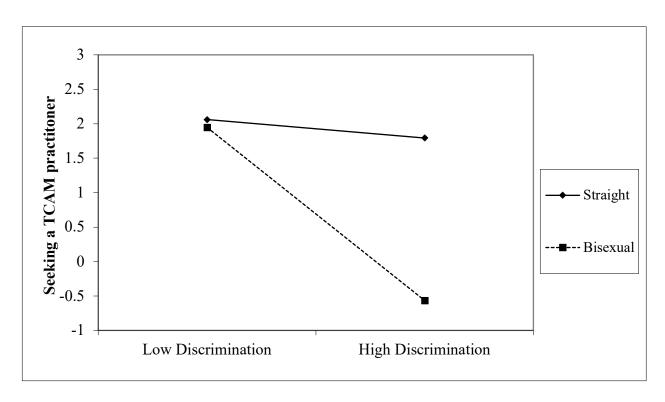
that they have. ($N = 508$; 4 missing cases).

*Figure 10.* Interaction term between mental health diagnosis (No Diagnosis = 1; Diagnosis = 0) and positive perceptions of mental illness (PPMI) predicting seeking any TCAM practitioner in logistic regression. Interaction is significant where $B = -0.83$, $OR = 0.43$, $p = 0.01$, indicating that as positive perceptions of mental illness increased, participants without a diagnosis were less likely to seek help from a TCAM practitioner than participants with a diagnosis of mental illness. Help-seeking is a binary dependent variable, where 0 means participant has not seen a TCAM practitioner and 1 means that they have. ($N = 508$; 4 missing cases).
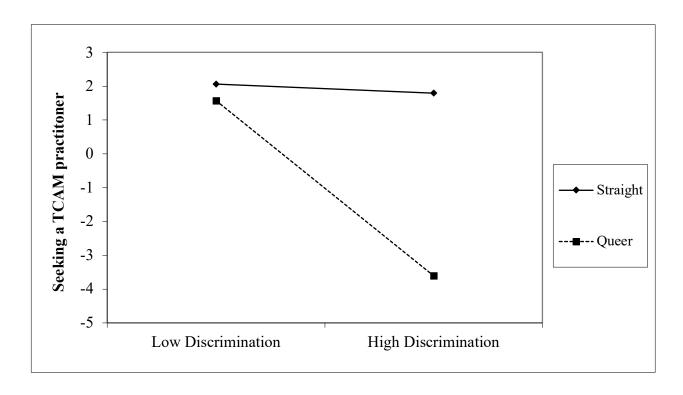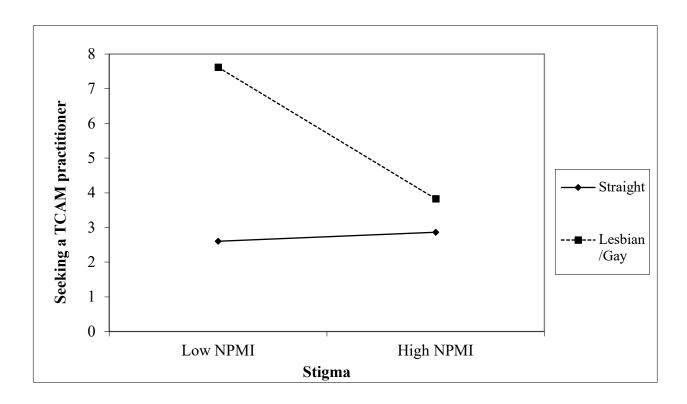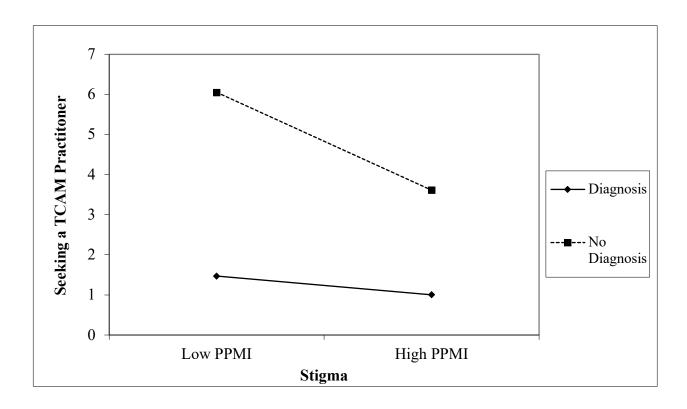
Appendix C

**Terminology**

Table C 1

*Glossary of Key Terms*

| Term | Definition |
| --- | --- |
| Bisexual | A person whose sexual orientation is towards individuals of more than one gender |
| Cisgender | A person whose gender identity is consistent with assigned sex at birth, and the social roles and norms associated with it (e.g. masculine, feminine, other gendered) |
| Heterosexism | Institutionalized norms and behaviours that arise from the assumption that everyone is/are heterosexual |
| Homophobia | The fear and hatred of (including negative attitudes or discomfort) individuals from the sexual minority |
| Lesbian/gay | A person who is attracted to the same gender (homosexual). "Gay" is typically used to refer to men, but can include women, although many women prefer the term "lesbian" |
| LGBTQ+ | An acronym to represent the sexual and gender minority. Stands for lesbian, gay, bisexual, transgender, and other queer identities |
| Trans man | An individual who was assigned female at birth and currently presents with the gender identity of a man |
| Trans woman | An individual who was assigned male at birth and currently presents with the gender identity of a woman |
| Transsexual | An individual who identifies as sex other than that assigned at birth. Some transsexuals may undergo gender reassignment surgery or hormone therapy to reflect these changes |
| Queer | A reclaimed term meant to denote an inclusive word for all of those within the sexual and gender identity minority |

*Notes:* Adapted from Barbara (2007).

Appendix D

**Survey Measures**

**Demographic Information**

1. **Age** (in years)? _____

2. **Gender Identity** - *Gender and gender-expression exists on a spectrum. In order to be as inclusive as possible, we have left an open space for each individual to identify their own gender. Some examples of gender include, but are not limited to, female, male, trans\*, two-spirit, and agender.*

   Gender: _____

3. **Sexual Orientation** - *Sexual orientation and self-expression exists on a spectrum. In order to be as inclusive as possible, we have left an open space for each individual to identify their own sexual orientation. Some examples of sexual orientation include, but are not limited to, straight, lesbian, gay, bisexual, and asexual.*

   Sexual orientation: _____

4. **Cultural Identity**

   *Your cultural identity is your self-defined sense of belonging to a group - which could include race, ethnicity, nationality, religion, province, locality - or any social group that has its own distinct culture.*

   *Please list/describe below which ethno-racial-cultural group(s) you identify with and/or that you consider to be part of your cultural identity. List as many as apply. Examples include Scottish, Mi'kmaw, Italian, African Nova Scotian, Lebanese, Inuit, Irish, Acadian, Jewish, English, Canadian, Quebecois, Chinese-Canadian, Colombian, Newfoundlander, German, Lebanese-Canadian, etc.*

   Ethno-racial- cultural identity: _____

5. **Duration in HRM -** How long have you lived in the HRM (in years)? _____

6. **Insurance Coverage** - Indicate which types of health care and/or health insurance plans that you are covered under (*select all that apply*):
   o Provincial Health Insurance (Nova Scotia Health Card)
   o Supplementary or extended health insurance (Pays for health services, such as prescription drug and dental services, that are not covered by provincial health plan)
   o Disability Insurance (Provides coverage if you cannot work temporarily or permanently due to a severe injury or illness. Usually also includes coverage for partial disability)
   o Critical illness or trauma insurance (Pays a one-time lump-sum payment if you are diagnosed with a critical illness that is specified in your policy, such as cancer or Alzheimer's disease)
   o Non-Insured Health Benefits (for Status First Nations and Inuit)
   o Medical expenses covered by other means
   o Don't know

**Mental Health Diagnosis**

7. Have you been diagnosed and/or told by a health care professional that you have any of the following mental/cognitive/learning conditions?
     o No mental health diagnosis
     o Anxiety Disorder
     o Attention Deficit Disorder/Attention Deficit-Hyperactivity Disorder (ADD/ADHD)
     o Bipolar Disorder
     o Depression (depressive disorders)
     o Learning disability
     o Substance use disorder
     o Other mental health disorder (*specify*): _____
     o Other cognitive or Intellectual disability (*specify*): _____

**Health Care Professionals**

8. Regardless of whether or not you have ever received any kind of diagnosis, have you ever seen or spoken to any of the following health care and/or support providers about your mental/emotional/psychological health or distress? (check all that apply)
     o I have not discussed my mental/emotional/psychological health or distress with any health care providers
     o Indigenous Elder, Healer, or knowledge holder
     o General Practitioner Physician (or Family Doctor)
     o Nurse
     o Psychiatrist
     o Psychologist
     o Counselor
     o Social worker
     o Naturopathic Doctor
     o Clinical/Medical Herbalist
     o Traditional Chinese Medicine
     o Acupuncturist
     o Massage Therapist
     o Chiropractor
     o Osteopath
     o Other (*specify*): _____

**Distress Disclosure Index**

| Item | Question | Strongly Disagree | | | Neutral | | | Strongly Agree |
|------|----------|:---:|:---:|:---:|:---:|:---:|:---:|:---:|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Q1 | When I feel upset, I usually confide in someone. | | | | | | | |
| Q2 | I prefer not to talk about my problems. | | | | | | | |
| Q3 | When something unpleasant happens to me, I often look for someone to talk to. | | | | | | | |
| Q4 | I typically don't discuss things that upset me. | | | | | | | |
| Q5 | When I feel depressed or sad, I tend to keep those feelings to myself. | | | | | | | |
| Q6 | I try to find people to talk with about my problems. | | | | | | | |
| Q7 | When I am in a bad mood, I talk about it with my friends. | | | | | | | |
| Q8 | If I have a bad day, the last thing I want to do is talk about it. | | | | | | | |
| Q9 | I rarely look for people to talk with when I am having a problem. | | | | | | | |
| Q10 | When I'm distressed, I don't tell anyone. | | | | | | | |
| Q11 | I usually seek out someone to talk to when I am in a bad mood. | | | | | | | |
| Q12 | I am willing to tell others my distressing thoughts. | | | | | | | |

*Notes:* (Kahn, Achter, & Shamaugh, 2001)

**Stigma and Strength Scale**

| Item | Question | Strongly Disagree 1 | 2 | 3 | Neutral 4 | 5 | 6 | Strongly Agree 7 |
|------|----------|---------------------|---|---|-----------|---|---|------------------|
| Q1 | I have been discriminated against in educational settings because of my mental health issues. | | | | | | | |
| Q2 | Sometimes I feel that I am being talked down to because of my mental health issues. | | | | | | | |
| Q3 | Having had mental health issues has made me a more understanding person. | | | | | | | |
| Q4 | I do not feel bad about having had mental health issues. | | | | | | | |
| Q5 | I worry about telling people I need or receive psychological treatment. | | | | | | | |
| Q6 | Some people with mental health issues are dangerous. | | | | | | | |
| Q7 | People have been understanding of my mental health issues. | | | | | | | |
| Q8 | I have been discriminated against by the police because of my mental health issues. | | | | | | | |
| Q9 | I have been discriminated against by employers because of my mental health issues. | | | | | | | |
| Q10 | My mental health issues have made me more accepting of other people. | | | | | | | |
| Q11 | Very often I feel alone because of my mental health issues. | | | | | | | |
| Q12 | I am scared of how other people will react if they find out about my mental health issues. | | | | | | | |
| Q13 | I would have had better chances in life if I had not had mental health issues. | | | | | | | |

| Item | Question | Strongly Disagree | Neutral | Strongly Agree |
|------|----------|-------------------|---------|----------------|
| Q14 | I do not mind people in my neighbourhood knowing I have had mental health issues. | | | |
| Q15 | I would say I have had mental health issues if I was applying for a job. | | | |
| Q16 | I worry about telling people that I take medicines/pills for mental health issues. | | | |
| Q17 | People's reactions to my mental health issues make me keep them to myself. | | | |
| Q18 | I am angry with the way people have reacted to my mental health issues. | | | |
| Q19 | I have not had any trouble from people because of my mental health issues. | | | |
| Q20 | I have been discriminated against by health professionals because of my mental health issues. | | | |
| Q21 | People have avoided me because of my mental health issues. | | | |
| Q22 | People have insulted me because of my mental health issues. | | | |
| Q23 | Having had mental health issues has made me a stronger person. | | | |
| Q24 | I do not feel embarrassed because of my mental health issues. | | | |
| Q25 | I avoid telling people about my mental health issues. | | | |
| Q26 | Having had mental health issues makes me feel life is unfair. | | | |
| Q27 | I feel the need to hide my mental health issues from my friends. | | | |
| Q28 | I find it hard telling people I have mental health issues. | | | |

*Notes:* (King et al., 2007)

**Kessler Psychological Distress Scale**

| Item | Question | None of the time | A little of the time | None of the time | Most of the time | All of the time |
|------|----------|------------------|----------------------|------------------|------------------|-----------------|
|      |          | 1 | 2 | 3 | 4 | 5 |
| Q1 | How often did you feel worn out for no good reason? | | | | | |
| Q2 | How often did you feel nervous? | | | | | |
| Q3 | How often did you feel so nervous that nothing could calm you down? | | | | | |
| Q4 | How often did you feel hopeless? | | | | | |
| Q5 | How often did you feel restless or fidgety? | | | | | |
| Q6 | How often did you feel so restless you could not sit still? | | | | | |
| Q7 | How often did you feel depressed? | | | | | |
| Q8 | How often did you feel that everything was an effort? | | | | | |
| Q9 | How often did you feel so sad that nothing could cheer you up? | | | | | |
| Q10 | How often did you feel worthless? | | | | | |

*Notes:* Participants were asked to answer these questions in relation to the past 30 days.

(Kessler et al., 2002).

Appendix E

**Principal Component Analyses**

Table E 1

*Principal Components of Distress Disclosure Scale*

| Item | Component |
|------|-----------|
| Q1 | 0.83 |
| Q3 | 0.83 |
| Q6 | 0.81 |
| Q11 | 0.81 |
| Q7 | 0.77 |
| Q12 | 0.75 |
| Q5 | -0.77 |
| Q9 | -0.79 |
| Q8 | -0.79 |
| Q4 | -0.80 |
| Q2 | -0.81 |
| Q10 | -0.81 |

*Notes:* Extraction method is principal component analysis.

Table E 2

*Principal Components of Stigma Scale*

| Item | Component | | | |
|------|------|------|------|------|
| | 1 | 2 | 3 | 4 |
| Q22 | 0.78 | | | |
| Q20 | 0.78 | | | |
| Q1 | 0.76 | | | |
| Q9 | 0.72 | | | |
| Q8 | 0.72 | | | |
| Q21 | 0.71 | | | |
| Q18 | 0.67 | | | |
| Q2 | 0.65 | | | |
| Q7 | -0.42 | | | |
| Q19 | -0.64 | | | |
| Q3 | | 0.87 | | |
| Q10 | | 0.83 | | |
| Q23 | | 0.71 | | |
| Q13 | | | 0.74 | |
| Q26 | | | 0.73 | |
| Q11 | | | 0.57 | |
| Q17 | | | | 0.65 |
| Q12 | | | | 0.72 |
| Q5 | | | | 0.73 |
| Q16 | | | | 0.69 |
| Q27 | | | | 0.76 |
| Q28 | | | | 0.80 |
| Q25 | | | | 0.80 |
| Q14 | | | | -0.53 |
| Q24 | | | | -0.61 |
| Q4 | | | | -0.48 |
| Q15[a] | | | | |
| Q6[a] | | | | |

*Notes:* Output from rotated component matrix with varimax rotation and Kaiser normalization.

Rotation converged in 5 iterations. Subscales are component 1, 2, 3, and 4, as discrimination,

positive perceptions of mental illness, negative perceptions of mental illness, disclosure,

respectively. Disclosure was excluded from analysis as it was not a variable of interest.

[a]Items factor loaded on two separate components (5 and 6). They were excluded from analysis.

Table E 3

*Principal Components of Kessler 10 Scale*

| Item | Component | | |
|---|---|---|---|
| | 1 | 2 | 1[a] |
| Q7 | 0.86 | | 0.81 |
| Q4 | 0.84 | | 0.84 |
| Q9 | 0.82 | | 0.81 |
| Q10 | 0.77 | | 0.81 |
| Q8 | 0.75 | | 0.78 |
| Q1 | 0.67 | | 0.73 |
| Q6 | | 0.85 | 0.64 |
| Q5 | | 0.85 | 0.65 |
| Q2 | | 0.66 | 0.73 |
| Q3 | | 0.60 | 0.76 |

*Notes:* Output from rotated component matrix with varimax rotation and Kaiser normalization.

Rotation converged in 3 iterations. Component 1 is depression subscale and component 2 is

anxiety subscale.

[a]Results from PCA with 1 component extracted. Results measure overall psychological distress.

Appendix F

**Focus Group Interview Guide**

**The following questions will be used to facilitate discussion during the focus group session with members of the Lesbian, Gay, Bisexual, Trans, Queer and other (LGBTQ+) community members. The questions will be presented in the order that they are listed. Probes will be asked to encourage discussion if needed.**

**Question Set 1: General questions about mental health.**

1. How have your symptoms or feelings of anxiety, depression, or general psychological distress influenced you and how you live your life?

2. How do you view your symptoms?

    a. Probe: What are some negative things that you associate with your mental illness?

    b. Probe: What are some positive things that you associate with your mental illness?

3. How do you (or how have you) managed or treated your symptoms? This can include seeing various health care providers, taking vitamins, or exercising, or any things that you have done for your mental health.

4. I will now list various health care providers. For each provider, if you have spoken to that provider about your symptoms or feelings of anxiety, depression, or general psychological distress, (1) why did you choose to see that provider? (2) what were your experiences? (3) Were you satisfied in terms of reaching your goals in relation to your symptoms (whether to treat or manage symptoms)? (4) For those who have not spoken to this particular health care provider, why didn't you?

    a. Health Care providers:

        i. General Practitioner

        ii. Psychiatrist

        iii. Psychologist

        iv. Any other mainstream health care practitioners (e.g. counselor, nurse, etc.)

            • *Note: participants will be asked to identify what type of provider they saw.*

        v. Any non-mainstream health care practitioner (e.g. naturopathic doctor, clinical herbalist, massage therapist, etc.)

            • *Note: participants will be asked to identify what type of provider they saw.*

5. What is your knowledge of non-mainstream (e.g., Traditional and complementary) medicine in treating symptoms of anxiety and/or depression?

**Question Set 2: Questions specific to experience as LGBTQ+ individuals.**

[Script:] Part of what we hoped to figure out from our initial survey was how the experiences of different groups (various cultures, races, and sexual/gender minorities) may vary. We weren't able to do this as a result of limitations in our statistical analyses, so we are holding this focus group to better understand the experience of LGBTQ+ individuals.

6. We want to know how your LGBTQ+ identity may have influenced how you view your symptoms and/or how you manage your symptoms including your help-seeking preferences?

7. [*Results from the survey will be shown using a PowerPoint as a visual aid*] How do these results compare to your experiences and reasons for seeking help from various health care practitioners? Has your LGBTQ+ identity played a role in this?

8. As a member of the LGBTQ+ community, do you feel that the services of the mental health care system are meeting your needs?