Mental Health Care with 2SLGBTQIA+ Clients during COVID-19

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Abstract

Research with 2SLGBTQIA+ communities is a growing domain of interest in Canada (MHCC, 2012), yet, still considered inadequate (Waite & Denier, 2019). Research on mental health, for instance, is robust in the description of the characteristics of mental health across these populations (Filice & Meyer, 2018; Kidd et al., 2016; McIntyre et al., 2011; Veltman & Chaimowitz, 2014); however, there are insufficient initiatives investigating the kinds of care and treatment that would best serve these communities (Pachankis et al., 2022).

2SLGBTQIA+ populations are known to be negatively affected by stigma and discrimination, which impact mental health outcomes and treatment access (Filice & Meyer, 2018; Kidd et al., 2016; McIntyre et al., 2011; Veltman & Chaimowitz, 2014). Thus, it is vital to understand how these communities experience oppression and find ways to buffer against the perils of prejudice. The pandemic is an exceptional circumstance that offers insight to exceedingly difficult conditions, which can shed light on exacerbated inequities, as well as protective coping strategies. Moreover, the pandemic impacted delivery of mental health care, with many practitioners transitioning to remote service provision. Mental health care providers working with 2SLGBTQIA+ populations during the pandemic are in an advantageous position to provide illuminating information on service provision, as well as the challenges and wellbeing of 2SLGBTQIA+ populations.

This study focuses on the experiences of mental health care service providers who worked with 2SLGBTQIA+ communities in Montreal, Canada during the first year of the coronavirus disease pandemic. Using the Integrated Social Justice Consultation Model (Sinacore, 2022) as an epistemological framework, this qualitative inquiry study employed interpretive phenomenology to explore clinician experiences. Participants were 14 members of a network of clinicians dedicated to providing affirmative mental health care for sexual and gender minorities. Data was collected via demographic survey, three focus groups, and 14 individual interviews. Two major domains emerged from the results: the evolution of service provision in response to the pandemic, and subsequent changes in therapeutic processes. These domains offer insight on remote therapy, approaches to practice, new clinical experiences that arose during the pandemic, clinician knowledge mobilization, clinician resource sharing, and how 2SLGBTQIA+ clients were impacted during the pandemic.

Keywords: coronavirus, COVID-19, infectious disease outbreak, pandemic, wellbeing, community psychology, mental health care, 2SLGBTQIA+, remote service delivery, social justice, minority stress

Résumé

Bien que la recherche en santé mentale au sein des communautés 2SLGBTQIA+ au Canada soit en constante évolution (MHCC, 2012) elle reste insuffisante et inégale (Waite & Denier, 2019). En effet, alors que les spécificités des troubles mentaux touchant ces populations sont plutôt développées (Filice & Meyer, 2018; Kidd et al., 2016; McIntyre et al., 2011; Veltman & Chaimowitz, 2014) les propositions autour des soins et des traitements demeurent en deçà de ce que mérite ces communautés (Pachankis et al., 2022).

Les discriminations et les stigmatisations dont sont victimes les communautés 2SLGBTQIA+ impactent les résultats sur la santé mentale et l'accès aux traitements (Filice & Meyer, 2018; Kidd et al., 2016; McIntyre et al., 2011; Veltman & Chaimowitz, 2014). Il est essentiel de comprendre l'oppression dont ses communautés font l'expérience et se prémunir contre les préjugés. Les circonstances exceptionnelles de la pandémie offrent un aperçu de la difficulté de la prise en charge, des conditions autour de celle-ci, et mettent en lumière les inégalités dans le traitement et dans la mise en place d'une stratégie de protection. La pandémie a également impacté l'accès aux soins en matière de santé mentale avec notamment la mise en place des consultations et des services à distance de la part des médecins et praticiens. Il est du ressort des professionnels de la santé mentale travaillant auprès des communautés 2SLGBTQIA+ d'apporter des informations sur l'accès des services, les défis rencontrés par ces populations et leur bien-être, pendant la période de pandémie.

Cette étude s'intéresse aux professionnels de la santé mentale œuvrant auprès des populations 2SLGBTQIA+ à Montréal pendant la première année de la pandémie de Covid19. Cette enquête qualitative base son cadre de travail épistémologique selon le Integrated Social

Justice Consultation Model (Sinacore, 2022) et explore les expériences cliniques selon une analyse interprétative phénoménologique.

Les 14 participants de cette enquête, sont tous des professionnels de la santé mentale travaillant avec les minorités de genre et de sexe. Les données ont été collectés selon une enquête démographique, trois groupes d'étude et 14 entretiens individuels. Deux sujets sont majoritairement ressortis de cette enquête : l'évolution des services de prise en charge à la suite de la pandémie et les changements dans les processus thérapeutiques. Ces résultats offrent un aperçu de la thérapie à distance et des nouvelles approches cliniques mises en place pendant la pandémie, ainsi que la mise en partage des ressources et des connaissances cliniques, et des répercussions de cette période sur les patients 2SLGBTQIA+.

Mots clés : coronavirus, COVID19, maladie infectieuse, pandémie, bien-être, communauté psychologie, santé mentale, 2SLGBTQIA+, service à distance, justice sociale, stress des minorités.

Dedication

I dedicate this project to the participants and their incredible network of clinicians. I could not have even dreamed of this project, much less begun this work, without this team. Thank you for your willingness to engage, be open, explore in the unknown, think through the impossible, and be in community. These relationships have been deeply formative, enduringly supportive, and somehow, both grounding and transformative. I cherish this community of care and I am pleasantly astonished by the magnitude of its reach and the creativity of its endeavors. Thank you, dear team members, for validating this work from the beginning and for your enthusiastic responses throughout.

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Contribution to Original Knowledge

This dissertation represents a contribution to original knowledge as one of the few studies to date to explore the experiences of a group of mental health care providers working with 2SLGBTQIA+ populations during the coronavirus pandemic in Canada. This study is unique in that it reflects the experiences of clinicians working with marginalized clientele, as well as the experiences of clinicians with marginalized identities. Further, as participants in this study were part of a network of clinicians, findings indicate the benefits of belonging to a professional community, particularly in navigating the difficulties of the pandemic. This study expanded on a growing literature that sheds light on how clinicians adapted their practices to the changing circumstances of the pandemic, and clinician perspectives on how this impacted care. Moreover, this study facilitated clinician understanding of their practices during the pandemic, as well as the ways their 2SLGBTQIA+ clients were affected by and coped with the conditions of the pandemic.

Findings from this study contributed to a body of knowledge exploring the transition of mental health care to remote service delivery during the pandemic. Uniquely, this study demonstrated the use of community-based knowledge mobilization amongst clinicians to transition their practices to remote care. The most widely endorsed resource that helped guide clinicians in this study set up and adapt their practices, was speaking with each other. Together, clinicians reported developing skills to adapt to the pandemic and gaining confidence in their work. Further, clinicians reported wanting to continue to collectively imagine ways to move forward and to navigate complex clinical decisions about future modes of remote, in-person, and hybrid service provision. Findings indicated that there were accessibility needs for clinicians during the pandemic and emphasized integrating the needs and preferences of clinicians, in addition to clients, into decisions about future service provision modalities (e.g., in-person, remote, hybrid).

Many of the results regarding 2SLGBTQIA+ populations in this study contributed to and are reflected in broader literature examining pandemic experiences. This study emphasized the impact of discrimination within these communities, as well as community capacity to foster collective resources. Clinicians demonstrated their awareness of how clients were discriminated against based on their identities within interpersonal relationships, as well as relationally within organizations, institutions, and societally. Results illustrated how clients with multiple intersecting minoritized identities (e.g., trans, neurodiverse, and experiencing financial precarity, or racialized, refugee, lingual minority and gay) were more likely to experience barriers to relationships and resources, in several ways at once. Additionally, this study illustrates creative ways clients navigated the risks and uncertainties of the pandemic, while also indicating that privilege facilitated this resource-intensive task. Some of the complexities of care indicated in this study reflect the likelihood of 2SLGBTQIA+ clients to be embedded into community-built systems of care, as well as the detriment of insidious prejudice and discrimination against these populations.

This study also contributed to literature exploring approaches to practice during the pandemic, particularly with 2SLGBTQIA+ clients. Participants were part of team of clinicians who facilitated systemic understandings and interventions. This study demonstrated the importance of clinicians working together, to share knowledge, resources, and community-based understandings of mental health care, which was exceptionally crucial to navigate the coronavirus pandemic. Further, this study emphasized the inherent personal value that clinicians derived from engaging in meaningful clinical work. For 2SLGBTQIA+ clinicians working with

2SLGBTQIA+ clientele, the skills and expertise needed to work within one’s own community were illustrated, as well as new challenges that arose working within small communities during the pandemic, when there were increasingly shared experiences between clients and clinicians. Lastly, findings illustrated how clinicians adapted therapeutic processes in response to changes to the therapeutic frame, or the parameters of therapy, (e.g., physical space, modes of communication, financial compensation), which were altered by conditions of the pandemic.

This study has contributed original knowledge to the understanding of mental health provision during the pandemic, in Canada, specifically with a team of providers working with 2SLGBTQIA+ populations. Findings provide insight on transition to remote care, adaptations to therapeutic processes, clinician experiences, and clinician perspectives of client experiences.

Contribution of Authors

I, Jann Tomaro, am the author of this dissertation. I was responsible for conceptualizing the study design, conducting the literature review, collecting data, analyzing and interpretating data, and writing this dissertation. However, I did not work alone. My doctoral research supervisor, Dr. Sinacore was involved throughout this research project, guiding the process of research, and providing invaluable feedback and recommendations at every phase. Dr. Sinacore and two independent researchers contributed to auditing the analyses of data. In addition, my work has greatly benefitted from feedback from Dr. Wendt at the time of my project proposal and final dissertation draft.

Chapter One: Introduction

The outbreak of the coronavirus disease 2019 (COVID-19) has had significant detrimental impact globally. Healthcare systems were overburdened for lengthy periods of time (Pujolar et al., 2022) and many people became acutely ill and died. Canada, and specifically Montreal, Quebec, were considered high-risk areas for COVID-19 at the time of this research study. Worldwide, countries, including Canada, responded to the fast spread of this highly infectious disease by enforcing quarantines, isolation, and social distancing policies (Brooks et al., 2020; *How it spreads*, 2020). These measures were enacted to slow the spread of the virus, allowing health care systems to be able to respond more adequately (*How it spreads*, 2020). At the same time, many services and business adapted to protect workers and general populations by limiting access or pausing service delivery. Across Canada, all businesses and services except those deemed “essential” were mandated to close during peak waves of the coronavirus pandemic during 2020, and many essential services moved to remote service delivery options (*Coronavirus disease (COVID-19): Prevention and risks*, 2020). Further, essential services faced restrictions; for instance, restaurants were limited to take out, and grocery stores implemented protective strategies, such as providing hand sanitizers, lowering store capacity, and providing workers with masks (see Appendix L for a timeline of Quebec closures and distancing mandates). Many forms of healthcare, including mental health care, began remote delivery, using phone and digital technology to provide care.

Remote mental health care was particularly important considering the tremendous mental health risks associated with experiencing infectious disease outbreaks, such as the COVID-19 pandemic (Torales et al., 2020). Psychological wellbeing is affected by the uncertainty and fears integral to infectious disease, as well as to certain conditions of outbreaks, including mandated quarantines, curfews, and social distancing. Provision of mental health services during pandemics is of the utmost importance due to high rates of negative psychological symptoms, including fears, anxieties, distress, and low mood (Brooks et al., 2018; Brooks et al., 2020; Chew et al., 2020). In response to the overwhelming mental health care needs at the time of the coronavirus pandemic, mental health practitioners in Canada and worldwide began remote delivery to ensure continuous service provision. Despite years of remote service delivery prior to the pandemic, and despite previous research calls for more access to remote therapy, never before had there been such a catalytic precedent to transition to remote therapy (Wind et al., 2020). It is necessary to understand the effects of this service delivery transition and the impact of the pandemic on mental health and mental health care.

Research from previous pandemics has demonstrated that certain populations and subgroups have unique experiences, resiliencies, and vulnerabilities during infectious disease outbreaks (Brennan et al., 2020; Holmes et al., 2020; Logie & Turan, 2020). The contexts specific to 2SLGBTQIA+[1] communities may influence the ways in which infectious disease outbreaks impact these populations (Brennan et al., 2020; Logie & Turan, 2020; Meyer, 2003). As the result of social, political, and historical inequities, sexual and gender minorities face challenges that can significantly impact their wellbeing; at the same time, however, these populations also have a history of developing empowering coping strategies to face adversity (Brennan et al., 2020; Greteman, 2021; Logie & Turan, 2020; Meyer, 2015). This combination

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[1] In this dissertation, "2SLGBTQIA+" is used to speak about the many representations of gender and sexualities that diverge from Canadian heteronormative and cisnormative models of gender and sexuality. It includes people who identify as Two-Spirit, lesbian, gay, bisexual, trans, nonbinary, queer, intersex, asexual, as well as a diversity of other genders and sexual orientations that would be impossible to capture, even imperfectly, within an acronym.

suggests that sexual and gender minorities are likely to face augmented hardships during the pandemic yet may also be likely to develop resources to deal with these challenges.

Research has demonstrated the many and pervasive effects of stigma that 2SLGBTQIA+ people face, stemming from cisgenderism and heterosexism, as well as gender and sexual phobias (e.g., homophobia, transphobia) (Hendricks & Testa, 2012; McInroy et al., 2022; Meyer, 2003; O'Handley, 2023). Relational consequences of prejudice include increased vulnerability to rejection and isolation, as societal views on gender and sexuality impact relationships for sexual and gender minorities in every realm, including with their families, work, friends, and intimate partners (Brennan et al., 2020; Logie & Turan, 2020; Meyer, 2003). During the context of the pandemic, positive social connection, a known buffer and antidote to the harms of discrimination, was limited by quarantine measures such as social distancing restrictions, leaving these communities with less protection from the perils of prejudice (Blair & Holmberg, 2008; Brennan et al., 2020; Logie & Turan, 2020; Meyer, 2003) (see Appendix L for a timeline of Quebec closures and distancing mandates). Further, the relational discrimination these communities face is associated with being at risk for experiencing physical and psychological violence (Brennan et al., 2020; Logie & Turan, 2020; Meyer, 2003). Early pandemic research demonstrated that domestic violence was reported at higher than usual rates during the pandemic (Campbell, 2020; Jenkins et al., 2021), and 2SLGBTQIA+ people may be more susceptible to this domestic harm than cisgender and heterosexual peers, with limited ways to protect themselves (Brennan et al., 2020; Logie & Turan, 2020; Meyer, 2003). Furthermore, elevated rates of mental illness within 2SLGBTQIA+ communities is well documented; these mental health disparities are attributed to the prejudice, discrimination, and stigma put upon these communities (Hatzenbuehler, 2009; Hendricks & Testa, 2012; Meyer, 2003). Pre-existing mental health conditions were predicted to be amplified by the stress, anxiety, and uncertainty provoked by the pandemic, and thus it was likely that these populations would experience higher-than-usual levels of mental distress (Brennan et al., 2020; Logie & Turan, 2020; Meyer, 2003). Moreover, there are medical interventions essential to the mental wellbeing of some within these communities (i.e., hormone treatment, gender reaffirming surgeries, STI testing, antiretroviral therapy) that were compromised by health system burdens and quarantine restrictions during the pandemic (Brennan et al., 2020; Logie & Turan, 2020; Rosa et al., 2020). Considering these parameters, at early stages of the pandemic, it was possible to predict a detrimental impact on 2SLGBTQIA+ mental health that warranted research as well as nuanced care from mental health practitioners.

However, sexual and gender minority communities are also known for their resilience and ability to overcome tremendous challenges and barriers (Asakura & Craig, 2014; Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017; Lev, 2015). Insights may be gleaned from 2SLGBTQIA+ populations on how to buffer against the difficulties of the pandemic. These communities hold a shared knowledge of navigating a complex infectious disease outbreak, learned from experiences of the HIV/AIDS pandemic beginning in the 80's (Logie & Turan, 2020). Moreover, these communities have a long history of using activism, advocacy, and social support as means of care (Asakura & Craig, 2014; Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017; Lev, 2015). With nurturing networks as a norm in these communities, there are likely to be distinctive ways of responding to the COVID-19 pandemic.

Governmental prioritization of research regarding mental health concerns for 2SLGBTQIA+ populations (MHCC, 2012) has supported researchers in detailing the rates and determinants of mental health across these populations (Kidd et al., 2016) and client experiences of mental health care (Filice & Meyer, 2018; McIntyre et al., 2011; Veltman & Chaimowitz, 2014). Yet research regarding these populations is still lacking (Waite & Denier, 2019). And, despite evidence of high mental illness rates within these populations, there are few research initiatives mapping out adequate mental health care approaches for sexual and gender diverse clients (O'Shaughnessy & Speir, 2018; Pachankis et al., 2022). Further, many clinicians lack comprehensive training in working with 2SLGBTQIA+ populations, (Melendez, 2021; Obasi et al., 2023; Rutherford et al., 2012; Stryker et al., 2022), which can result in providing insufficient or even harmful care (Morris et al., 2020; O'Shaughnessy & Speir, 2018). However, there are some specialized practitioners working with 2SLGBTQIA+ populations who have developed distinct knowledge and approaches to practices (Rutherford et al., 2012). The unique experiences of service providers trained to work with 2SLGBTQIA+ clientele can provide greater understanding of care for sexual and gender diverse communities.

Considering the ongoing impact of stigma and discrimination faced by 2SLGBTQIA+ populations, it is vital to gather more information about how these communities experience oppression and find ways to buffer against the perils of prejudice. The pandemic is an exceptional circumstance that offers insight to exceedingly difficult conditions which can shed light on exacerbated inequities, as well as protective coping strategies. Mental health providers working with 2SLGBTQIA+ populations hold an advantageous position that can provide illuminating information on service provision as well as the challenges and wellbeing of 2SLGBTQIA+ populations during the pandemic. Moreover, the pandemic impacted delivery of health and mental health care services, with many practitioners offering remote care. Research is necessary to fully understand the implications of this pandemic on mental health and mental health care. Potential gains include insights on mental health risks, remote care delivery, wellbeing practices, and resiliencies that may inform future initiatives.

This study worked with mental health practitioners serving 2SLGBTQIA+ communities to gain deeper understanding of the ways in which the pandemic impacted mental health care delivery, 2SLGBTQIA+ communities, and mental health care clinicians working with gender and sexual diverse populations. The aim of this research was to examine the experiences of mental health care service providers who work with 2SLGBTQIA+ communities in Montreal, Canada during the first year of the COVID-19 pandemic. An Integrated Social Justice Consultation Model (Sinacore, 2022) was used to guide the epistemological framework of this study. Interpretive phenomenology, a qualitative inquiry approach used in psychological research to capture detailed descriptions of personal lived experiences (Eatough & Smith, 2008; Smith & Osborn, 2015), was selected to guide data collection and analysis. Data was collected via demographic survey, focus groups, and individual interviews.

Chapter Two: Review of the Literature

Mental Health and Infectious Disease Outbreaks

Infectious diseases are profound in the ways they shape society and culture (Huremović, 2019). Looking to previous infectious disease outbreaks can provide insight for predictions, preventative measures, and useful coping mechanisms, (Brooks et al., 2018; Brooks et al., 2020; Chew et al., 2020). Yet, few psychological studies have actually examined the effects and lessons gleaned from past outbreaks (Huremović, 2019). The studies that do exist demonstrate the significant impact on mental health and community wellbeing from previous infectious diseases, such as various Ebola outbreaks (beginning in 1976 with the largest outbreak in 2014-2016), the severe acute respiratory syndrome (SARS) in 2002/2003, the H1NI influenza in 2009, the Middle East respiratory syndrome (Camargo et al.) in 2012 (Chew et al., 2020) and the HIV/AIDs pandemic (Betancourt, 2020; Edelman et al., 2020; Hargreaves et al., 2020; Logie & Turan, 2020). Studies indicate that there are pervasive psychological repercussions associated with infectious disease outbreaks that affect all populations, even those within populations uninfected by the disease, which can have long-lasting effects after the outbreak (Chew et al., 2020). Psychological responses across these infectious diseases have included anxiety, fear, depression, anger, guilt, grief, loss, stigmatisation and symptoms of posttraumatic stress (Chew et al., 2020). However, positive responses have also been recorded and include positive social connective factors such as empowerment and compassion towards others (Chew et al., 2020).

Research on COVID-19 has demonstrated the pandemic’s deleterious effects on mental health across populations, including elevated rates of anxiety, depression, suicidality, and substance use (Jenkins et al., 2021). These high symptom rates are associated with isolation measures, unemployment, economic uncertainty, burdening caregiver roles, housing instability and food insecurity (Jenkins et al., 2021). Further, burgeoning literature is documenting how the risk of mental health challenges increases in relation with social inequities, which are determined according to privileges and power associated with social indicators such as race, gender, age, language, religion, disability, sexual orientation, prior mental health conditions, and resources (e.g., employment, income, food, housing, social support) (Jenkins et al., 2021).

Certain populations are at greater risk for mental distress during pandemics, according to research on prior infectious disease outbreaks. For instance, those working in primary health care roles during infectious disease outbreaks are known to suffer severe mental health outcomes (Brooks et al., 2018; Brooks et al., 2020; Nobles et al., 2020; Pfefferbaum & North, 2020). Risk for psychological distress is linked to working conditions that impact mental health, such as feeling untrained and unprepared; not having personal protective equipment; being exposed to high-risk work environments (e.g., feeling unsafe or at risk of infection); having to make difficult decisions about limited resources; having a lack of control in work; feeling compromised in the ability to perform expected roles; experiencing stigma; and, experiencing social rejection and isolation (Brooks et al., 2018; Brooks et al., 2020; Nobles et al., 2020; Pfefferbaum & North, 2020). The greatest mental health risks for health care professionals are attributed to social isolation. Lack of connection with colleagues, isolation from friends and family, and rejection due to stigma were associated with low mood and low motivation (Brooks et al., 2018; Brooks et al., 2020; Nobles et al., 2020; Pfefferbaum & North, 2020).

Not surprisingly, quarantines are known to be one of the most profound factors to worsen mental health during infectious disease outbreaks (Brooks et al., 2018; Brooks et al., 2020; Nobles et al., 2020; Pfefferbaum & North, 2020). Being quarantined has been associated with symptoms including suicidality (Barbisch et al., 2015), acute stress (Bai et al., 2004) and posttraumatic stress (Wu et al., 2009), as well as a lack of motivation to work, deterioration of work performance (Brooks et al., 2018), increased alcohol use (Wu et al., 2008), feelings of stigma (Brooks et al., 2018), anger, and avoidant behaviors (Marjanovic et al., 2007). Due to the emotional distress caused by restrictions, research participants have reported that it was difficult to fully comply with quarantine protocols during previous quarantines (Pfefferbaum & North, 2020). Brooks and colleagues (2020) outlined the difficulties of quarantines during past outbreaks, noting of the social separation, restriction of freedom, uncertainty, and boredom, all of which created an unpleasant experience and contributed to irritability, depression, low mood, insomnia, emotional disturbance and emotional exhaustion. The length of quarantine and extensions of quarantine were known to worsen negative psychological symptoms (Brooks et al., 2018). Moreover, negative psychological symptoms lasted well after the quarantine ended, coupled with other long-term effects such as a delayed return to normal functioning, vigilant handwashing, and avoidance of crowds (Brooks et al., 2020).

Insights from previous pandemics should be used to mitigate adverse psychological effects in current or future infectious disease outbreaks, such as the coronavirus pandemic. For healthcare workers, feeling trained, being prepared, and having sufficient resources to carry out work tasks contribute to the protection of wellbeing. But most impactful is having support from employers and colleagues (Brooks et al., 2018). In general, support and perceived support from others, including friends and family, buffered negative mental health outcomes in past infectious disease outbreaks, and was considered essential for those in quarantine (Brooks et al., 2018). Additionally, those who spent less time in quarantine and who stayed physically healthy had better mental health outcomes (Brooks et al., 2018).

Lessons from HIV/AIDS for COVID-19

Extant research from previous infectious disease outbreaks has focused on health care workers, leaving out the experiences of others, namely 2SLGBTQIA+communities. What is known suggests that these populations are vulnerable to mental health risks, even more so during extreme social isolation conditions, such as those implemented during the COVID-19 pandemic. However, in addition, research is beginning to show that these populations are likely to have specific experiences that may actually be beneficial for navigating the complexities of infectious disease outbreaks (Betancourt, 2020; Guta & Newman, 2021; Haritaworn, 2020; Quinn et al., 2021). We see evidence of these lessons from the HIV/AIDS pandemic.

The human immunodeficiency viruses (HIV), which if untreated, can cause acquired immunodeficiency syndrome (AIDS), is an infectious disease that first saw a widespread outbreak in the 1980s (*HIV/AIDS*, 2019), and which offers valuable lessons for the COVID-19 pandemic (Edelman et al., 2020; Guta & Newman, 2021; Hargreaves et al., 2020; Logie & Turan, 2020). Worldwide, HIV has affected many people and remains an ongoing present-day endemic disease (*HIV/AIDS*, 2019). Historically in North America, HIV has had devastating impacts on 2SLGBTQIA+ communities (*HIV/AIDS*, 2019). Gay and bisexual men and trans women have been disproportionately affected by HIV/AIDS in North America, as have racialized people, injection drug users, people in prison, sex workers and their clients (*HIV/AIDS*, 2019).

HIV is considerably different from COVID-19, being more deadly and spreading less quickly, mainly through the exchange of bodily fluids such as blood, breast milk, semen, and vaginal secretions. In contrast, COVID-19 kills a small percentage of those infected but is transmitted easily with close physical proximity through coughing and sneezing (Edelman et al., 2020; Hargreaves et al., 2020; *HIV/AIDS*, 2019). Despite their many differences, there are similarities between these diseases. For example, both disease outbreaks have highlighted fault lines in health care systems. Initially there were no cures, pharmaceuticals, or vaccines for either. Additionally, population behavior interventions were widely endorsed means to slow transmission for both COVID-19 and HIV (Hargreaves et al., 2020). Socio-demographics including gender, sexual orientation, race, and ethnicity are considered risk factors for HIV as well as COVID-19, pointing to the vulnerabilities faced by marginalized communities in many health crises. Further, during both outbreaks misunderstandings of undergirding health determinants contributed to the perpetuation of forms of stigma and prejudice for select populations, such as 2SLGBTQIA+ people (Edelman et al., 2020; Hargreaves et al., 2020). The dearth of adequate response to the HIV outbreak from governments in North America and Europe is known to have been fuelled by discrimination towards sexual and gender minorities. While response to the COVID-19 pandemic overall has been much more vigorous, the lack of early reaction is similar to the political reluctance to address HIV outbreaks. Similarly, the activism that played a critical role in shedding light on HIV was reflected in scientific and health care efforts to bring awareness to COVID-19 (Edelman et al., 2020). Further, health care system inequalities and inadequacies that were highlighted with the arrival of HIV and resulted in healthcare system changes, are patterns that have reverberated with COVID-19 (Edelman et al., 2020).

Early on it was apparent that there would be many repetitions of mental health issues with COVID-19 that were seen before with HIV (Hamza Shuja et al., 2020; Shalev & Shapiro, 2020). Stigma plagued persons living with HIV/AIDS, their caretakers, and populations associated with the disease (Edelman et al., 2020; Hamza Shuja et al., 2020; Hargreaves et al., 2020). Similarly, throughout the COVID-19 pandemic, stigma and prejudice were aimed at health care workers, authority workers, and people of Asian descent. These attacks included rejection, threats, and violence, as well as scorn from political leaders (Hamza Shuja et al., 2020). Loss and grief which were pervasive with HIV arose again with COVID-19 (Edelman et al., 2020). HIV/AIDS created extremely challenging psychological contexts which persisted for years, namely of navigating uncertainty and managing a lack of knowledge about the virus including effective treatments. This context similarly marked the beginning of the COVID-19 pandemic (Edelman et al., 2020). Feelings of paranoia and mistrust for medical care which were prevalent with the outbreak of HIV also returned during the coronavirus pandemic (Hamza Shuja et al., 2020).

However, alongside these calamities, several beautiful outcomes emerged: social connectivity and social change occurred in tandem during the HIV pandemic and have re-emerged during COVID-19. Researchers have noted higher rates of social support, community connection, optimism, and hope, factors known to have tremendous power to mitigate negative mental health symptoms and contribute to better disease control (Edelman et al., 2020; Hamza Shuja et al., 2020). Further, increased participation in activism and advocacy, as well as critical consciousness-raising were parallel outcomes across both disease outbreaks (Betancourt, 2020; Guta & Newman, 2021; Haritaworn, 2020; Quinn et al., 2021).

Remote Mental Health Care

In response to the pandemic, many mental health care providers began to offer remote services to provide mental health care without risking infection. Early on, there was a flurry of expedited papers reporting on mental health care during the pandemic (*CORD-19*, 2020). The sudden switch to remote therapy that was necessary for most practitioners was a turning point in mental health service provision (Wind et al., 2020). Despite previous barriers preventing implementation of remote therapy, the context of the pandemic enticed many, if not most, clinicians to offer remote services, and prompted mental health care systems worldwide to include digital technologies (Aghili & Arbabi, 2020; Nobles et al., 2020; Stoll et al.; Torous et al., 2020). In Canada, the associations regulating mental health practices (i.e., Canadian Psychological Association, Canadian Counseling and Psychotherapy Association) encouraged remote therapy and offered free online workshops and best practice guidelines to help clinicians transition their practices (*COVID-19 Member Messages*, 2020). More online mental health services have emerged since the beginning of the pandemic, such as crisis lines, youthlines, chat support and peer support groups. A free online mental health care service to support primary health care workers was also developed by volunteer mental health care providers (*COVID-19 Member Messages*, 2020). Additionally, new policy was developed in response to the pandemic. For instance, insurance companies extended coverage to mental health services delivered by psychotherapists and counsellors, lifting the previous limitation of services provided only by psychologists (*COVID-19 Member Messages*, 2020).

Review of Remote Mental Health Care

Remote mental health care comes in many forms and by many different names including e-mental health care, web-based therapy, teletherapy, online therapy, video therapy, computer-based therapy and phone therapy, to name a few (Lal & Adair, 2014). Essential to remote services is delivery of care without in-person contact. While a single description may not capture the scope of remote mental health care, a widely used definition is as follows: “mental health services and information delivered or enhanced through the internet and related technologies” (Christensen et al., 2002, p. 3). Most definitions incorporate the use of technology into services (Oh et al., 2005). The range of activities included in remote mental health care may include screening, assessment, prevention, treatment, monitoring, social support, training, psychoeducation, administrative support, and research (Lal & Adair, 2014). Historically, remote services have been used to serve many differing populations (Cwikel & Friedmann, 2019) including youth, low social economic status populations, rural and northern communities (Lal & Adair, 2014), Indigenous peoples (Schellenberg et al., 2014; Toombs et al., 2020), people with limited mobility, the incarcerated, the elderly, infant care-takers (Cwikel & Friedmann, 2019), patients with social phobia and agoraphobia (Arnberg et al., 2014; Bouchard et al., 2004), and 2SLGBTQIA+ communities living in rural areas and small towns (Bowman & Fox, 2020).

There are many forms of remote mental health care developed with evolving technology that are transforming the Canadian mental health system (Schellenberg et al., 2014). Teletherapy, such as talk therapy delivered via the telephone, is an early conceptualization of remote therapy that is still prominent today due to its ease of use. Video conference platforms are slightly more complicated in their setup but allow clients and clinicians to see and hear each other. In addition to these traditional therapies, people can also access chat or text-based support, and online peer support (Schellenberg et al., 2014). In the current age of computers, and tablet and phone applications, new formats of mental health care are emerging, such as wearables, monitoring devices, and apps designed to assess, prevent and educate about mental health (Schellenberg et al., 2014). Games and virtual reality are another new frontier that are challenging previous notions of mental health care delivery, offering players a new way to assess, learn, build skills and take on new roles to manage their mental health (Stoll et al., 2020). Similarly, computerized treatments for specific mental health gains, such as mitigating depression or fostering resiliency in young adults, are being designed and implemented. These interventions do not require a clinician and are typically designed as psychoeducational tools to develop awareness and skills

(Schellenberg et al., 2014). Beyond mental health care platforms for clients, technological tools are also being implemented within clinical practice and mental health care systems. Online practice tools keep track of appointments, assessments, and notes and payment, and big data can be used to track large scale trends (Schellenberg et al., 2014).

Remote therapy is known to be advantageous for numerous reasons. The most widely endorsed and researched benefits of remote therapy include increased access, availability, and flexibility in service provision (Stoll et al., 2020). If services can be accessed anywhere, anytime, this extends the reach of care and allows for more immediate and frequent care opportunities (Stoll et al., 2020). A prominent argument for remote therapy is its potential to reduce costs of mental health care and thus increase accessibility (Bennett & Glasgow, 2009; Griffiths et al., 2006; Lal & Adair, 2014). Research demonstrates that therapy can be enhanced with remote delivery, for instance by adding online modules, by allowing therapists to easily attend *in vivo*, or real-life exposure interventions, virtually, and through online documentation of progress (Stoll et al., 2020). Moreover, data suggests that online modalities are as efficient, effective, and efficacious as traditional therapy, or more so (Andersson et al., 2019; Berryhill et al., 2019; Christensen et al., 2002; Karyotaki et al., 2018; Stoll et al., 2020; Warmerdam et al., 2010). Remote therapies can be useful in addressing specific client characteristics, such as rurally located clients, and mobile-impaired clients, as well as clients whose symptoms are a barrier to service, such as agoraphobic and socially phobic clients. Remote therapy is able to serve mildly symptomatic clients who can benefit from online education programs, as well as clients in crisis who need immediate intervention (Stoll et al., 2020). A recent review of remote therapy practices found that clinicians and clients perceived remote therapy as convenient and acceptable and expressed interest in engaging in remote therapy (Stoll et al., 2020). Remote therapies have been used in Canada for over 50 years and have been integrated successfully into public health care plans in the UK and Australia (Stoll et al., 2020).

Despite the advantages of remote therapy, there are arguments that caution against employing technology for mental health care provision (Humphreys et al., 2000). At the top of these concerns are issues related to privacy, confidentiality, and data security (Alleman, 2002; Humphreys et al., 2000). Training is required to provide remote therapy, particularly in regard to selecting and integrating technology safely (McBeath et al., 2020; Rutkowska, 2022; Stoll et al., 2020). Clinicians are not able to rely solely on in-person skills that are currently the focus of most training curricula and, instead, require training specific to the remote therapy being employed (McBeath et al., 2020; Rutkowska, 2022; Stoll et al., 2020). A noted difficulty of remote therapy is working with less access to emotions and other non-verbal cues, which contribute important clinical information (McBeath et al., 2020). These forfeited data can contribute to miscommunication or skewed assessments. Even though research suggests remote therapy is as effective or can even be more effective than traditional therapy, many researchers claim that the extant research is insufficient and cannot give adequate evidence that remote therapies are comparable to in-person treatment (Schellenberg et al., 2014; Stoll et al., 2020; Warmerdam et al., 2010). In fact, contrary to popular opinion, remote therapy is not always accessible. For instance, in rural and northern Canada, funding and infrastructure limit the availability of and access to remote therapies (Bouchard et al., 2004; Dyck & Hardy, 2013). Clientele without access to private space or technology is unlikely to be able to access remote therapy without considerable effort organizing these essential structures. Further challenges to remote services include the verification of client identity and location, and navigation of emergency situations (Alleman, 2002; Humphreys et al., 2000).

In addition to these difficulties, mental health care in Canada has been slow to adopt new technologies that are now commonplace within the general health care system, such as technologies to screen, track and control for illness (Vis et al., 2018; Wind et al., 2020). This trend is not unique to Canada – barriers to remote mental health care stall implementation in other countries as well, including Sweden and the Netherlands (Vis et al., 2018; Wind et al., 2020). Training has been named as one barrier to being able to integrate technology into practice (Cwikel & Friedmann, 2019; Schellenberg et al., 2014). Training programs lack adequate curricula to prepare mental health professionals to open remote practices (Murphy et al., 2008). Additionally, remote service provision involves technologies which evolve quickly, and also require competency in areas that may be less familiar for clinicians, such as data security and technology (Alleman, 2002; Schellenberg et al., 2014). One of the biggest barriers to the adoption of remote care is the lack of acceptance of remote practices by mental health professionals, who feel they are not prepared to deliver therapy online and are not convinced that the results will be equivalent to in-person approaches (Topooco et al., 2017; Vis et al., 2018; Wind et al., 2020). Since the care model was long established to be in-person, the biggest barrier is getting a shift in mindset.

2SLGBTQIA+ Populations

The lived realities, histories, and social locations of 2SLGBTQIA+ populations in Canada may contribute to unique experiences of the COVID-19 pandemic. These populations are vulnerable to a host of dangers including health risks, economic precarity, and social disparities contributing to mental health perils that were likely to be worsened in the circumstances related to the pandemic (Egale, 2020). At the same time, 2SLGBTQIA+ people have a history of resilience that has mitigated the hazards of discrimination, and which predicts the ability to navigate hardships, such as the COVID-19 outbreak (Betancourt, 2020; Guta & Newman, 2021; Haritaworn, 2020; Meyer, 2015; Quinn et al., 2021).

Research for 2SLGBTQIA+ Populations

Research with 2SLGBTQIA+ populations is a domain of interest that is growing, yet still considered inadequate in Canada (Waite & Denier, 2019). There is a paucity of population-wide data on 2SLGBTQIA+ people in Canada and researchers face many challenges in assessing the extant Canadian 2SLGBTQIA+ literature (Waite & Denier, 2019). For example, few studies thoroughly span the diversity of identities subsumed in the 2SLGBTQIA+ acronym, as it is nearly impossible to represent the breadth of these populations, yet, in addition, few studies focus on specific identities (Waite & Denier, 2019). Moreover, focusing on specific identities, rather than gender and sexuality as experiences, can have complications. For instance, many people span several identities within this acronym (e.g., an asexual nonbinary queer person). There are also imprecisions in the commonly used definitions of sexuality and gender identities, as well as insufficient explanations of the definitions used to describe populations. To exemplify, some people do not identify as gay, lesbian, bisexual or queer, even though they may participate in sexual behaviors or have sexual attractions with genders of their own (Graham et al., 2011; Waite & Denier, 2019). Most research relies on shared definitions of sexual and gender identities, rather than allowing participants to self-identify. When studies do allow for self-identification, the vast permutations and understandings of identities are apparent (Watson et al., 2020). Similarly, the complexity and variations in gender along with the generative language used for gender diversity are often poorly addressed in research (Graham et al., 2011; Greytak et al., 2014).

Scoping reviews of sexual and gender minorities present another research issue: even those conducted by Canadian-based scholars do not focus specifically on Canadian populations (Filice & Meyer, 2018; Kidd et al., 2016; Seeman, 2015). There are far more reports summarizing the lives and health of 2SLGBTQIA + populations in the United States than in Canada, which makes sense according to population sizes, but also means Canadians often rely on U.S. data. Of course, some factors contributing to mental health concerns, such as discrimination, affect the lives of 2SLGBTQIA + people in both countries (Meyer, 2003; Veltman & Chaimowitz, 2014); however, it does so differently. There are laws, policies, and cultural differences that impact the lives of 2SLGBTQIA+ populations in disparate ways. For instance, in Canada, many rights are countrywide, such as same sex marriage, legal gender change, and recognition of non-binary gender identities. However, in the United States, these rights vary by region, such that countrywide there is a lack of unified consensus around the legitimacy of diverse genders and sexualities and their deserved rights. For instance, in Florida the HB 1557 law (passed in 2022), known as the “Don’t say gay” bill, prohibits discussion of gender identity and sexual orientation in public schools before grade four. There are also differences across health care systems, which impact access to treatments specific to these communities that affect mental health, such as gender affirming care, STI testing, and fertility support. For example, in Canada, but not the United States, many gender affirming treatments are covered by public health care plans, making these treatments accessible financially. Further, experiences of sexuality and gender are inextricable from intersections of other social locations, such as social economic status, religion, location, language, ability, race and ethnicity, immigration status and age. Identity, cultural, and location are interconnected and thus understanding gender and sexuality in context requires contextualized research. Current research fails to capture these vast experiences, and does not accurately capture 2SLGBTQIA + lives, thereby perpetuating the marginalization of these populations (Wada et al., 2019). Canadian scholarship is necessary to better understanding the lives of 2SLGBTQIA+ populations within Canada.

Health Disparities for 2SLGBTQIA+ Populations

There are significant health inequalities for 2SLGBTQIA+ populations in Canada that are related to social injustice and systemic discrimination (Mulé, 2015; Mulé et al., 2009). Mulé and colleagues (2009) have outlined a framework detailing the systemic oppression that contributes to worsened health for gender and sexually diverse populations. For instance, policy and care has overlooked these populations to such a degree that it is common for the needs and experiences of 2SLGBTQIA+ populations to be missing from health care services altogether (Mulé, 2015; Mulé et al., 2009). The resulting syndemics, or concurrent health disparities due to structural inequities (Singer, 2009), of these overlooked communities contribute to even lower health indexes across these populations.

Due to the social inequalities of health and health care in Canada, marginalized communities face greater risks of infection of COVID-19, have less access to treatment, and experience higher rates of mortality (Choi et al., 2020; Rosa et al., 2020). 2SLGBTQIA+ populations are vulnerable to these risks, and some may experience compounding marginalization due to other social locations they inhabit. Critically, acronyms like "2SLGBTQIA+" can lead to understanding diverse populations as a homogenous group, when these populations are composed of many variations in sexual orientations, sexualities, and genders that lend to diverse social positions (Rosa et al., 2020). Inclusive amongst these groups are the many other intersecting identities that can shape one's social position, including race, ethnicity, age, location, citizenship, socioeconomic status, physical ability, language, and religion, resulting, at times, in multiple, intersecting marginalized social locations facing exponentially worse health outcomes. The overall health of diverse 2SLGBTQIA+ populations in Canada is threatened during a pandemic, where there is less access to health care and greater danger of contracting a deadly infectious disease (Choi et al., 2020; Mulé et al., 2009).

In addition to being at greater risk for contracting COVID-19, the reduction in health care services due to the pandemic worsened unmet health care needs for gender and sexually diverse populations (Brennan et al., 2020; Rosa et al., 2020). There are specific treatments that are essential to the health and wellbeing of these communities, such as access to antiretroviral therapies and STI testing, reproductive services, gender affirming surgeries, and hormone therapy (Brennan et al., 2020; Rosa et al., 2020). Moreover, the health care system provides treatment for many of the health issues with high prevalence in 2SLGBTQIA+ communities, including substance and alcohol use, smoking, psychiatric disorders, and eating disorders (Mulé et al., 2009). The conditions of the pandemic greatly reduced services and treatment in general and more so for 2SLGBTQIA+ affirmative services, impacting the health of these populations (Brennan et al., 2020; Rosa et al., 2020).

Health was also compromised as rates of physical violence towards sexual and gender minorities increased during the pandemic. Researchers documented augmented rates of domestic violence in general populations (Campbell, 2020; Jenkins et al., 2021), and specifically toward sexual and gender minorities (Xue et al., 2020). Family violence toward 2SLGTQIA+ youth was documented as worsening during the pandemic, oftentimes resulting in homelessness (Abramovich et al., 2022). Sexual and gender minorities faced higher rates of physical violence than their cisgender and heterosexual peers, and often had limited options for protection, due to pervasive societal discrimination (Brennan et al., 2020; Logie & Turan, 2020; Meyer, 2003).

Access to Work for 2SLGBTQIA+ Populations

Employment can be central to wellbeing, contributing to financial stability to secure necessary resources (e.g., housing, food, clothes, safety), as well as nurturing identity, adding meaning to life, and facilitating schedule structure (Waite et al., 2019). Discrimination, as well as fears of discrimination often shape the employment of 2SLGBTQIA+ people (Gibb et al., 2020; Goldberg, 2020; Waite et al., 2019). Studies on employment experiences show that it is common for 2SLGBTQIA+ individuals to experience discrimination and prejudice at work, including being fired, not being promoted, and earning less compared to cisgender heterosexual peers (Gibb et al., 2020; Goldberg, 2020; Waite et al., 2019). Avoiding discrimination, or not being able to find work in the first place, limits the type of work available to these populations (Gibb et al., 2020; Goldberg, 2020; Waite et al., 2019). Other intersecting identities, such as race, disability, language, and class also impact employment experiences and accessibility. Moreover, geography is an influential factor. Wage gaps are larger for 2SLGBTQIA+ populations in rural areas compared to Montreal, Toronto, and Vancouver (Denier & Waite, 2017). Notably, in these major Canadian cities, gay men and lesbian women fare better than other sexual minorities and trans populations in the world of work, experiencing less discrimination and more opportunities for employment, as well as more comparable wages to cisgender peers (Waite et al., 2019).

Many workplaces experienced closures during the pandemic, creating financial distress, particularly for those without savings or access to support from family. Workplaces that did not close may or may not have provided safe working environments for employees. The overall precarity of work for 2SLGBTQIA+ populations suggests that these populations were more likely to be out of work during the pandemic, or working in less-than-ideal contexts, which has been confirmed in research (Gibb et al., 2020; Prokopenko & Kevins, 2020). More research is needed to fully capture the experiences of 2SLGBTQIA+ employment experiences; however, there is evidence that these communities were likely to experience psychological distress in relation to work inequities that were exacerbated in the conditions of the pandemic (Gibb et al., 2020).

Mental Health in 2SLGBTQIA+ Populations

2SLGBTQIA+ populations in Canada are known to face greater risks for mental health disorders than heterosexual and cisgender populations (Kidd et al., 2016; Kidd et al., 2011; O'Neill et al., 2015; Pakula et al., 2016; Rutherford et al., 2012; Simeonov et al., 2015; Veltman & Chaimowitz, 2014). Of these groups, gender minorities, such as transgender, non-binary, and gender diverse populations report some of the highest mental health risks (Moody et al., 2015; Rotondi, Bauer, Scanlon, et al., 2011 et al., 2011; Rotondi, Bauer, Travers, et al., 2011 et al., 2011). Depression prevalence rates in transgender populations are above 60% (Rotondi, Bauer, Scanlon, et al., 2011 et al., 2011; Rotondi, Bauer, Travers, et al., 2011 et al., 2011) and suicidality rates are high as well: multiple studies demonstrate that over 40% of trans and gender diverse participants have attempted suicide at one point in their life (Bauer et al., 2013; Moody et al., 2015; Scanlon et al., 2010). Intersex populations also lack adequate research attention, yet the few extant studies show vulnerability to mental health risks and cite high rates of affective disorders (e.g., anxiety, depression, posttraumatic stress disorder) (Sanders et al., 2021).

Research focusing on sexual minorities indicates higher rates of anxiety, mood disorders and heavy drinking in comparison with heterosexual peers (Pakula et al., 2016). Within sexual minorities, research shows worse mental health outcomes for bisexuals than their gay and lesbian peers, including higher rates of anxiety, mood disorders, and drinking (Pakula et al., 2016; Steele et al., 2017). Few studies have been conducted with asexual populations; however, a recent study indicated that asexual adolescents and young adults may be vulnerable to mental health risks due to difficulty with identity integration and self-stigmatization (McInroy et al., 2022).

Most studies tend to centre white sexual and gender minorities; however, the few studies that attend to racialized 2SLGBTQIA+ populations indicate mental health disparities compared to non-racialized peers (Williams et al., 2022). Sexual- and gender-diverse Indigenous communities, including Two-Spirit[2] people, are known to be all the more vulnerable to mental health risks including anxiety, depression, complex trauma, substance use, and addiction (Hardy, 2022; Hunt, 2016). These perils to wellbeing are considered to be the consequences of the pervasive cultural violence stemming from the impact of colonialism on Indigenous communities (Hardy, 2022).

While overall 2SLGBTQIA+ research is limited, it consistently indicates that the mental health of sexual and gender minorities in Canada is in peril (Veltman & Chaimowitz, 2014; Waite & Denier, 2019). Higher mental illness rates within minority populations, such as 2SLGBTQIA + populations, are considered a product of minority stress, a phenomenon wherein discrimination and prejudice contribute to a mental state that is hypervigilant to adverse events based in discrimination as well as higher rates of self-stigmatization due to internalized negative societal messages (Hatzenbuehler, 2009; Hendricks & Testa, 2012; Rutherford et al., 2012; Simeonov et al., 2015). Moreover, mental health issues across 2SLGBTQIA + communities are

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[2] Two-Spirit is an umbrella term recognizing that Indigenous understandings of gender and sexual are not distinct from culture and community Hardy, Z. B. C. (2022). Indigenous LGBTQ and Two-Spirit health. In E. K. Amy Bourns, Allan Peterkin, Cathy Risdon (Ed.), *Caring for LGBTQ2S People: A Clinical Guide* (2nd ed., pp. 465-490). University of Toronto Press. https://doi.org/https://doi.org/10.3138/9781487515249-015 , Hunt, S. (2016). *An introduction to the health of Two-Spirit people: Historical, contemporary and emergent issues*. National Collaborating Centre for Aboriginal Health Prince George, BC. . This term is used by some but is not accepted as a reflective term by all.

not presumed to be caused by gender identity or sexuality (Meyer, 2003; Veltman & Chaimowitz, 2014). Rather, many of the mental health issues prevalent in these communities are linked to societal mistreatment that spawns from heterosexist and cisgenderist values that have historically shaped Canadian society, and as such have also influenced psychology and mental health care services (Meyer, 2003; Rutherford et al., 2012; Schudson, 2021).

Throughout the pandemic, researchers have found sexual and gender minorities in Canada experienced worse mental health outcomes compared to cisgender and heterosexual populations (Jacmin-Park et al., 2022; Jenkins et al., 2021; Slemon et al., 2022). In Quebec, one study demonstrated that more marginalized sexual identities, such as asexual and bisexual participants, saw worse mental health than other sexual and gender minorities (Jacmin-Park et al., 2022). Further, rates of suicidality and substance use increased among sexual and gender minorities during the pandemic (Slemon et al., 2022). Pre-existing mental health challenges were seen as risk-factors to worse mental health outcomes during the pandemic (Slemon et al., 2022)..

Mental Health Care Utilization

Considering the prevalence of mental health risks in 2SLGBTQIA+ populations in Canada, it follows that these populations are more likely to access mental health care services, and we see evidence that they do (Filice & Meyer, 2018; Rutherford et al., 2012; Tjepkema, 2008). Unfortunately, research shows that 2SLGBTQIA+ populations face barriers in accessing care; barriers such as prohibitive costs, difficulty finding service providers, delays in accessing care, long wait lists, lack of 2SLGBTQIA+ competent service providers, and negative experiences with service providers (Filice & Meyer, 2018; McIntyre et al., 2011; Simeonov et al., 2015; Steele et al., 2017). 2SLGBTQIA+ service users with severe mental illness reported facing heteronormative and cisnormative stigma when trying to access services (Kidd et al., 2011). Burgeoning research shows that intersecting identities and social locations compound mental health status and service experiences (e.g., experiences of being a racial minority as well as sexual minority may lead to greater health risks and worse service experiences) (Filice & Meyer, 2018; Giwa & Greensmith, 2012; Simeonov et al., 2015; Veenstra, 2011). Community action and research call for future studies to attend to the many identity factors that interact with homophobia and transphobia to gain more nuanced understanding of how systems of oppression affect mental health status and service use (Filice & Meyer, 2018; Giwa & Greensmith, 2012; Simeonov et al., 2015; Veenstra, 2011).

In the few Canadian studies examining client satisfaction with mental health services, results are varied (Filice & Meyer, 2018; Simeonov et al., 2015). Many 2SLGBTQIA+ service-users are satisfied with services; however, service-users also report screening mental health professionals and seeing several service-providers before finding appropriate care (Filice & Meyer, 2018; Simeonov et al., 2015). Research demonstrates that there are insufficient service providers to meet mental health care needs in 2SLGBTQIA+ communities (McIntyre et al., 2011; Rutherford et al., 2012). Additionally, not all 2SLGBTQIA+ clients experience service satisfaction (Filice & Meyer, 2018; Simeonov et al., 2015; Steele et al., 2017). It remains that 2SLGBTQIA+ populations have unmet mental health needs, despite being more likely to access care than cisgender, heterosexual peers (Seeman, 2015; Simeonov et al., 2015; Steele et al., 2017). Moreover, those with the highest mental health care risks, such as Two-Spirit, trans, gender diverse and bisexual people, have the highest rates of unmet mental health needs and experience the lowest rates of satisfaction with mental health care services (Filice & Meyer, 2018; Robinson, 2022).

The pandemic made it even more difficult to find affirmative mental health care clinicians, leaving 2SLGBTQIA+ populations in need and without access to care (Chaiton et al., 2021; Kennedy et al., 2022). Further, other mental health supports were limited during a pandemic. 2SLGBTQIA+ affirmative spaces foster important opportunities to connect and share without fears of discrimination (Slemon et al., 2022). These kinds of spaces and experiences are linked with wellbeing and buffer against the harmful rejection from family and friends situated in cisgenderist and heterosexist values (Garcia et al., 2020; Hoy-Ellis et al., 2016; Watts & Thrasher, 2023). Closure of physical spaces during the pandemic left 2SLGBTQIA+ people without their usual networks of care. In addition, 2SLGBTQIA+ subpopulations such as teens, seniors, and immigrant/refugee, religious minorities, lingual minorities, racial minorities, were more likely to be isolated from crucial community support. Research conducted during early phases of the pandemic in Quebec highlighted the relationship between lack of social support and worsened mental health (Jacmin-Park et al., 2022).

In addition to the lack of support, for some, social distancing procedures may evoke previous traumatic experiences relating to rejection, discrimination, and prejudice. The fears, pain and hypervigilance associated with minority stress is likely to be heightened in these conditions (Hatzenbuehler, 2009; Hendricks & Testa, 2012; Meyer, 2003). On a similar note, some 2SLGBTQIA+ community members may be psychologically transported to the trauma of the HIV/AIDS outbreak beginning in the 1980s (Goldberg, 2020). These communities endured incredible uncertainty while watching many community members die, resulting in tremendous loss. The egregious lack of initial response from governmental and health care systems during the HIV/AIDS endemic may elicit fears and mistrust of the structures in place to protect the population.

Clinicians Working with 2SLGBTQIA+ Populations

Many mental health care providers do not have adequate training or experience working with 2SLGBTQIA+ populations (Canvin et al., 2022; Melendez, 2021; Obasi et al., 2023; Rutherford et al., 2012; Stryker et al., 2022), which can result in perpetuating harmful biases in their work (Morris et al., 2020; O'Shaughnessy & Speir, 2018). Research has indicated that overall clinicians are more comfortable and knowledgeable working with sexual minority clients than with gender minorities (Singh & dickey, 2016; Stryker et al., 2022). While some mention of these populations may be present within graduate courses, there are few opportunities to engage in comprehensive trainings or clinical experiences (Canvin et al., 2022; Stryker et al., 2022). Research regarding clinicians working with 2SLGBTQIA+ populations is sparse and tends to focus on attitudes of practitioners or training experiences (Canvin et al., 2022; Stryker et al., 2022). However, studies that examine how clinicians work with 2SLGBTQIA+ populations contribute valuable insight on clinical approaches to practice (Ali, 2014; Banks, 2021; Kahn et al., 2017). Some research has indicated how clinicians working with 2SLGBTQIA+ clients were motivated to gain experience, which tended to be due to personal connection with these communities (being or knowing someone in these communities) (Rutherford et al., 2012; Stryker et al., 2022).

Resiliencies Among 2SLGBTQIA+ Populations

Conditions of the COVID-19 pandemic provoked many factors that were likely to impact wellbeing for 2SLGBTQIA+ communities, including over-stretched health and mental health services which have left many without adequate care. Yet, the rich history of resiliency within these communities is a protective factor that may help to buffer against these harms. Research has begun to analyze the many ways in which 2SLGBTQIA+ populations are resilient and have embedded resiliency practices into the norms and values of their communities (Meyer, 2015).

Resiliency is the ability to positively cope with significant stress or adversity (Fergus & Zimmerman, 2005). Models of resiliency facilitate and promote positive contributions to wellbeing, and illustrate how resiliency can be developed within individuals, as well as in social and cultural norms (Colpitts & Gahagan, 2016). 2SLGBTQIA+ communities have made significant societal advances to cultivate resiliency through advocacy and activism. For instance, anti-discrimination and rights campaigns develop positive self-esteem and self-acceptance, while reducing shame (Colpitts & Gahagan, 2016). Genders and Sexualities Alliance Clubs in schools have also fought for gender and sexual orientation to be included in human rights charters, and advocated for equality in workplaces and health care systems (Colpitts & Gahagan, 2016). Other influential initiatives include increased positive media representation of 2SLGBTQIA+ people, as well as education outreach for families, schools and workplaces (Colpitts & Gahagan, 2016). Not only do these methods foster positive acceptance in individuals and society, but they also demonstrate triumphs over difficult challenges, triumphs that can motivate and inspire future generations in the face of other hardships.

It is the connectivity, support, care and resourcefulness of 2SLGBTQIA+ communities that is most often noted for developing resiliency within these populations (Abreu et al., 2021; Lev, 2015). Community experiences can affirm and mirror identities, foster a sense of belonging, and reduce negative mental health outcomes (Saewyc et al., 2020). Visible 2SLGBTQIA+ community spaces are important ways to promote positive representation, as well as create locations where 2SLGBTQIA+ people can safely spend time without fear of harassment. In Canada, and in Montreal, for example, there are many 2SLGBTQIA+ spaces, including centres for social services, community activities, refugee support, religious practices, art-making, HIV/AIDS support and many kinds of activism (Labelle, 2019; Tremblay, 2015). Networks of care that are part of the social norms of many 2SLGBTQIA+ communities within Canada model mutual support and affirmative approaches to relationships (Tremblay, 2015). Participation in these kinds of communities mitigates the effects of social rejection and isolation that many 2SLGBTQIA+ people face, while promoting resilience.

During the pandemic there were also new initiatives started by and serving 2SLGBTQIA+ communities. For example, Haworth (2022) wrote about peer-support projects that addressed mental health concerns and isolation, as well as the use of remote technologies to include reach people in exceedingly oppressive regimes. And in Montreal, researchers noted the creative appropriation of Zoom technology to foster online queer social space by creating "Club Quarantine" events (Duguay et al., 2022). In the United States, when researchers asked LGBTQ participants how they were resilient during the pandemic in addition to building community and engaging in support for others, participants indicated that previous hardships had fostered resilience and use of radical acceptance contributed to resiliencies (Gonzalez et al., 2021). Many 2SLGBTQIA+ initiatives have not been and are unlikely to be captured by research; however, more research is starting to highlight the ways in which resilience is fostered within sexual and gender communities (Duguay et al., 2022; Gonzalez et al., 2021; Haworth, 2022; O'Handley, 2023). This is exceptionally important, as it moves away from the deficit models that dominate 2SLGBTQIA+ research, which can contribute to further discrimination of these communities (Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017).

Research Questions

The mental health disparities faced by 2SLGBTQIA+ populations are attributed to stigma-related stressors (Bränström, 2017; Hendricks & Testa, 2012; Kidd et al., 2011; McInroy et al., 2022; Meyer, 2003; Meyer, 2015; O'Handley, 2023; Pachankis et al., 2022). Further, stigma can contribute to structural barriers that impact access to adequate mental health care (Filice & Meyer, 2018; Hatzenbuehler & Pachankis, 2021; Kidd et al., 2011; McIntyre et al., 2011; Simeonov et al., 2015). While some studies have shown that 2SLGBTQIA+ populations seek mental health care at higher rates than the general population (Cochran et al., 2017; Filice & Meyer, 2018; McIntyre et al., 2011; Tjepkema, 2008), these populations also report higher rates of unmet mental health needs (Filice & Meyer, 2018; Simeonov et al., 2015; Steele et al., 2017). Further, these populations experience challenges to accessing care, including predicting and experiencing discrimination during treatment from provider (Cronin et al., 2021; Kcomt et al., 2020; Simeonov et al., 2015), or difficulty finding 2SLGBTQIA+ affirmative providers (Ferlatte et al., 2019). These challenges are not unwarranted; few mental health care providers have adequate training in working with 2SLGBTQIA+ populations (Melendez, 2021; Obasi et al., 2023; Rutherford et al., 2012; Stryker et al., 2022), which can result in perpetuating harmful biases in their work (Morris et al., 2020; O'Shaughnessy & Speir, 2018). Moreover, insufficient research has been dedicated to developing appropriate, effective mental health interventions for 2SLGBTQIA+ populations, as research has predominately focused on describing the mental health experiences of these communities, rather than developing strategies to improve wellbeing (O'Shaughnessy & Speir, 2018; Pachankis et al., 2022).

Yet, there are clinicians committed to working with 2SLGBTQIA+ populations. Practitioners with expertise working with this clientele are specialized clinicians with distinct knowledge and skills sets that go beyond traditional mental health care treatment protocols (Rutherford et al., 2012). Training is these areas is not widely available nor easily obtained and thus requires exceptional motivation (Stryker et al., 2022). While not a requirement, often practitioners specialized in 2SLBGTQIA+ mental health care are also members of these communities (Rutherford et al., 2012; Stryker et al., 2022). Despite the long-standing knowledge that most clinicians are inexperienced in working with 2SLGBTQIA+ populations, and that research lags in providing effective best practice treatment guides, few studies utilize the experiences of clinicians specialized in these areas to advance research and clinical practice. Practitioners working with these populations are likely to have unique experiences and important perspectives that may contribute generatively to the wellbeing of clients, as well as treatment planning and approaches to practice.

It was predicted at early stages of the pandemic that subpopulations facing marginalization, such as sexual and gender minorities, would experience worsening conditions (Holmes et al., 2020). Research that has since been published has validated this prediction, demonstrating how the multifaceted disparities that 2SLGBTQIA+ populations face were exacerbated during the pandemic, including disparate inequities in health (Egale, 2020; Pujolar et al., 2022; Tami et al., 2022), mental health (Jenkins et al., 2021; Kidd et al., 2021; Slemon et al., 2022), employment (Egale, 2020; Ghabrial et al., 2021; Smith et al., 2021), and housing (Abramovich et al., 2022; Chaiton et al., 2021; Egale, 2020). Predictions also indicated that these populations may have unique ways of coping with calamities, developed through facing past hardships, such as navigating the HIV/AIDS pandemic, as well as navigating ongoing pervasive discrimination (Edelman et al., 2020; Quinn et al., 2021). Research is beginning to illustrate the strengths of these communities and shed light on the ways in which they have endured oppressive forces (Duguay et al., 2022; Greteman, 2021; O'Handley, 2023).

More research is needed to understand the experiences of 2SLGBTQIA+ populations in general, and in the face of stigma and discrimination. Examining the impact of the exceptional conditions of the pandemic, which in many cases exacerbated pre-existing inequities, is likely to shed light on challenges faced by these communities and ways of overcoming them. Further, the pandemic transitioned most mental health care to remote service delivery, and research is necessary to understand the effect of these changes. Mental health providers working with 2SLGBTQIA+ populations during the pandemic have unique experiences that speak to pandemic-related service provision changes, as well as the care for 2SLGBTQIA+ populations.

This study focuses on experiences relating to mental health care for 2SLGBTQIA+ clients during the COVID-19 pandemic. The aim of this study is to gain insight on how clinicians working with 2SLGBTQIA+ clients describe and understand their experiences of the pandemic and the impact it has had on their work. The research question for this study is: How do clinicians serving 2SLGBTQIA+ communities describe their experiences and the evolution of their clinical practice in response to the coronavirus pandemic?

Chapter Three: Methodology

This study explores the experiences of mental health care providers offering care to 2SLGBTQIA+ clients during the COVID-19 pandemic. Members of "The Network," a team of independent mental health clinicians in Montreal, QC, dedicated to providing accessible, affirmative mental health care to 2SLGBTQIA+ populations, were invited to be participants of this study. This team of clinicians will be referred to as The Network going forward. The goal of this study is to describe the experiences of clinicians working with 2SLGBTQIA+ clients during COVID-19, to gain perspective and a richly detailed understanding of the ways in which this pandemic has influenced 2SLGBTQIA+ mental health care. The design and plan for implementation of this study was approved by the Research Ethics Board-II at McGill University.

This qualitative research study used the Integrated Social Justice Consultation Model (Sinacore, 2022) as an epistemological framework and applied interpretative phenomenology to guide the method and analysis. Surveys were used to collect basic demographic data. Focus groups and interviews were conducted with members from The Network to facilitate participants in describing their understanding of their experiences providing mental health care services during the COVID-19 pandemic. Focus group participants had the opportunity to add additional thoughts through an online questionnaire administered post-focus group.

Researcher's Assumptions and Context

Qualitative research does not claim to focus on objectivity nor generalizability. Rather, it strives to produce contextual knowledge and understanding that can be transferable. Some scholars have described this as interpretation-driven research, as it centers interpretation as the mode of knowing (Levitt, 2015). Study design serves to illustrate the parameters of interpretation, such as how the goals of research are aligned with the epistemology, data collection, analyses, and the views of researchers (Levitt, 2015). As research is influenced by the values, biases, and assumptions of those engaged in the research design and implementation, it is important to provide information about relevant assumptions and circumstance, as well as philosophical frameworks, to contextualize the study design and interpretative findings (Levitt, 2015).

Relational Context

First, it is important to acknowledge that I, Jann Tomaro, the principal research investigator, am a member of The Network. Within qualitative inquiry, developing relationships with a group of study participants is common, and even recommended in some cases, to assure that research is purposeful and welcome for those involved. Relationships are important for establishing trust and enough safety to share personal experiences. Research conducted without prior relationship can be harmful to participants, who may not have enough information to be able to trust the researcher and the research agenda. Relationship building is particularly important for underserved populations, like 2SLGBTQIA+ communities (Harrison & Michelson, 2022). Furthermore, research without connection to participants can be extractive, reproducing certain hierarchies and power dynamics, serving researchers and institutions, without considering the needs and aims of participants. While there is always an inherent imbalance in the position between researcher and researched, it is important for researchers to consider their position in relation to participants and the impact it will have. Relationships within research are complicated and require ongoing researcher reflexivity, as well as openness to feedback from participants to think through ethical dilemmas, conflicts of interest, and the impact these relationships may have on participants (Råheim et al., 2016). In this study, I practiced reflexivity alone and with my academic research supervisor. Further, I offered discussion with research participants during and after data collection. Members of The Network already had a practice of discussion in place prior to research; and, since The Network is a group of mental health clinicians skilled in communication, I trusted that it would be possible to bring up issues as they arose. Further, as this group shares common goals, I trusted that were issues to arise, participants would be motivated to resolve them. One additional step I took to ensure relational safety for participants was to create an online questionnaire that allowed participants to be able to communicate anonymously.

As mentioned, 2SLGBTQIA+ populations have been underrepresented within research, and additionally, these individuals are underrepresented in positions within academia and research (Harrison & Michelson, 2022). Yet, it is predominantly 2SLGBTQIA+ people who advocate for and conduct ethical research with these communities. Further, there are many instances where without the input of the community being researched, research initiatives embedded in discriminatory beliefs have caused pervading harm, a pattern that has repeated across many different groups who are not signaled as the hegemonic deserving norm (Buchanan et al., 2021; Gagné-Julien, 2022). Research perpetuating stigmatizing views has contributed to harmful treatment of 2SLGBTQIA+ communities. For example, minoritized sexual orientations and gender identities have been considered mental health disorders that were included in the Diagnostic Statistical Manual (Drescher, 2015). Further, conversion therapies were recommended to treat these so-called “disorders” (Drescher et al., 2002). Hence developing relationships with research participants, or even initiating research out of group-based desire or concern, can result in ethical research processes that invest in and enrich participants’ lives.

This research project was inspired by processes of knowledge mobilization that are inherent to The Network, as well as challenges The Network faced in providing services during the pandemic to marginalized clients. Before initiating this study, I reflected on reasons for engaging in research, discussed the ethics of this project with my academic supervisor, and approached The Network to see if this specific project would be of interest. There were no voices of dissent and members of The Network encouraged moving forward with the project. The overarching aim was to design research that was useful to participants during participation, as well as through the dissemination of results. My initial hope for this research was that it would make a direct impact on specific challenges faced by The Network, namely adapting modes of service delivery during the pandemic. I hoped that engaging in research would facilitate a meaningful process of working with this challenge, as well as serve as a legacy document, and potentially inform future initiatives. Further, it was my hope to connect academic research and The Network, bridging the gap between research and practice, as well as scholastic endeavors and community. Even though there is a long history of activism lead by 2SLGBTQIA+ people in Canada, and Montreal, many of the sustaining initiatives of these groups are not represented within academic realms, contributing to the erasure of theses groups' initiatives, and contributing to a lack of knowledge sharing between institutions and grass-roots organizations.

Personal Context, Biases, and Assumptions

As the primary investigator, I, myself, identify within the 2SLGBTQIA+ umbrella, and have long practiced an authentic exploration of my sexuality and gender. I am deeply grateful to be engaged with 2SLGBTQIA+ communities, and could not imagine my life without the vitality, connection, and knowledge that has come from my relationships with other queers. One of the lessons fostered from within these communities that is integral to my beliefs, is to strive to engage with all humans in a way that is socially just and compassionate. I hold all genders and sexualities in equal positive regard and believe that all humans deserve to live in a world that reflects this understanding.

I also recognize that I have been taught many biases by living in hetero- and cis-normative contexts, that are founded by colonial capitalist frameworks which hierarchize people along the lines of social locations and identities (e.g., race, class, ability, age, gender, sexuality), resulting in the promotion, empowerment, and prioritization of select identities to the detriment of others. I understand that gender and sexuality are contextual, influenced by culture, and deeply relational, and acknowledge that current understandings of gender and sexuality have been impacted by contemporary and historical sociopolitical agendas. I recognize that I hold many privileges due to present day hierarchies, and I strive to utilize my privilege in ways that do not perpetuate this system of harm. I endeavor to bring these biases into my awareness and to push back against the oppressive forces they may hold. And I acknowledge that there are influential values embedded in society regarding social locations including race, ethnicity, age, ability, religion, language, and social economic status, such that I may hold and enact biases and prejudices without awareness. I am engaged in ongoing work to be reflexive, open, and responsive in understanding my biases and critically questioning my values, with the goal of holding all people in my mind and all interactions in a way that is equitable and honors positive regard for others. Thus, my assumptions and values are in accord with and are reflected in the epistemology, theoretical framework, and research design of this study. These assumptions and values are integral to conducting research that does not further harm sexual and gender minoritized populations.

Epistemological Framework

The Integrated Social Justice Consultation Model (ISJCM) is a specific social justice framework that was selected to guide the epistemology of this study (Sinacore, 2022). As an organizational consultation and research model, the ISJCM examines issues across varying levels, such as the individual, institutional, community, and societal (Sinacore, 2022). The ISJCM is useful for analyzing systemic issues, like health care systems and pandemic-related societal changes, due to its attention to complex variables that play out at multiple levels of interaction. There are five principles integral to the ISJCM;

> **Principle I:** Inequities within institutions are biproducts of an organizational climate that reflects a broader socio-cultural context.
>
> **Principle II**: Power dynamics contribute to and result in the silencing and marginalizing of certain individuals and groups.
>
> **Principle III:** Rules that govern social interactions and decision-making processes take into account individuals' multiple intersecting identities.
>
> **Principle IV:** Institutional, social, and structural change may result in controversy, which can productively lead to positive change through dialogue and education.
>
> **Principle V:** Advocacy and outreach are essential components of social justice. (Sinacore, 2022, pp. 299-300).

Further, intersectionality and analyses of the ways intersecting identities relate to power and oppression are fundamental to the ISJCM (Enns & Sinacore, 2005). Intersectionality is a framework that brings understanding to the ways that oppression and empowerment may be uniquely experienced in relationships to intersecting identities (e.g., race, age, gender, location, religious affiliation, disability) an individual holds (Runyan, 2018). These principles illustrate contexts that affect knowledge creation and speak to factors that impact whose knowledge is prioritized. This is essential to epistemology, or the study of knowledge production, as it points to the ways in which knowledge is created, validated, and utilized, as well as barriers that may prevent knowledge from being considered. To employ an epistemology grounded in social justice is to uphold and advocate for the equal rights of all people.

The ISJCM was formed over many years, beginning in counselling psychology education and scholarship led by Enns and Sinacore (2005). Social justice tenets that are integral to counselling psychology were initially studied via feminist and multicultural theories (Enns & Sinacore, 2005; Vera & Speight, 2003). Then, a social justice pedagogy was created by analyzing common factors across feminist and multicultural theories (Enns & Sinacore, 2005), which eventually informed principles of the ISJCM (Kassan & Moodley, 2021; Sinacore, 2022).

Undergirding the ISJCM framework is a constructivist epistemology. This epistemological approach asserts that knowledge is known through subjective interpretation (Raskin, 2002). Raskin (2002) maintains that constructivist approaches bridge tenets of realism and idealism, where realism contends that “material objects exist externally to us and independently of our sense experience,” (Chiari & Nuzzo, 1996, p. 166) and idealism posits that “no such material objects or external realities exist apart from our knowledge or consciousness of them, the whole world being dependent on the mind” (Chiari & Nuzzo, 1996, p. 166). Thus, constructivist epistemologies hold that there is an objective world to be known, but the world is never directly accessible and thus knowledge is known through the interpretation of the world, by the knower (Raskin, 2002). Chiari & Nuzza elucidated on interpretation describing it as “historically founded rather than timeless, contextually verifiable rather than universally valid, and linguistically generated and socially negotiated rather than cognitively and individually produced" (1996, p. 174). Thus, constructivist epistemologies indicate that knowledge is created through meaning made from experiences, which is done in relation to an individual's past and current subjective contexts (Raskin, 2002). Due to this subjective stance of knowledge, constructivist epistemological approaches assert that multiple valid realities exist, based on the experiences and contexts of each knowing subject's interpretations.

However, employing a constructivist epistemology alone would not serve this project well, as it does not require researchers to attend to the oppressive forces in society that contribute to marginalization of experiences, nor the utility of advocacy in face of these forces. As Levitt (2015) holds, a social justice epistemology is useful for research objectives that "bring into focus marginalized experiences with the aim of raising consciousness and repairing practices that maintain social biases and an awareness that my process of inquiry itself can be fundamentally influenced by these biases" (p.459). Use of the ISJCM requires acknowledgement of the ways in which power can affect knowledge creation across multiple levels (e.g., interpersonally, societally, institutionally). The five principles of the ISJCM attend to specific ways that knowledge may be created, utilized, or ignored, invalidated, thwarted.

The ISJCM model is appropriate to guide this study, which looks at mental health care with marginalized communities during the first year of the COVID-19 pandemic, as it allows the researcher to attend to how individuals, subcommunities, and systems of care were impacted by societal changes made in response to COVID-19. A social justice approach requires recognition of intersectionality and analysis of the ways intersecting identities relate to power and oppression (Enns & Sinacore, 2005). This framework is relevant for work with marginalized populations, such as mental health care clients and sexual and gender minoritized communities who may experience social and economic threats (Glassgold et al., 2009). Research conducted from an epistemology that holds respect for diverse voices is able to seek understanding, validate silenced realities, and showcase unheard experiences in a way that has the potential to honor and empower all of those who are involved. Research approaches without a social justice commitment to improving inequitable conditions may further perpetuate marginalization and discrimination of vulnerable populations.

Research Method

Interpretative Phenomenological Analysis (IPA), used to guide this project, is a qualitative approach that has been used in psychological research to capture detailed descriptions of personal lived experiences (Eatough & Smith, 2008; Smith & Osborn, 2015). The aim of IPA is to understand personal accounts of an event, rather than obtain an objective report (Smith & Shinebourne, 2012). An IPA approach is considered useful for examining complex, novel, and emotionally laden topics, as well as processes (Smith & Osborn, 2015; Smith & Shinebourne, 2012). Explorative research methods, such as IPA, are also appropriate for examining new phenomenon that have yet to be studied in great depth. It is therefore a useful method to explore mental health care provision during an unfolding viral pandemic. IPA recognizes that humans have a process of making sense of their experiences; capturing the ways in which participants and researchers are making meaning is foundational in this methodology (Smith & Shinebourne, 2012). IPA allows the research participant to be in an active role of making sense of their experiences and the researcher to be in a role of making sense of this process, with emphasis on the subjective nature that is inherent in these tasks (Smith & Shinebourne, 2012). As the COVID-19 pandemic was a new and changing impactful experience with a great deal of uncertainty, it is crucial to record and understand the ways in which meaning was made of this experience.

IPA is typically used with small sample sizes, to allow for detailed, in-depth case analysis and is best used to study participants who are homogeneous to each other in some way (Smith & Shinebourne, 2012). In this study, IPA was employed with a group of mental health care professionals who provide services for 2SLGBTQIA+ communities. While there is considerable diversity within this group, there is a degree of professional homogeneity, as all participants shared the experience of providing mental health care to 2SLGBTQIA+ communities during the COVID-19 pandemic.

IPA often uses interviews as a means of data collection to focus on individual experiences and sense-making; however, there is also a vibrant if short history of using IPA with focus groups, beginning in the early 2000s (Palmer et al., 2010; Phillips et al., 2016). Some advantages of using focus groups with IPA are in accessing pre-existing groups who are accustomed to sharing, which is the case for the participants selected in this study, as well as capturing a breadth of experiences (Dunne & Quayle, 2001; Earle et al., 2005; Phillips et al., 2016; Sternheim et al., 2011). Furthermore, newer IPA approaches maintain focus on individual experiences while also attending to group dynamics and larger contextual or structural influences that are embedded in understanding and sense making (Palmer et al., 2010). Whereas individual experiences may be lost in some focus group analyses, IPA can provide a way to capture personal meaning-making and shared meaning making, as well as the ways in which groups mediate these experiences of meaning making (Palmer et al., 2010).

There are many advantages for participants in participating in focus groups. With respect to the conditions of the pandemic, focus groups were selected as a method that places low burden on the research participant, with the potential to provide an experience that offered connectivity and support, vital resources during the isolation that ensued. Research has shown that the group experience is more stimulating and can benefit participants more than other forms of data collection (Bristol & Fern, 1996). This was useful as mental health care providers are not only in primary support roles; they also often work alone. Furthermore, focus groups are recommended for working with marginalized communities. When there is group belonging around shared experiences, the group scenario can be minimally threatening for participants and can facilitate ease of discussion (Krueger & Casey, 2000). Focus groups are also used for their ability to be inclusive, to develop community, and to encourage participation from those who feel they have nothing to say, or who are reluctant to be interviewed alone (Bristol & Fern, 1996; Halcomb et al., 2007; Kitzinger, 1994; Kroll et al., 2007).

There are also advantages for researchers in employing focus groups, which include capturing both breadth and depth in data collected (Kidd & Parshall, 2000). Researchers can work efficiently with multiple participants at the same time to elicit extensive, rich data (Krueger & Casey, 2000). The dynamic of a group often generates ideas and can allow for a range of views to be captured, which may not surface in individual interviews (Kidd & Parshall, 2000). Many studies have shown that focus groups may also capture more personal experiences, as well as facilitate more sharing about sensitive topics than individual interviews, particularly in health research (Guest et al., 2017).

There is no set protocol for an IPA methodology, rather it is a process (Palmer et al., 2010; Phillips et al., 2016). Recent literature has outlined several approaches integrating IPA with focus groups, with emphasis on capturing the individual experiences as well as attending to group dynamics, including positionality, roles and relationships, organizations and systems, stories, and use of language (such as metaphors, patterns of speech, function of the language used, and emotive language). Careful attention to each aspect of the research process (i.e., recruitment, group formation, questions, facilitation and analysis) is required to set up a research design that speaks to personal experiences and is able to describe the meaning making associated to these experiences (Palmer et al., 2010; Phillips et al., 2016).

Methodological Coherence

An important consideration in designing research is methodological coherence, which refers to the degree to which epistemological assumptions and research methodologies are aligned. There are complementary intersections between IPA, which seeks understanding of the individual's experience, and the ISJCM, which puts into perspective power dynamics that control whose narrative is validated. The ISJCM focuses attention on the barriers that participants may face in being able to speak and make sense of their experiences. Moreover, a social justice lens is useful in acknowledging challenges and inequities experienced by 2SLGBTQIA+ communities. Awareness and inclusion of these challenges is essential in understating the meaning-making process of service providers speaking about experiences with 2SLGBTQIA+ clients. Given that many of the participants engaged in this study identify within 2SLGBTQIA+ communities, as well as within other marginalized identities, the ISJCM works to ensure that often ignored experiences are carefully recorded.

Coherence between the epistemology and research methods also align in attention to varying levels of impact. For instance, IPA attends to the individual, interpersonal, group, and larger organizational dynamics that contribute to the meaning-making of experiences, particularly with focus groups (Palmer et al., 2010; Phillips et al., 2016). This mirrors the attention the ISJCM focuses on multi-level analyses. IPA aims to capture rich individual experiences, while also situating these experiences within group and larger societal/systemic dynamics. Similarly, the ISJCM recognizes the ways in which larger socio-cultural contexts impact personal experiences. These fundamental shared approaches to understanding experience are also useful in empowering participants within research. The ISJCM requires power dynamics to be considered with research design at all stages of research, for example from how participants experience being part of the study, to the ways in which findings may impact participants. Attending to these dynamics allowed me to think through experiences that may inhibit or enable participation, perpetuate oppression, or facilitate positive reactions for participants. Moreover, noting that the ISJCM dovetails with IPA in analysis of personal experiences, permits the centering and validating of the perspective of each participant while also recognizing the impact of my own subjectivity in this process. Both social justice practices and IPA methods seek to hear from all voices, even those that may otherwise be overlooked, thus empowering participants in the act of knowledge production.

Participants

As discussed, participants were members of The Network, a team of 25 independent mental health care service providers dedicated to providing affirmative mental health care to 2SLGBTQIA+ populations.

The Network consists of mental health clinicians who live and practice in Montreal, QC, Canada, and who hold varying professional titles, including psychotherapist, psychologist, counsellor, art therapist, drama therapist, sexologist, couples therapist, and social worker. Team members also comprise a range of career stages, from new trainees with two years of experience to clinicians with over 24 years of practice. All but one participant had a master’s degree, four participants had obtained PhDs and two other participants were currently in doctoral studies. Two participants had post-doctoral training. The majority of participants identified as cisgender, white, female, Canadian sexual minorities. Two participants were men and one replied to the inquiry of gender with a question mark. Three participants had immigrated to Canada from other countries and three other participants identified as mixed race. All but two participants were citizens of Canada; those two were permanent residents. Ages ranged from 27-63. All participants spoke English, most also spoke French, and half of the participants knew at least one other language. Half of the participants identified a religious affiliation. All participants engaged in individual interviews and 12 of the 14 participants also engaged in focus groups.

Membership within The Network requires that team members commit to the team mission statement and attend an annual training focusing on mental health care with 2SLGBTQIA+ clients. Additionally, The Network offers monthly supervision, resource sharing, and ongoing ad-hoc training between annual trainings. Membership in The Network is voluntary, and tasks include organizing initiatives of the team, such as making team policy, fielding questions from the public, building and maintaining a website, responding to public events, organizing and delivering trainings, booking meetings, accounting, team emails, facilitating meetings, keeping meeting minutes, and archiving team activities.

Accessibility, Compensation, Confidentiality

In designing this project, I prioritized reducing participation burden and increasing accessibility to engage in this study. I aimed to reach these goals by informing participants that accommodations could be made to facilitate ease of engagement. I invited hearing about any participation challenges and concerns, and I was available to think through accommodations, while also welcoming suggestions. I made closed captioning available to participants via Zoom, and I offered breaks during interviews and focus groups. I was flexible in scheduling according to participant needs and I was careful to respect time commitments. And I compensated participants $50 to participate in focus groups, as well as $50 to participate in individual interviews.

I also acknowledged the dual relationship I held with participants when introducing the study, as well as at the start of each focus group and interview. I provided space for discussion about my roles as a member of The Network and the principal investigator of this research project. I was transparent with participants about my commitment to keeping data collection confidential and safeguarding who did and did not participate in this project. Additionally, I acknowledged that participation in this study could change team relationship dynamics and I offered participants an opportunity to discuss any concerns in the moment or in the future, if concerns arose. No such concerns have been raised.

To protect the confidentiality of participants and minimize the potential for any readers, including other team members, to recognize participants' identities, limited information regarding individual participants was made available. I used numbers to distinguish between interview participants, but did not use pseudonyms, to avoid suggesting any personality characteristics that may contribute to identification (whether false or not). Further, I did not link interview participants to focus group participants, as this could reveal information regarding who participated in focus groups and who declined. To protect the confidentiality of participants, specific focus groups were not designated; however, all groups were represented equally throughout this study. I also removed vocal disfluencies, or common filler words (e.g., frequent use of words such as "like" or "um") from quotes that may facilitate reader recognition of participant identities.

During interviews and focus groups, participants were asked to think carefully about the ways in which information was presented, so as not to reveal the identities of third-party others who had not consented to engaging in research. For instance, if participants wanted to speak about experiences of other colleagues or a clinical issue, it was necessary to avoid any identity revealing details. Further, during focus groups, I asked participants to keep the identities of other participants confidential and participants agreed not to reveal who was or was not present in their focus group.

Materials

Materials and technologies needed for this study included Zoom; Lime Survey; NVivo; informed consent forms for service-providers to join focus groups (Appendix A) and individual interviews (Appendix B); demographic survey forms (Appendix C); focus group interview questions (Appendix D); individual interview questions (Appendix E); an anonymous online questionnaire for additional feedback post focus group (Appendix F); invitations to join the study (Appendix G); invitations to engage in anonymous online feedback (Appendix H); the transcription agreement of confidentiality (Appendix I); and finally, the script for verbal invitation to join study (Appendix J).

Informed Consent for Participants

These forms (Appendices A, B) outline a) the purpose of the research study; b) data collection procedures and data use; c) participants' rights; and d) confidentiality and its limits. The goal of the consent form was to inform participants of how their data were to be collected, used, and stored, the risks and benefits of participation, and their rights as participants.

Demographic Form

Participants were asked to complete the demographic form (Appendix C). This form collected information about participants' age, race, ethnicity, sexual orientation, gender, education, and professional title.

Interview Protocols

Semi-structured interview protocols (Appendices D, E) were used to guide the interviews and focus group processes. A semi-structured format allowed for flexibility while ensuring the research agenda was fulfilled. The focus areas of the protocols were the evolution of practice, client experiences, and clinician experiences.

Online Questionnaire

An online questionnaire (Appendix F) was conducted through Lime Survey to allow participants a chance to provide additional information after focus groups. The aim was to capture any forgotten information, to hear from participants about topics that may be difficult to share in a group setting, and to provide an opportunity for anonymous feedback, in case there was a barrier to sharing data directly with me, the principal investigator.

Procedure

A step-by-step protocol of data collection procedures is detailed in Appendix K. Following ethics board approval, I began this study by asking members of the Network if they were interested in engaging in this project. I introduced the study during a team meeting, verbally explaining the project and answering questions. Members of The Network consented to the scope of this project, and so I proceeded to send individual invitations to all team members via email, to join the study. Using McGill's LimeSurvey Platform, potential participants were able access the online consent form and to fill in the demographic survey. Next, I contacted consenting participants via email to arrange focus groups and interviews.

Data Collection

To protect the confidentiality and privacy of participants, all hard copy data was stored in a locked filing cabinet at McGill University. Data were de-identified. Digital files were password protected and stored on McGill University computers behind password protected user profiles set up specifically for this research project, with access limited to principal investigator and supervisor.

Focus Groups. Three semi-structured online focus groups of 3-4 service providers were conducted: each lasted 90 minutes. Focus groups were held online using the secure video-conferencing platform, Zoom, with password entry. There was a 10-minute break after 45 minutes. Focus group topics explored working with 2SLGBTQIA+ clients in Montreal, Canada, during the first year of the COVID-19 pandemic and focused on: 1) clinicians' evolution of mental health service provision in response to the pandemic; 2) clinicians' understanding of the experiences of their clients as a result of COVID-19; 3) clinicians' understanding of their personal experiences as mental health care providers during the COVID-19 pandemic. Focus groups were audio recorded and transcribed by a professional service, contracted with a confidentiality agreement (Appendix I).

Following the focus groups, participants were invited to an online questionnaire to add any additional feedback that may have been forgotten or difficult to say in a group context. Two participants gave feedback in the online questionnaire.

Individual Interviews. Fourteen participants engaged in semi-structured interviews that were 45-60 minutes long, which I conducted online using a professional Zoom account. The interview topics explored working with 2SLGBTQIA+ clients in Montreal, Canada during the first year of the COVID-19 pandemic and focused on 1) clinicians' evolution of mental health service provision in response to the pandemic; 2) clinicians' understanding of the experiences of their clients as a result of COVID-19; and 3) clinicians' understanding of their personal experiences as mental health care providers during the COVID-19 pandemic.

Data Analysis

Focus Groups. I employed interpretative phenomenological analytical approaches to analyze focus group data from demographic surveys, transcripts, and questionnaires with the assistance of NVivo software (Palmer et al., 2010; Phillips et al., 2016). First, I read each focus group transcript to orient myself in the data. Next, I read each focus group transcript with my attention focused on individual participant experiences. As is typical of interpretative phenomenological analysis, I focused attention on the claims and experiences of participants, which I then recorded, summarized, and sorted into themes (Palmer et al., 2010; Phillips et al., 2016). Two independent researchers with qualitative research training and commitments to social justice, who had no connection to The Network, reviewed de-identified transcripts and the themes I had created. These researchers indicated whether they agreed with the themes I had created, as well as indicated any other themes they thought were relevant. Themes identified across researchers were kept and those without consensus were reviewed and updated.

Next, I read each focus group transcript with a focus on group dynamics within each focus group. I followed IPA suggestions to examine group dynamics that attended to positionality, roles and relationships of researchers and participants, references to organizations and systems, and participants use of language (such as metaphor, patterns of speech, function of the language being used, emotive language) (Palmer et al., 2010; Phillips et al., 2016). There were limited interactions between participants, which I hypothesized to be a consequence of working via Zoom. I have included examples of participant interactions in the results.

After this, I analyzed data across focus group themes to see commonalities and differences between groups. I conducted a final analysis focused on a broader picture of experiences described by the participants.

Two participants responded to the online questionnaire following focus groups. Both responses indicated additional pieces of information that participants had forgotten to mention during focus groups. I integrated these responses into the appropriate themes within my analyses. My hypotheses as to the limited use of the online questionnaires are threefold. Firstly, many participants also engaged in individual interviews following focus groups, where they had further opportunity to share their experiences. Secondly, based on the positive responses regarding this research process, which are recorded in the results, and the group cohesion developed prior to this project, I suspect participants did not feel the need to disclose information outside of focus groups and interviews, as they were comfortable enough to express their opinions within these arenas. This is further evidenced in moments where participants openly disagreed with each other, and in instances where participants shared vulnerable personal experiences. Thirdly, I believe that due to limited personal capacity, most participants could not engage further with this study. This is based on participant reports of being busier and more tired than usual, due to pandemic related conditions.

Individual Interviews. I employed interpretative phenomenological analytical approaches to analyze individual interview data from demographic surveys and transcripts with the assistance of NVivo software. (Eatough & Smith, 2008; Smith & Shinebourne, 2012). First, I read each interview to orient myself in the data. Then I created summaries of each transcript that I sent to participants to review, offering an opportunity to adjust or approve my understanding of the interview. Most participants responded indicated the summary accurately captured their intended meaning from the interview. One participant offered clarification about a specific word used in the summary to expand its meaning, which I updated. Three participants did not respond. Next, I read each transcript and sorted the data into themes. Two independent researchers with no connection to The Network reviewed de-identified transcripts and initial themes. These researchers indicated whether they agreed with the themes I had created, as well as indicated any other themes they thought were relevant. Themes identified across researchers were kept and those without consensus were reviewed and updated. Finally, I analyzed themes to see commonalities and differences across interviews, forming more general themes that captured multiple participants' experiences.

Once I had completed analysis of demographic information, focus groups, questionnaires, and interviews, I looked for commonalities and differences between these forms of data collection. I found many similarities in overarching themes, which was predicted as the majority of participants engaged in all forms of data collection.

My doctoral supervisor reviewed my analyses on an ongoing basis and discussed my process at many check points, including after analyzing the first focus group and first interview, after analyzing all focus groups and all interviews, and to review overarching themes. Our process included reflexive conversations about personal assumptions prompted by the data and analytic process.

Trustworthiness and Rigour

I aimed to design and conduct this study to ensure quality and rigour of the research, by applying the standards of qualitative research set by Morrow (2005), which include sensitivity to context, credibility, dependability and catalytic validity.

Sensitivity to Context

There is strength in qualitative research that facilitates deep understanding of a phenomenon, including the context in which it is situated (Camic et al., 2003; Stiles, 2014). Through research design (i.e., epistemology, data collection, analysis, dissemination), a qualitative study can attune to the context of the participants involved and the phenomenon of interest (Wilkinson et al., 2004). In this study, I selected a social justice framework to attend to important contexts that may influence the study, such as the social locations of researchers and participants, systemic pressures and changes, and group dynamics. I also used IPA to guide the research methodology and analysis, as this framework facilitates the ways in which participants and researchers make meaning and understand their lives (Eatough & Smith, 2008; Smith & Shinebourne, 2012). IPA with focus groups allowed me to capture meaning-making on an individual level, as well as within the group (Palmer et al., 2010; Phillips et al., 2016). Engagement in on-going reflexivity aids researchers in being open to the data and reduces the likelihood of distorting the analysis with a personal agenda or biases that do not serve the goals of the research. Thus, sensitivity to context was monitored through a practice of reflexivity, wherein the I kept a field journal of personal reflections and emerging interpretations, as well as any assumptions and biases that were apparent (Yardley, 2015). I also shared aspects of these reflections with my supervisor to process my perspective and its impact on the data.

Credibility

Lincoln and Guba (1985) deemed credibility in qualitative research as how the study produces accurate descriptions of the phenomenon of interest, such that the participants can recognize and agree with the data. Strategies for credibility include sound research methods, multiple forms of data collection, verification, member checks, and field journals (Lincoln & Guba, 1985).

Clarity and appropriateness of methodological coherence is essential to sound research. Sound research methods can be established through the research design and understanding of research theory and practice. I selected an epistemological framework that aligns with the research methodology as well as the research goals, research questions and contexts in which data was collected.

Triangulation of data, which refers to comparing multiple data sources on the same topic, adds rigour and validity to the results. In this study, participants had multiple ways to provide data: through demographic surveys, focus groups, and written online questionnaires, as well as via interviews. This offered a robust data collection that corrected for difficulty participants may have in sharing information verbally, in written format, or in an individual/group context. For instance, if participants had barriers to participating in a group context, individual interviews were possible.

Verification also contributes to credibility when research is audited by others. The design of this study was examined by senior researchers, as well as a research ethics board. The study was supervised by my doctoral supervisor, Dr. Ada L. Sinacore, and she audited the research process, including reviewing analysis and interpretations of data. Further, two research assistants aided in a process of thematic review to reduce any biases in analysis.

Member checking is another way to establish credibility in research. This involves inviting participants to verify the accuracy of the analysis. Participants were able to review individual transcript summaries. Most participants engaged in this process and of those, all summaries were approved, with one minor revision.

Field journals have been recommended as a way for researchers to practice reflexivity (Lincoln & Guba, 1985). As IPA requires subjective interpretations from the principal investigator, it is essential to minimize imposing assumptions and biases onto the data. Self-reflexivity is a strategy to minimize this risk and field journals are a strategy to develop and practice this strategy. Therefore, I kept a field journal of my reflections throughout the research process, detailing my thoughts, interpretations, assumptions and hypotheses about the research, data, and analyses.

Dependability

Dependability is documentation of the research process such that others can examine, assess, and follow the steps of research that have been taken and understand the outcomes. Dependability was established by recording all research activities at each step of the research process, including design, recruitment, data collection, analysis, and publication. The records serve as an audit trail and were checked for clarity by the doctoral supervisor, Dr. Ada L. Sinacore.

Catalytic Validity

Catalytic validity is a concept referring to the extent to which participants gain or enhance their own understanding through the research process (Kincheloe & McLaren, 2005). Underlying this principal is the idea that research should be a valuable process of knowledge production for participants, as much as it is serves to contribute to institutional knowledge bodies. I invested in fostering catalytic validity through the research design of this study. For instance, I selected a social justice framework to support research processes that empower participants. The ISJCM addresses barriers that may impede participants from being able to fully participate and benefit from research processes, and challenges power dynamics that can hinder knowledge production (Sinacore, 2022). Moreover, IPA as a process of examining meaning making with participants and researchers, thus catalytic validity is inherent to this method. Awareness of the process of understanding is essential to IPA. I invited participants to actively make sense of their experiences and in parallel, I endeavoured to bring awareness to my own experience of making sense of participants' views. Further, since focus groups can help elicit sharing of personal experiences, group dynamics can generate greater understanding for participants through shared reflections, clarifications, perspectives, compassion, and empathy, as well as alternative perspectives.

One of the best indicators of catalytic validity in this project, as was reflected in the data, was that many participants reported that they came to understand their own personal experiences as well as the experiences of their colleagues with more clarity due to participation in this study.

Chapter Four: Results

Results from interviews and focus groups illustrated clinicians' experiences working with 2SLGBTQIA+ clients during the first year of the COVID-19 pandemic. Results were grouped into two overarching domains: The evolution of service delivery during the pandemic and changes in therapeutic processes.

Evolution of Service Delivery During the Pandemic

Analyses of interviews and focus groups described clinicians' processes of learning how to deliver services in the context of the pandemic restrictions (see Appendix L for a timeline of Quebec closures and distancing mandates). Aspects impacting the evolution of service delivery included being inundated with requests for services, feeling fatigued, adjusting fees, and gratitude for having meaningful work. Clinicians spoke about necessary preparations to provide remote services from their homes, as well as the needs and requirements of their clients to access these services. Some clinicians reported navigating in-person service delivery during the pandemic and described the coordination and flexibility between clinician and client to be able to safely share physical space. Resources that helped clinicians set up new modes of service delivery were discussed. Clinicians agreed that remote services were effective and discussed the benefits and consequences of working virtually and in-person. Predictions regarding service delivery models in a "post-Covid world" were made. These processes of setting up and delivering services during the pandemic are represented thematically in Table 1 (next page).

Service Demands

Participants reported being flooded with requests for clinical services during the pandemic. The growing demand for care was linked to participant fatigue, as well as financial stability during a time when many others faced precarity. Clinicians discussed how to ethically navigate the cost of services in light of the complex circumstances of the unfolding pandemic.

Table 1

Summary of Themes and Sub-Themes of Evolution of Service Delivery Domain

Themes	Sub-Themes
1. Service Demands	(a) Increase in Demand for Services (b) Clinician Fatigue (c) Cost of Care (d) Meaningful Work
2. Learning Remote Service Delivery	(a) Early Days of Remote Work (b) Home Office, Virtual Care (c) Service Users Adapting to Remote Care (d) In-Person Work Experiences (e) Learning Resources (f) Participating in Research
3. Advantages for Remote and In-Person Services	(a) Schedule Flexibility (b) Gender-Affirming Care Support (c) Clinician Comfort (d) Client Access to Therapy (e) Benefits of In-Person Work (f) Future of Service Delivery

Increase in Demand for Services. All participants reported a surge in requests for therapeutic services as the pandemic began, sustaining an entire year, until data collection. Participant 2 stated, “there was really a huge wave of requests, and they continue throughout.” Clinicians emphasized the intensity of requests they received as an unprecedented phenomenon that indicated unmet needs. Requests for services were not only from new clients, but also from clients who had previously sought treatment and wanted to return to therapy for support during the pandemic. In one focus group, discussants agreed when a participant stated, “an influx of clients that I had previously worked with are wanting to have sessions too.” The demand for therapeutic services was described many times, often in a way that highlighted the extent of requests, as captured by Participant 3. “The amount of requests I get at this point, weekly, is beyond what I could ever hope to manage.” And, as unimaginable as the number of requests, was the time spent responding to the service inquiries, clinicians reported.

A challenge in fielding requests for therapy was that clinicians lacked referral options: private practicing clinicians were full, and public services had exceedingly long waitlists. Participant 13 succinctly reflected the situation. “Everybody's at full capacity.” Many participants cited how clients interested in clinicians with specific competencies (i.e., expertise in gender, sexuality, disability, anti-oppressive framework) had even fewer options in potential service providers, as captured by a focus group participant. “The LGBTQ+ queer community has very specific concerns and challenges that not everybody is equipped or informed to respond to. So, you're dealing with a smaller group of providers who I can refer to.” Clinicians stated the importance of clients working with knowledgeable providers, to avoid harm that may come from working with uninformed clinicians. Participant 8 shared how clients have spoken up about their need for knowledgeable clinicians, citing a client who said: “I really need an affirmative therapist; these have been my experiences and they're not great and really harmful.” This participant, who works for a larger organization with over a hundred practitioners, said only a handful of clinicians had experience working with 2SLGBTQIA+ communities, highlighting the lack of referral options. Another important factor, which was named by Participant 3, illustrated financial limitations in accessing services. “The increase in the demand is not only people needing services, but people needing free services. And that's basically unavailable.”

Clinicians described the intense feelings engendered by the struggle to field a bombardment of service requests with no possible referral sources. Most participants shared feelings of discomfort being swamped with inquiries for therapy while having no viable resources for clients. Clinicians described being haunted by the amount of people waiting to work with them and the difficulty of knowing that many people were in need, yet not being able to help them. Participant 1 stated that, “it's hard to know so much, it's hard feeling that there’s a world of need out there that I can't meet.” And Participant 3 reported taking on more hours to respond to need. “Especially with how much demand for support and how much my work has increased since the pandemic started. It's a lot. I work overtime every single week since the pandemic started.”

While notably difficult, participants also recognized the privilege of being able to continue to work during the pandemic, a time during which many lost jobs. Participant 2 said, “I’m one of the privileged ones whose possibility for gainful employment has increased.” Participants even expressed feeling guilty for being in the position of being able to work, describing, “the strange situation of almost benefiting from this situation professionally, by growing my practice and having more long-term clients.” However, navigating how to work during the pandemic came with challenges.

Clinician Fatigue. Participants reported higher than normal levels of fatigue throughout the first year of the pandemic, up until data collection. Participant 12 plainly said, “I feel more tired.” Participant 13 contextualized the tiredness as a result of the conditions of the pandemic. “It's really the tiredness of this situation that is really present.” Participant 8 named facing pervasive negative information as a contributor to fatigue and linked that to personal content consumption on the internet. “The doom scrolling phenomenon really tires me out.” Low energy levels impacted clinicians’ wellbeing, effectiveness as therapists, and lives. Participant 10 aired worries about building a tolerance to fatigue. “I have been on the border of feeling burnt out a few times and I’ve been getting a lot better at this, so I would just go on, go on, go on until my body couldn't do it anymore." This clinician also spoke about feeling irresponsible to family when work required more energy. Other participants also voiced how fatigue became a barrier to engaging in activities, such as continuing education. A focus group participant lamented, "I did nothing else. I let all of the courses go by. I was immediately very tired. I'm less tired now than I was then, but I was exhausted for the first many months." Some participants recalled wishing clients would cancel sessions and others described hoping the workload would lighten, as mentioned in a focus group. "I wanted to reduce my practice, but people never went on vacation, so I actually didn't reduce it as much as I wanted to. I thought I would do fewer and fewer hours, and everyone just stuck." Working remotely during the pandemic also evoked reflections on workload. A focus group clinician explained how remote work "drew my attention to how many activities I was doing." The change in work modalities drew attention to work and this clinician realized that even prior to the pandemic, the workload was too much.

Clinicians reported that a stressor contributing to fatigue was that clients were struggling more than ever and had lost many of the supports in their lives. Clients were facing bigger challenges with diminished access to friends, family, activities, and thus fewer viable coping strategies. Participant 1 reflected on the impact of caring for clients facing so many burdens with limited support. "The work itself is harder, absolutely." Participants described how for 2SLGBTQIA+ clients in particular, the pandemic may mean moving back home with transphobic parents, in addition to no longer being able to access any queer-affirming spaces. Some clients were isolated in especially challenging contexts, while also grieving, facing uncertainty, without work, and facing the many other adversities brought by the pandemic. Participant 12 reported the dire impact of becoming the main resource for clients. "I feel more tired. I feel that I wasn't allowed to take as many breaks. I was getting depressed, and I was burnt out. I was extremely fatigued.” Many others reported feeling these pressures. Similarly, Participant 3 shared that there are, “more people in crisis, a lot more people in precarity and that's a lot. It's hard to hold.” Clinicians were managing their own grief and adjustment pains, while working with the experiences of others, with few opportunities to replenish their spirits or guide clients to additional resources.

Cost of Care. Clinicians discussed the responsibility of offering financially accessible services to clients during the pandemic. Participant 2 described working through how to support clients who lost work. “They lost their jobs, they lost their income, there was no longer any revenue and so then there was a huge adjustment on that level. I had to really think about ‘okay, I need to continue working with them.’” Focus group participants also discussed wanting to respond to clients who had lost work by adapting fee structures to allow for clients to be able to continue care. “As a practitioner in private practice, I've adjusted, and I think that there's a real social responsibility to be able to meet people.” In parallel, Participant 12 reported that some 2SLGBTQIA+ clients struggled to pay for therapy. “It was difficult, they lost their jobs, which we did try to figure out: sliding scale or putting on bi-weekly, and so we found different ways to manage it.”

Responsibility to financial accessibility was not limited to pandemic-related job-loss. Prior to the pandemic, as part of membership requirements to join the Network, clinicians agreed to offer sliding scales and low fee spots to support 2SLGBTQIA+ clients in accessing therapy, as these populations often faced barriers that prevented financial stability. Yet, even with significantly lower costs, clinicians reported that clients were not always able to access services, or able to engage in long-term, comprehensive care. Clinicians discussed that navigating how to offer lower cost therapy was difficult. A focus group participant inquired, “As far as accessibility goes, there was that question of ‘Okay, well, how much do I adjust for that and how much do I offer?’” Participant 13 similarly spoke about not knowing how to determine who would qualify for low-cost therapy. “I cannot offer everybody $40. But then I don’t find it truthful or equal if one person pays a $100 and the other one pays $40 and the other one at $100 could have benefited from the $40.” Focus group participants shared hopes that mental health care would be covered by public funding: “There's more of an emphasis on funding for mental health services and it's renewed my desire of commitment to ‘how do we get actually this psychotherapy to get coverage and how to get it on a systemic level as well.’”

Meaningful Work. While participants reported difficulty managing energy and facing the burden of working during the pandemic, they also expressed gratitude for having meaningful work. Participant 1 expressed this sentiment while speaking about fatigue. “I continue to be grateful to have meaningful work. I think having meaningful work through this experience has been a resource for myself.” In a similar vein, Participant 6 described working as a therapist as a protective factor and said “I don't think I felt the hardships, like feeling isolated, in a way. I know therapy, it's not quite the same because you're not sharing about your life, but you're still having a social interaction and a meaningful social interaction.” Other clinicians also described meaning work brought into their lives. For instance, Participant 3 voiced how, “it truly feels like a huge privilege to be able to offer these services, especially at this time.” And along these lines, Participant 9 recalled the beautiful moments as clients overcome past traumatic experiences. “The shift in the work is really quite astounding as compared to working with those with everyday problems, when you're working with trauma, for me anyways, what I see that in the shift is beautiful.”

Learning Remote Service Delivery

March 14, 2020, Premier Legault officially declared a public health emergency in the province of Quebec and instituted a series of "lockdown measures" in the surrounding days, in response to COVID-19. Participants in interviews and focus groups described transitioning to remote service delivery, which included working via video conference platforms (including camera on, camera off, and chat features), as well as via telephone. Most clinicians began working remotely in March 2020, when mandated. However, some clinicians had different, unique experiences. For instance, Participant 7 described seeing clients virtually before it was mandated. "I did it pretty early. I am one of those highly anxious people and had been following this and so I was thinking about it in January and so I think I did it maybe about a week earlier." Participant 8 took a different approach, deciding on a two-week hiatus from work before beginning to offer remote sessions. "I was in a personal situation that was okay. I had the finances to be able to not work for that period and I am in a living situation which was comfortable." Nearly all participants indicated that they worked remotely throughout the first year of the pandemic, beginning in March 2020 until focus groups and interviews took place, in February and March of 2021. In addition, during this year, a few clinicians worked in-person at times when restrictions allowed for this (see Appendix L for a timeline of Quebec closures and distancing mandates).

Adapting to virtual therapy demanded a dramatic shift in how services were delivered, which required clinicians and clients to make significant changes. Clinicians described the steep learning curve of quickly transitioning to offer remote services, setting up technology for virtual services, as well as dedicated therapy space within clinicians' and clients' homes.

Early Days. In focus groups and interviews, participants spoke about initial days of the pandemic and in particular, the lockdown, as a markedly different period of the pandemic. Remembering the period when information about the COVID-19 was prevalent, but a global pandemic had not yet been declared (e.g., early 2020), Participant 14 described the confusion that had been present. “There was the weirdness of the first week where people were hand sanitizing and not knowing where this would go.” This participant spoke about screening clients before sessions and speaking with clients about the possibility of transitioning to remote work. Similarly, Participant 12 recalled the uncertainty in the first months of the pandemic. “Comparing before the pandemic with the first four months of the pandemic, which was confusion and resistance and for everyone: it was not just for the clients, for myself too. It’s just adapting to the whole new reality.” Adding to that confusion, one participant who worked for a governmental health care organization described not knowing how best to reach clients initially, when it was not possible to go into the clinic to access files and before their clinical organizations had decided on the means of remote delivery (e.g., phone, video conferencing platforms). Clinicians described the challenges of finding ways to contact at-risk clients and younger clients who lived with their parents but were old enough to have confidential health records. Participant 11 recounted, “It was quite challenging at the beginning. What I remember is, the two places I was working having different rules, but it was sudden. ‘Oh, now you can’t see patients anymore.’” This clinician explained the confusion of early days. “It was difficult to know. What can we do? What can we not do? I was worried for some people and how to access people.” Further, Participant 11 reflected the unfamiliarity of the situation. “So that was quite challenging. Can we do psychotherapy? Can we access the people for psychotherapy? And how we do that, on phone? Never did that before. Then Zoom was right after.” Participant 14 shared the skepticism clients and clinician initially had about engaging in remote sessions. “There was a lot of ambivalence, I think both by the clients and myself, about working 100% remotely.”

Other participants described an easier time adjusting to remote service delivery. For example, Participant 6 shared, “I felt working from home was a pretty easy transition.” Participants who had already worked remotely were more confident in adapting to remote service delivery, as Participant 9 reported: “Moving online, I didn't notice so much because I worked internationally for 10 years.” Similarly, a focus group participant noted, “I found the transition relatively seamless. I've been seeing clients previously who weren't in province or who were away for some reason or another so that part I didn't find too difficult.”

For those new to remote work, experience was gained. As participants spent more time offering virtual services during the pandemic, they reported becoming more confident in their ability to work remotely. Participants described learning to use video conferencing platforms, and finding ways to overcome internet connection issues, for instance by using a video platform as well as the telephone so audio that could remain stable even if there were connection issues. Participant 14 summarize learning how to provide remote services. “I really learned how to connect virtually, even with new clients. So now I have started and ended [clinical relationships] for example. But it was not automatic.” Participant 11 also shared progress within the process of learning to provide remote services “I will not say I’m comfortable, but I’m more experienced with that.” Some participants reported that initially they had doubts that remote therapy would work. With time, participants indicated that remote services were effective, and that this came as a surprise, as many clinicians had feared that technology would disrupt the relationship and compromise the impact of therapy. Participant 13 declared, “We still manage to work deeply, I find, and I was even surprised the first few times on Zoom, [clients] can actually have emotions, even on Zoom." Developing confidence in remote services was described as helpful for doubtful clients as well. Participant 14 said "As that experiential learning occurred, that's helpful. As you believe, your clients can believe also, right? There's kind of a shared hope that this can be functional." Participants also spoke about feeling hesitant to take new clients while working remotely until they had gained more experience and felt comfortable with the new way of offering services.

Home Office, Virtual Care. Participants described the challenges they faced setting up for remote service delivery. Some participants spoke about encountering obstacles trying to quickly convert their in-person practices to function remotely, which required furnishing home offices and selecting appropriate virtual technology. Participant 14 recalled: "In the beginning there was a very quick turnaround that was required." Participant 7 reflected the sentiment many clinicians felt in adapting to remote delivery initially. "It was a bit of a scramble to figure out how to do it online and what platforms to use… some people preferred phone; some people preferred video." Setting up a home office was discussed in most interviews and in focus groups. Participants said they had to purchase home office supplies including furniture (e.g., desks, chairs) and technology hardware (e.g., web cameras, headsets, screens). Participant 5 spoke to the challenges of equipping a new office during the pandemic. "There was a certain amount of stress about, not so much about working online as such, but sort of everything around that. So, making sure I had the right equipment, making sure that I felt safe with data security issues." This participant also noted that there were supply shortages resulting from the impact of the virus on workers and from new supply demands because of the surge in people establishing home offices.

As Participant 5 indicated, another aspect of setting up remote services was the process of ensuring secure data privacy for remote services. Participant 4 reflected that clients were informative during the decision-making process. "I had some clients who didn't feel comfortable with some platforms and that might have been part of, or connected to, their thoughts and feelings about digital security and privacy." This clinician surmised that many queer and trans clients are also more socially engaged and more knowledgeable about data privacy, stating that: "finding the platform that I ended up using was also influenced by the kind of social activist work that some of my own clients were doing."

In addition to gathering office furnishings and selecting digital platforms, clinicians needed to make decisions about where to install offices in their homes. Many clinicians reported not having dedicated closed offices available in their space. Participants described making decisions about what would be visible to clients, and how to separate their space to delineate work from home. For instance, Participant 1 shared, "this is the place on the sofa that I sit, and if I sit here for work also, I'm going to lose my mind, I'm going to be 24/7 in the same spot in a way that's no good." This participant described the process of rearranging furniture and revisioning home space. "I use the chair that's across on the side of the room, that I never sit in, and I dragged a coffee table from a different room to be my desk and it created 'work.'" Confidentiality was another concern inherent in the home, particularly for clinicians who did not live alone. A focus group participant explained, "the privacy thing had been a bit of an issue at first, where I'm living. My partner and I had our offices right across the hall from each other." This clinician described trialling multiple adaptations to establish appropriate home offices. "We had a white noise machine going, but it didn't feel comfortable, so we actually had to reconfigure the house and move an office to the back and that feels a lot more comfortable." Not all clinicians could find solutions at home. Participant 14 described working remotely from a clinic, due to lack of confidential space at home and limited internet bandwidth. However, this clinician faced issues accessing workspace. “I went in, and it was actually very difficult because I was being asked by the building manager ‘why was I there?’ And I was very nervous that the building might shut down completely.”

Clinicians reported that they checked with governing colleges about the rules and regulations for working remotely. Some participants had difficulty finding information that pertained to their specific practices. For instance, social workers who offer psychotherapy in private practice struggled to find information that was relevant to their work context. Participant 5 reported, “I've found myself between two chairs in terms of my professional organizations and one is that the OPQ [Ordre des Psychologues du Québec, Order of Psychologists of Quebec] - their recommendations are based on the setup for psychologists and the OTSTCFQ [Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec, Order of Social Workers, Family, and Marriage Therapists of Quebec] under whose rules of ethics I operate.” Participant 8 described similar challenges faced as an art therapist trying to access resources to guide remote practice. “It has been hard, there not being a ton of online therapy and online art therapy resources.” Clinicians aired the challenges they faced in quickly learning the rules and setting up new agreements with clients, which included consenting to virtual care, as Participant 7 exemplified. “I remember feeling a bit lost trying to get a consent form up and going about consenting to remote sessions.”

Participants reported needing to develop an assessment of client capacity to access services, which comprised access to technology, interest in remote care, and privacy. This required explicit conversations before beginning work, as a focus group clinician described.

"Before starting with a new client, having a much longer conversation about fit, about how I only work remotely, about internet connection." This clinician noted that consent forms were part of that conversation. "I also changed my consent forms, they're much longer, they go into depth about the tele-psychological services and what is required. So, I have mentioned a longer preamble about details, including internet connections." Clinicians also indicated they used ongoing assessments of privacy within therapy sessions, particularly for clients who were living with others. Participant 11 described assuming some sessions were family sessions, even if the intention was to be working one-to-one. "I was working with an individual and now I'm working with a family. A queer single mother with children and the children are at home." Due to the abrupt transition to remote work, the participant described not knowing which topics were okay to discuss when children were listening. This clinician spoke about needing to learn how to evaluate who was present in the session in a specific moment. "So, I said the name of everyone to be sure and when I hear '*Yeah?*' I know they can hear us. That was kind of some strategies I tried."

Service Users Adapting to Remote Care. While clinicians needed to adapt significantly to offer remote services, clients also adjusted to be able to access remote services. Participants described the barriers clients faced in securing confidential space and discussed how some clients were unable to overcome certain barriers and thus were not able to continue therapy remotely.

Many participants spoke about clients lacking private space where they could attend therapy sessions. This was discussed in a focus group. "Well, they might have challenges too, of just having a literal space to attend a session at home." Another clinician replied, "For sure. I had a client who sometimes saw me in the bathroom." Clinicians reported that clients employed many different ways to secure privacy, as Participant 7 detailed: “clients have been really creative in terms of sending their partners out on their weekly walk or getting in their car or them going for a walk.” Similarly, Participant 14 spoke about feeling confident in knowing how to navigate clients who wanted to have sessions while walking, after reading about it. “In an article one psychologist was doing therapy walking down the beach. So, actually, I had a couple of clients that to ensure their privacy and calmness, they would be outdoors.” This clinician reported that documenting the location of the client while walking was required to stay within professional regulations. Participants described feeling more flexible about making changes to the locations of therapy over time and spoke about the new possibilities for work that bloomed during the pandemic. In one focus group a clinician said: “the ideas on how different people were practicing just opened up additional spaces and being, always professional, but more flexible, with thought-out boundaries in that flexibility.” Participants also experimented with technology to protect confidentiality, for instance, using the chat feature on video platforms with clients to convey information without saying it out loud, as was shared in Focus Group 2. “And so being able to type something rather than say it out loud for safety reasons has also been really, really, really helpful.”

Participants reported that few clients ended therapy, yet one of the main reasons for terminating was due to lack of private space. Participant 12 described how the combination of therapy without privacy had resulted in domestic abuse, and thus it had been necessary to end therapy. “I see my clients being affected, clients who live with families. I had to terminate two clients who didn’t have any privacy at home to talk and even just having therapy was turning into more violence.” Some participants also reported that clients did not want to work remotely and chose to end services. Participant 5 described: “I did have a small number of clients who dropped out because they did not want to work by tele-practice.” A focus group participant illustrated specific concerns of immigrants and refugees, who were reluctant to share sensitive information online or on the phone due to “fear that someone could be listening.” This participant explained that clients’ past experiences could make it difficult to trust remote services, and further, it was not possible for clinicians to guarantee privacy. Overall, participants reported that most clients remained in therapy and were able to find ways to access therapy remotely.

In-Person Work. Participants who worked in-person during periods when pandemic restrictions were lifted described how they navigated this shift. Participants named reasons for working in-person which included having migraines from working online, preferring in-person work over remote, finding in-person sessions facilitated their approach better, and extending services to clients without remote technology access. One participant reported returning to remote work after finding the in-person safety protocols distracting in session. Another participant stated that they considered in-person work but did not take steps to return the office to see clients.

Participants shared that setting up in-person work required extensive consideration and planning. Thinking through the feasibility of in-person work and needing to make decisions about who would be able to access in-person sessions, were necessarily considerations, along with determining levels of tolerable risk, who would be impacted by risk, what safety precautions were necessary, how to put them in place, and what indicators would prompt a return to remote sessions. Participants reported using many different strategies to prevent viral infection during in-person work, including rearranging office furniture to put distance between clinician and client, masks, shields, and sanitization of hands, surfaces, and materials.

Participants described adhering to safety protocols as challenging, as well as disruptive to therapy. Some of the safety measures created distance between the client and clinician, as described in focus groups: “I realized it was very sterile, almost because people are wearing masks, I was wearing a mask, a visor. I mean we did manage, but it was complex because of all the disinfecting, the protocol, the screening before.” This clinician described how safety measures changed the felt sense of therapy. “At one point when somebody was crying, asking permission to remove the mask. So, it was actually a very complex dynamic.” During the first year of the pandemic, there were changes in the governmental rules that imposed work-from-home orders, which allowed clinicians to work in-person for periods of time and then forced clinicians to change from in-person back to remote work quickly. Clinicians struggled to stay up to date with these rules, as Participant 13 summarized. “The stressful part was also with Santé Publique always changing their guidelines for us in person. So, I think the first month or the first two, three months I would email my clients every two weeks with the new directives.”

In addition to adapting to changing rules and protocols, clinicians described thinking about their clients differently, as their clients’ activities had the potential impact their own wellbeing, as well as others in their life, including other clients. Participant 13 described worrying about client contact with other people between sessions and using this information to determine if in-person sessions were safe to continue. “I think what's really hard is being, not the authority, but keeping track in a way with what's happening in the client’s life.” This clinician described the discomfort of tracking clients’ activities and reported thinking about how the clients’ risks became the therapist’s. “I have to consent in a way, and I have to think about my safety.” Participant 13 described thinking about client disclosure of COVID-19 risk during sessions: “If you're at risk why are you here? You're putting me and my clients at risk.” This was a new kind of clinical scenario that changed how clinicians thought of their clients, bringing more attention to the possible threat associated with client activities. Participants traced safety between themselves and the client, as well as between the others in their lives and their clients' lives, as was discussed in focus groups: "The question of seeing people in person was also about my comfort as a pregnant person and not wanting to get sick for that reason and of course not wanting to get other people sick too." It was reported that that working in-person added considerable mental activity to calculate the factors contributing to safety and to flexibility respond.

Learning Resources. Participants shared the supports that helped them adapt their practices during the pandemic. Participants stated that talking with others was one of the most important ways they learned about how to adapt their work to the new and changing contexts. Participant 1 shared, "I didn't do a lot of the trainings that came out, or reading the guidelines, I didn't do a lot of that at all. I did a lot of thinking things through with friends." Most participants reported that they regularly spoke with other clinicians to gather and process information. Participant 8 said, "I would say the people in my professional life have been the best resource." Participants reported that supervision was essential for gathering and processing information about the pandemic and service delivery decisions. For example, Participant 8 described meeting with a supervisor who was also navigating adapting practice during the pandemic and said, "I really look up to her as somebody who logistically has her work together and is very good at executing the logistics of therapy in an ethical way, so that's been really helpful to meet with her." In addition to supervision, some participants found therapy to be a crucial resource during the pandemic. Participant 12 stated, "I couldn't imagine going through this without having my own therapist supporting me and being supervised every week." Participants spoke about learning from research colleagues within their professional networks as well. This provided access to data that had not yet been widely published, which participants used with clients, particularly for guiding safety concerns. Participant 11 described how, “with other post-docs who were in public health, we’re working on projects and that was helping me to know that I can give information that are up to date.” This participant reported being able to collaborate with others about specific concerns not addressed yet in mainstream publications, for instance how essential workers could protect themselves and families.

To stay current about information relating to the pandemic, many participants spoke about reading the news more often than before. Some participants reported following news from other countries who were further along in the pandemic for insight on what may come next, as Participant 12 described. “I followed the experts or people who were involved in other countries who were more advanced than Canada because they got it earlier.” Participants shared that staying current with the news was difficult during the pandemic, particularly in the beginning when much was unknown, and information was rapidly changing. A focus group participant discussed the stress associated with digesting vast amounts of news, “hearing [it] every day, the *new* news, sometimes from our very clients before we read it in the newspaper or heard it on the news or whatever. That was wild!” Participants reported that hearing news from clients was dysregulating and made it challenging to stay in a therapeutic stance. Participants felt they needed to follow the news more closely than they would normally, to prevent dysregulation in session. As Participant 1 described, “hearing news from my clients wasn't useful. And, it wasn't ideal, both in terms of the amount of self-regulation that it might require and also trying to stay present for people.” As the pandemic wore on, some participants indicated that they could no longer process the same quantities of news, and many reported curbing their news intake.

Participant 8 stated, “in terms of keeping up with the pandemic, I was really good until October [2020], reading the news and staying informed and now I've chosen to check in once a week unless there's a big event.” Clinicians also spoke about using specific websites, such as governmental websites, to obtain information about the virus, and from their provider associations and colleges for therapy-related information.

Participants noted that they often felt they lacked resources that would be helpful to their clients, as pandemic-related resources often ignored the realities of their clients and failed to consider their experiences and needs, relating to gender and sexuality, as well as other social locations. Participant 11 recounted thinking about some of the mental health coping strategies offered that did not align with client needs. “Doing yoga when people don’t have even the space to sit on the floor, that was some stuff that I thought, ‘I’m not sure I will advise yoga right now.’ Plus, it’s quite a religious-based activity.” Clinicians felt in need of harm reduction approaches to navigate the viral risks of attending, or spiritual-social risks of not attending, religious practices. Clinicians also spoke about needing to tailor some resources to client needs. Participant 9 said, “sometimes I find resources but that I can't share because the language is too complex and the ways that it's presented, the clients I have aren't gonna be able to relate to that.” Few available resources were comprehensive enough to be relevant considering multiple intersecting identities of clients. Most participants wished there had been appropriate resources for their clients, both client-facing and for service-providers. Participants also wished for more information about setting up remote services properly and navigating privacy concerns, as well as resources for provider self-care. Participants spoke about using resources designed for trauma, chronic illness, and disability as helpful frameworks to process aspects of the pandemic and navigating restrictions. Additionally, participants noted that trainings were more accessible than ever before, as exemplified by Participant 5, “It's been nice to have some kinds of training, it's not so much specifically about dealing with the pandemic but training in general, it's been more accessible.”

Experiences Participating in Research. Consistent with the reports that speaking to other professionals was one of the most helpful ways of learning how to navigate the pandemic, many participants identified this research project as contributing to their understanding of their experiences. Participant 1 shared, “it has been a really interesting process to have the opportunity to think these things through and respond to the questions. I appreciate that.” Clinicians stated that it was satisfying to hear others had faced similar challenges, and useful to hear how others had managed. Participant 3 spoke about the process of the research and the potential of the experience of the focus groups themselves, as much as the end results of the research, to inform and benefit clinicians. “Part of what is so interesting about this research project is it's particularly important as a resource, like, figuring out what is needed and what are people doing and how can we resource each other.” Others also commented that developing thoughts was a benefit of engaging in this project, like Participant 6. “These are the kinds of things that have come up that are like shapes of thoughts that aren't really formed completely yet.” And others commented on their personal findings, like Participant 4. “I was actually surprised by some of the things I ended up talking about because I haven't really thought about them. I was able to see and understand something about the place of therapy for my clients.” Throughout interviews and focus groups, participants referenced their experiences participating in this research project, as well as interacting with each other.

There were many positive interactions between participants during focus groups. It was easy to see that participants were listening to each other and having their own thoughts and experiences evoked by what others said. Even at times when participants shared different experiences, the conversation respectfully reflected those differences. Often participants would be prompted by others, for example, a focus group participant led with, “Just to jump off of what [*Participant*] just said…” Clinicians also ensured others had a place within the conversation. For instance, a participant said: “I'm just trying to keep space because I'm wondering if [*Participant]* is sort of gearing up to say something.” Participants demonstrated respect for others to have the time and space needed to speak comprehensively. In one instance, a participant asked, “Are you done?” And was answered, “Yeah, go for it!” before beginning to talk. In another example, a participant apologized, saying, “I think I interrupted you,” after jumping in to speak excitedly. There were no examples of participants engaging disrespectfully.

Some participant interactions were moments when focus group participants offered each other advice and shared solutions. Participants spoke about how sharing and talking through experiences was helpful and one of their most useful resources during the pandemic. A participant described the group sharing together in team meetings. “We met on a monthly basis and exchanged and talked about our Zoom fatigue, our challenges, that was really appreciated. We could express our own anxieties, challenges, and as therapists had that shared common experience which was also very rich.” Other participants agreed that it was helpful. Focus groups were useful to explore differences amongst clinicians, and helped clinicians understand their own experiences as well as others.

Many participants spoke about wanting to thoroughly answer questions and expressed hope that they were offering enough information to make the research project feasible. Participant 1 said, “I'm just mindful of wanting to give you everything you need so, am I? Am I doing it?” Participants also sought clarification about questions, suggesting they wanted to ensure they offered pertinent examples. For instance, in focus groups, participants sought more detail about an interview question regarding changes to practice, asking: “What kind of changes?” Additionally, some participants shared concerns that they had insightful information on the topic. At the end of the interview Participant 13 offered feedback on the experience and revealed previously held worries about offering useful data. “It's a pleasure. At first, I was like, ‘Am I gonna even help? I don’t know what to say.’ Now I'm like, ‘Oh, I did say a lot, I'm okay.’” It is important to analyze if demand characteristic were elicited such that participants were wanting to be “good participants.” Indeed, there are shared values between the researchers and participants that would make it plausible that there is a social desirability to present information in a specific way. However, participants were willing to volunteer on a team holding these values prior to research, indicating these are authentic shared values, not derivative of research conditions. Further, participants willingly shared challenging experiences and struggles that they faced, indicating that it was a setting in which authentic expression was possible.

Advantages of Remote and In-Person Work

Across interviews and focus groups, participants spoke about the benefits and consequences of remote work and in-person work. Participants reported many advantages inherent in offering services remotely, including ease of scheduling for clients and clinicians, as well as opportunity to work from varied locations. Additionally, clinicians found remote work more comfortable. Yet, participants did not discount the experience of in-person work and its merits.

Schedule Flexibility. Providers described scheduling as more flexible when offering remote services, benefiting most clients as well as clinicians. Participant 11 reported that clients with busy schedules preferred remote sessions. “Going to therapy means losing time off work or something else and so they can go to therapy while not changing their schedule.” Working remotely meant no longer adhering to an office schedule, which allowed clinicians to more easily change their schedules to fit their own needs, as well as client needs, as Participant 2 described. “I think that in terms of being able to be more flexible, that was the something certainly marked. You can switch things around on screen; it's a lot easier, you're in your environment.” This was notable for clinicians who were renting or sharing offices with others, as noted in focus groups. “If you have a shared office, for example, and someone's like ‘can you just see me on Thursday?’ and you don't have the office on Thursdays, then you can't see them on Thursday.” Participant 10 spoke to the additional time and energy spent on administrative aspects of renting shared office space, as well as financial concerns. “I didn’t have my own office, so I was renting from [a clinic], which was not very convenient because it was quite expensive, but also, I don’t like having a different office every time.” Participants also reported that if clients cancelled sessions, they felt less frustrated, because they were not stuck at their office. Participant 2 exemplified: “I could be a lot more flexible around client demands for rescheduling. And when people would miss, it just wasn't such a big deal.” Clinicians spoke about being able to be more accommodating of client needs as well, finding it less complicated to reschedule, or to offer varied kinds of support. One participant spoke about deepening therapy by seeing a client twice a week, which was not previously possible due to limited shared office hours. Another clinician offered different kinds of sessions, including shorter check-ins to respond to crises or ground a client.

Free of the confines of sharing a clinic office, Participant 5 described being able to devise a schedule that provided more rest and time off, which replenished energy levels. “I moved to a setup where I work Mondays and Tuesdays every week, and I work Thursdays and Fridays in alternating weeks, and this means that every two weeks I have from Wednesday to Sunday off.”

This clinician noted how this would have been more difficult, if not impossible in-person. “The fact that I'm seeing everybody from home gives me flexibility in that regard. It would have been much more complicated if I'd had to deal with scheduling office time and all that.”

Remote work also benefited participants’ schedules, eliminating time spent commuting. Participant 6 realized how taxing travel was on energy levels. “Being able to practice without travelling to and from work, being able to be more flexible with my schedule was actually a very big relief to me. I was feeling quite burnt out before the pandemic.” Another advantage to remote work that participants mentioned was being able to work from other locations. For instance, one participant spoke about working from a cottage in a rural area and enjoying being closer to nature when work finished. Remote work also made services available to clients at distant geographical locations. For some this meant being able to work with 2SLGBTQIA+ clientele who may not have access to proximal affirming practitioners.

Most participants found remote work improved scheduling, but some clinicians, especially those with children, indicated that in-person work facilitated ease in their schedule. Participant 10 shared how scheduling was more complicated when working from home due to frequent Covid-19 scares at day care. “As soon as someone has a fever, a cold or something, they are home so I’m spending all of this time to figure out my schedule.”

Gender-Affirming Care Support. Working remotely offered flexibility that made it easier for clinicians to support gender-affirming care. Participants reported that they were able to take on more assessment sessions to write letters for accessing gender-affirming medical care, such as hormone therapy and surgeries, as scheduling was more feasible without physical offices and commute travel time. Participants discussed how it was easier to schedule assessments into cancellations spots with virtual care compared to in-person. Focus group participants discussed the difficulties of finding appointment times for short term therapeutic encounters, like surgery assessments, when working in person. “It's harder to fit someone into the day, physically.” Clinicians reported being able to schedule assessments in off-hours to accommodate clients because they were not sharing offices or inconvenienced by traveling to the office. Further, focus group participants reported that assessment required less of a robust therapeutic alliance compared to therapy, indicating the viability of remote sessions. **“**It's a slightly different thing than starting a therapy process, in terms of the intensity of the alliance that you need to build, it's a different kind of alliance that you build, quicker, and doesn't need to last.”

Clinician Comfort. Clinicians discussed finding remote work from home to be more comfortable than working in a clinic. Participants indicated that they had more freedom in how they could spend their breaks, which meant they may be better rested for the next session. Participant 7 reported having more substantial breaks that involved taking naps or making tea. “I like being able to take more of a real break than if I was at my office.” Participants also spoke about feeling more grounded and centered in their own homes and named being at home as contributing to their wellbeing. Clinicians described a sense of relief not having to commute, which for some, provoked social anxiety. Sharing a workspace could further exacerbate social anxiety. Working from home alleviated these anxieties and allowed practitioners more attention and focus for their sessions. Participant 5 illustrated, “Sometimes it has felt almost like a help because I have some social anxiety stuff and not having to go outside all the time, not having to go downtown to work and all that sort of thing has been enjoyable.” Similarly, participants indicated that working from home offered more opportunity to ease physical pains. Participant 7 shared, “as someone with a lot of chronic health issues, it's been wonderful to stay home and be able to put a heating pad on my belly and just have the things that I need to feel more comfortable.”

Client Access to Therapy. Participants reported that remote therapy was more accessible for some clients. Removing the commute to therapy was helpful for clients with depression, anxiety, executive functioning difficulties, sensory stimulation overload, chronic pain, and chronic illness. Participant 1 illustrated, “People who chronically cancel and no show, don't do that anymore. So, it's definitely provided an accessibility in that you don’t have to leave in order to come to therapy.” Focus group participants discussed how clients no longer cancelled sessions when they went on vacation. Instead, clients brought their therapist by having remote sessions while travelling. Participants reflected about the meaning this may have for clients, including the wish to share more of their lives with their therapist. “It raises a lot of interesting questions about how the clients are understanding that [having sessions while on vacation] and what their fantasies are about, ‘oh, my therapist comes with me everywhere I go.’” Participant 3 spoke to the utility of remote sessions considering co-morbidities within neurodivergent populations: “A lot of folks are also dealing with all kinds of chronic pain and illness and unpredictably, right? So, there's days where I'm meeting with them [virtually] in their bed because it hurts too much to go anywhere else.” Participant 11 captured the anxiety some clients experienced attending sessions in person, which could be avoided by meeting remotely: “Huge amounts of stress from talking to the receptionist, from knowing how things work, waiting. A lot of anxious thinking about how they’re late one-minute. Things like that were creating an amount of stress that I never saw online.”

Clinicians reported that audio sessions offered a way for clients to attend therapy without being seen. Participant 10 described only using phone with one client. “She has a hard time dressing and washing so she doesn’t want me to see her, and it’s been working very well for her because it turns out that she’s able to open up.” Participants reported that some clients who experience gender dysphoria found turning off their camera useful to reduce barriers to attending therapy. A focus group participant said, “I have a lot of folks I work with who, for dysphoria reasons, aren't comfortable turning their cameras on and that's fine.”

Video conferencing platforms offered new features for therapy, like text-based chat boxes and screen sharing, which also increased accessibility. Participant 5 reported working with a recently deaf client who needed the clinician to type communication using the chat feature. “It wasn't a question of using an interpreter and so we would connect, and I would type questions on the keyboard, and they would respond verbally.” Participant 3 named numerous ways that online platforms facilitated work with neurodivergent clients. For clients who struggle with verbal communication, the chat function allowed for new methods of communication. “We do speak verbally, but there's certain folks who I meet with, or I have met with, who it's only by chat, which is something that I didn't really have a good setup for before the pandemic.” Regarding the chat feature, this participant also offered, “If there's things that are too hard to say out loud or they're having a day where they're mostly non-verbal or whatever, it's so, so helpful to be able to use the chat.” Participant 3 also noted that the screen share feature was helpful for clients who needed assistance understanding emails or filling out applications. Further, video features allowed the clinician to see into a client’s space, which could allow the clinician to help a client organize items or problem solve with the client, with added visual information.

Benefits of In-Person Work. When speaking about in-person work, many participants described it as a richer experience with more easily available interpersonal information. Some participants spoke about preferring the way in-person sessions feel, as Participant 7 noted:

“There is something I miss about being in-person though. There's a quality of perception. I don’t get to really feel people's energy as the same, remotely.” Clinicians also pointed to the benefits of in-person work by describing the challenges of working remotely, such as finding it harder to connect with their clients and feeling the experience was diminished or less full. Participant 12 surmised, “I feel like I put in more, and I received less.” Participants reported having a more difficult time gleaning information from clients and found it more complicated to express themselves when working remotely. Participant 2 explained, “Not being able to read people's bodies is definitely an aspect, and not being able to express myself the way I normally express myself. And I think I move a lot and I'm dynamic in that way.” The participant motioned with their hands to add expression to their words, gesturing outside of the video frame, while explaining how they lack non-verbal information from clients’ body language in session, as well as ease in their own range of expression. “I had to try and reframe and say, ‘you can't see what I'm doing now, but this is what's happening…’ And I'd have to wonder what their hands were doing, what their feet we're doing, so that was a change.” Without the full embodied experience, some clinicians found that both clinician and client were less present in session. Participant 2 explained, “People not being quite as focused, and myself included. There's just more wiggle room, right? When you can be in front of somebody and your hands can be doing something else, you can be distracted in a way.” Participants indicated that not only do they have less clinical information, but they find the experience less enjoyable online and more pleasant in person. For some, working online had deterring consequences, as Participant 10 shared, “I really found that it was hard, and I started having migraines.” Participants also noted that in-person sessions did not suffer from disruptions due technology issues. A focus group participant recalled the many times when sessions for interrupted by technical errors. “The irritations of, ‘my connections not very good' or 'what, what did you say?' Or spending ten minutes saying, 'maybe if you log in again, blah, blah.'" This participant reported missing in-person sessions and said, "it would be kind of relaxing to just be in the same space and not have to deal with all of that stuff."

Some clinicians stated that working remotely was more tiring than working in-person. As Participant 14 described, "I was Zoomed out at the beginning. Exhausted." Similarly, participant 8 reported: "feeling a lot of fatigue. Feeling, a lot of my days, even though they're the length they've always been, feeling really drained after that, especially working online." The demands of virtual sessions curbed how much work clinicians could do. A focus group participant reported how, "because of Zoom fatigue, or just feeling I've been online all day, I don't want to do another meeting." Participant 12 shed light on another way in-person work was energizing and preferable: it allowed connection with colleagues. "When you're in the clinic and that five minutes, ten minutes break you have you go to the kitchen, go grab a glass of water, you see your colleagues you exchange a smile or joke or something." This clinician mourned the loss of smaller interactions and described no longer being able to ask colleagues quick questions between sessions and spoke about the difficulty of connecting with other clinicians in the evenings after a long day of video conferencing at work. Isolation and fatigue were elements integral to working remotely, and it was challenging to invite smaller social moments into the day or have enough time to schedule time to connect with others. This clinician noted the difficulties of working in private practice, where clinicians must intentionally plan for peer interactions, pay for supervision, and may not have any collegial support.

Future of Service Delivery. Participants made predictions about their plans to continue to offer remote services in the future. Most participants indicated that they would offer a combination of remote and in-person services to accommodate a range of accessibility needs for clinicians and clients alike. Not only did many clinicians prefer to work remotely as least part of the time, but they also predicted clients would want to continue to access services remotely. As many participants found benefits to both types of service delivery, being able to work in both formats was indicated as advantageous.

Participants imagined having hybrid practices in the future, that offered remote as well as in-person services. Participant 6 worked through scenarios that may arise, such as clients wanting to switch last minute from one modality to another: “When I do go back to in-person sessions and a client decides one day they don't want to come in and they want to do online instead, I think it's going to be hard to negotiate that.” This clinician did not have answers for the future, but was thinking about how therapeutic services may change, and was curious about the impact of those changes: “As I'm thinking about it, maybe there's something that feels a little bit casual with the process.” This participant felt there may be advantages to both modalities and wanted to feel confident in knowing how to make decisions about service delivery.

Similarly, Participant 12 expressed interest in research looking at the different factors that contribute to effectiveness of service delivery in-person or virtually. “I’m interested in knowing about evidence that will come out that can objectively compare remote work, with the in-person work in our field, and not just during the pandemic.” This clinician also envisioned offering hybrid services in the future and hoped to see more evidence-based literature review the implications of blended services. “I’m very much looking forward to seeing good studies, objective studies, on comparing the disadvantages and overall impact on the system, on people and everything.”

During focus groups, participants explored how to respect clinician preferences for in-person work and brought curiosity to how service provision may impact clinicians as well as clients. A clinician imagined what it would be like to not offer remote services. “I feel like I'd have to justify it or something, especially if someone was like, ‘well, going out in the world is really hard for me and I don't feel safe for whatever reason so why do you make me come to your office where it's not accommodating in all the ways that I need?’” Another participant offered a way a responding to the hypothetical client. “I think you can be like, ‘I prefer to work in this way, and I totally get it if it doesn't work for you.’” Discussing together, these participants underlined how accessibility can serve clinicians as well as clients and the complexity of deciding what is possible to offer. On an individual level, clinicians explored how to comfortably provide services and work effectively, while also thinking through how to provide accessible services for clients, across many therapists.

In addition to thinking through preferences for hybrid service delivery or other modalities, participants spoke about the potential to meet clients whom they have only worked with virtually, in-person. Participants predicted this would be a surprising experience where they suddenly have new information about clients after working intimately for a long time, virtually. Participants noted that it would be helpful to have group discussions together to process the return to in-person work so that this transition goes smoothly.

Changes in Therapeutic Processes

Analyses of interviews and focus groups organized participants' experiences of providing clinical services in the context of the pandemic and the ensuing restrictions (see Appendix L for a timeline of Quebec closures and distancing mandates). Clinicians shared their observations regarding client contexts during the pandemic, which included changes in mental health experiences as well as the consequential impact on community and relationships due to pandemic restrictions. Clinicians also discussed changes to therapeutic contexts. A major challenge faced by clinicians was to provide therapy to clients within the unfolding, unfamiliar, and yet strikingly mutual experience of the pandemic. Clinicians described how they adapted their therapeutic approach to grapple with clients' experiences, which were ubiquitously parallel to their own. Therapeutic adaptations for working virtually were also discussed. Participants needed to honour new information that came from working remotely, such as seeing into clients' and clinicians' homes, and adjust to lost information, such as visual cues of emotion. The rituals of arriving, attending, and leaving therapy changed and participants spoke about the perceived impact this had on therapy and ways they tried to reinstate this ritual. Clinicians' descriptions of their experiences providing and adapting services to 2SLGBTQIA+ communities during the pandemic, are represented thematically in Table 2 (next page).

Observed Changes in Client Contexts

Participants commented on the ways in which mental health was impacted during the pandemic. Participants discussed detrimental changes for many clients, as well as the pervasive isolation and its effects on clients. Yet, some relief was offered for certain conditions, such as social anxieties and sensory overstimulation. Participants noted differences in gender exploration, wherein individual exploration was more possible but interpersonal experiences were limited.

Table 2

Summary of Themes and Sub-Themes of Changes in Therapeutic Processes Domain

Themes	Sub-Themes
1. Observed Changes in Client Contexts	(a) Worsening Mental Health Conditions (b) Stressor Relief (c) Building Structure and Routine (d) Gender Identity (e) Finances and Work (f) Making Changes (g) Engagement in Therapeutic Work
2. Perception of Client Relationships and Community	(a) Impact of Pandemic Restrictions (b) Isolation and Loss of Community (c) Family (d) Social Media (e) Social Movements (f) Communities of Care
3. Changes in Therapeutic Practices	(a) Clinician-Client Parallel Experiences (b) Evolving Therapeutic Approaches (c) In Each Other's Homes (d) Personal Disclosures (e) Physical Space (f) Location (g) New Clients

Worsening Mental Health Conditions. When asked how clients fared during the pandemic, clinicians reported that overall, mental health worsened. Clinicians attributed this to pandemic-related conditions which included tremendous uncertainty, health fears, job loss, precarity, isolation, continuous tragic news, and limited access to resources, among other factors. Participant 2 reported that more people were seeking therapy without a history of mental health concerns, due to the contextual difficulties of the pandemic. "They are experiencing the consequences of the pandemic and so, they're traumatic, they're not having the same contact, they're feeling isolated." Participant 12 also noted that many people were traumatized during the pandemic, on multiple levels, and that this was more prevalent with marginalized clients who faced prejudice, stigma, and discrimination. "I can say that there is more trauma and systemic trauma and family trauma and abandonment present in my clients with minority statuses including sexual minority, including gender minority." This clinician went on to explain some of the challenges faced. "They've been affected because of losing their access to the support system they had, and many lost their jobs. It's a kind of like a snowball of adversity." Describing how marginalized clients were impacted, this participant illustrated how the context of the pandemic shed light on the ways in which people experience prejudice and discrimination. "Pandemic happens, revealing all the problems that is already there, but it's more naked." Along with others, this participant demonstrated how the mental health of clients worsened due to the increased quantity and intensity of barriers and discrimination faced by marginalized clients.

Participants also discussed the ways in which existing mental health conditions were exacerbated during the pandemic. Many participants reported that depression worsened. Participant 1 reported, "People who struggle with chronic depression did a dive. A scary dive." Similarly, Participant 7 stated, "some of my clients who have dealt with depression, I don't feel like this has been helpful for their depression. I feel like it's deepened that experience for them, or a lot of them." Participant 10 described a client with depression who had made significant progress in therapy and was at a point of socializing and engaging in hobbies. When the pandemic hit, this client regressed, no longer leaving the house, or engaging in pleasurable activity. Participant 5 detailed how the conditions of the pandemic contributed to depressive symptoms. "The really, really pathological way of living in the now that you have in depression where it's impossible to consider you will ever feel anything different from the way you feel now." The pandemic offered few opportunities for interruptions to this way of thinking, and as Participant 5 explained, "the idea that this feeling will go away at some point becomes literally not possible to think." A focus group clinician reported the graveness of situation, describing clients who "fell into a deep depression eventually. And I see the deterioration of the situation. Lots of suicidality."

Depression was not the only mental health condition that was aggravated during the pandemic. Participant 7 explained how myriad other symptoms were provoked. "I feel a lot of folks who had stuff in remission, like eating disorders and addictions, that those have been reactivated." Participant 5 described how this phenomenon surfaced artifacts of mental health in a way that bombarded clients. "Issues are coming up in a very blatant rapid-fire kind of way, which is stressful." And similarly, Participant 1 recounted, "people have been, and it would include these depressed folks, triggered into their trauma patterns of that feeling of unsafety." This participant emphasized the severity, saying, "A lot of people went back to their most intense place." Trauma was also discussed in focus groups. As one participant described, it was "an imposed opportunity to work with trauma, because the beginning of the lockdown and last year and all the changes and confinement, triggered the experience of being trapped for many trauma cases that I worked with." This clinician described how the experiences of traumas emerged more intensely. "They started to re-experience lots of dreams, lots of vivid dreams about their trauma, the fears came up and it would have taken me, for example, a couple of years to get that much material from them." Another focus group clinician also described this haunting of the past. "The other thing I personally have been struggling with a little bit is the regression, the eating disorder for clients who had the history of eating disorder, getting back again to those old habits." Clinicians illustrated how clients with prior trauma or mental health conditions were provoked in a way that elicited feelings of those previous experiences, and at the same time, evoked previously used coping mechanisms. A focus group clinician described how clients had fewer outlets and supports, due to social restrictions, which had helped mitigate symptoms before the pandemic. Without these resources, the clinician said it made sense that clients returned to early coping mechanisms. “I'm not surprised about it, getting back their old habits in this kind of circumstance is not surprising.” Participant 8 also spoke about clients struggling to take care of themselves, without access to supports they had put in place before the pandemic and had relied upon. “Especially with COVID, they're in the down space a lot of the time because they don't have the different coping mechanisms that they would use before COVID, like socializing and things like that.”

Clinicians discussed how clients at different phases of treatment were impacted uniquely. Pulling from trans-theoretical models of stages of change (Prochaska & DiClemente, 1983), clinicians described how clients in the action stage, who were beginning to feel more agentic and capable of making change, experienced the pandemic as an abrupt ending to all the progress they had made. As depicted by Participant 1, clients who “were left on a real cusp of change, approaching a moment where things felt possible that hadn't felt possible for so long, are now confronted with the world shutting down.” This clinician stated that this was relevant for people who were recovering from trauma and described a client with complex trauma who said, “I'm never going to get to have a good life. I spent all this time healing and now the world is ending.” The impact of the pandemic on quality of life directed impacted clients’ sense of hope. Participant 1 also described clients in a developmental stage that is planning for a future. “I work with a lot of young folks, like under 30 and there's a real confusion about how to move forward.”

The uncertainty and the lack of opportunity to engage with others were seen as stunting clients who were considering their futures.

Stressor Relief. In contrast to the worsened mental health conditions participants reported, many also noticed ways in clients experience relief, and a break from having overwhelmed nervous systems. One domain where this played out, was social anxiety. Clinicians reported that levels of social anxiety were lowered during the pandemic for some clients. Limited social interactions offered relief to socially anxious clients. Reduced social anxiety provided clients with a rare opportunity to experience living without this burden. Participant 7 reported, “My clients with social anxiety, their anxieties have gone down because they are not social at all. So, they're feeling a lot more comfortable.” Similarly, Participant 9 explained the deep physical impact of no longer feeling anxious. “They're experiencing a state of calmness, but for an extended period of time. A state which their body has not been in for probably many, many years.” This clinician found the break to be useful for recovery, to allow clients to feel in a way they have never felt before. “The isolation has become reparative in a way that they can experience what it is like to be in a relaxed state and understand themselves differently.” A focus group participant referenced the typically increased rates of social anxiety in LGBTQ communities. “Particularly LGBTQ+ clients of mine, social anxiety is prevalent there and many [LGBTQ+] people experience social anxiety.” This clinician also described mitigated symptoms of social anxiety. “Not being exposed to the society and doing most of their social life through the screen and through the phone, I found it to be a gradual desensitization of the social anxiety.” Another focus group participant emphasized the positive effect of reduced anxiety. “Especially with social anxiety clients, it's felt like staying off a broken leg.” This participant recounted a client’s description of the effect, “I felt like I've been having some time to heal and to get eager to be with people again. And because I have less incidental contact with people, I have more reserves left for the socializing that I do."

Social anxiety was not the only relief clients experienced. Clinicians also noticed that clients with sensory difficulties were no longer forced into overstimulating conditions, as Participant 3 explained. "Not having to deal with other people in a small space or a lot of the very physical, sensory things." Additionally, clients who struggled with executive functioning faced fewer barriers attending events, no longer needing to plan travel routes. Participant 3 described clients "not having to take the metro, not having to navigate trying to find a place or understand bus schedules or, not panicking if you miss the bus. All that kind of stuff." Clinicians also reported that clients who experience discrimination were able to avoid some types of interactions with potential for discrimination, at workplaces or in public, even travelling to therapy.

While clinicians were positive about clients having a break from social anxiety and discrimination, as well as limiting overload of sensory stimulation and executive function tasks, clinicians expressed worry about how clients would respond when the pandemic restrictions ended, and social events returned. Participant 5 wondered whether the respite would help clients long term. "Socially anxious people, having had a year off from having to interact with people socially and sort of unavoidable ways that they're not comfortable with all the time, whether they'll feel more able to handle that in the future?" Similarly, a focus group participant was curious about what would happen over time "The exposure in the real life will be even more difficult after this? Or no, this is desensitizing them in their social interactions and then it will be easier?" Participant 11 noted worries came from seeing clients struggle during periods when the pandemic saw fewer cases of COVID-19 and restrictions were lessened, in Spring 2020. "The period after the first big wave, this pre-summer, last days of school, I think when they are meeting, had things to go to, or trying to find job and it was quite challenging for some of them." Participant 8 reported that clients also had fears about social anxiety symptoms returning. "I've had a few clients recently be like, 'you know, when things open back up and go back to normal, the new normal…' feeling scared about being able to adjust back to that."

Building Structure and Routine. Clinicians spoke about the loss of routine as consequential of social distancing restrictions. Clinicians perceived difficulties that clients faced due to having so many activities that reinforced schedule and routine, cancelled. This was brought up as notably difficult for neurodivergent populations but was reported as a general challenge for many clients. As Participant 3 described, "A lot of folks struggle to make their own routines. A lot of folks have been relying very heavily on external routines, so, work and school and stuff like that." Speaking to the impact of routine disruption, Participant 3 emphasized how, "having lost routine also is really, really, really messing with people." Similarly**,** Participant 12 stated, "I found for many clients, lack of a structure to be something that they struggle with and self-disciplining and putting the structure themselves." Participant 13 described difficulties clients had without separation between roles and tasks, and without outlets, breaks or opportunities to relax. "Finding it hard sometimes with their day jobs and their maybe different hats too, or different roles as a partner but also maybe as parents and stuff. So having to manage it all and sometimes it's 24-7." Participants reported that it was also very difficult for clients to engage in rituals that would be integral to routine and structure, and furthermore, contribute meaning to life. For instance, regarding religious events, Participant 11 reported that clients from Muslim and Arab communities were asking: "And how you do rituals in this time?"

A prevalent change among clients that participants described, was setting up routines and finding ways to implement new forms of structure. Participant 3 described how neurodivergent communities utilized online community commitments for structure. “There's a very high concordance between neurodivergent people and nerds, so there's a lot of people who were doing Dungeons & Dragons online before the pandemic and I think has been really helpful.” Similarly, Participant 4 discussed how clients who found affirming identity-based communities online prior to the pandemic, may be more internet savvy and comfortable connecting to others online: “It wouldn't surprise me if there is an element there that was more accessible to people because of because of building an alternate community online.” Participant 7 described how the lack of structure was beneficial in rebuilding better schedules: “For some clients it actually gave them more time to develop healthier habits and healthy routines and spend more time focused on themselves in a really healthy way.” This clinician spoke about how restrictions and pandemic funding afforded clients time and money to build new routines that improved their lives. “Some of my clients started exercising regularly, some of them started eating better, some of them started having nice relaxing routines at bedtime that they were never able to kind of have before.” Participant 7 spoke about finding disability literature helpful for “thinking through routines with people and developing routines; thinking a lot about mutual aid in terms of brainstorming with folks who are really feeling completely alone and who live alone and getting them hooked into community and community resources.” This clinician underscored the importance of maintaining structure and routine, even when circumstance changed and like Participant 3, described the importance of community to support routine and structure. Participant 5 described how to support clients in reinventing social routines: “I've been encouraging some clients to ‘make dates to talk to with your friends on Zoom’, or ‘make dates to set up activities with your friends on Zoom', the same way you would do in real life, using the same procedures." This clinician spoke about how pre-emptively scheduling in time to socialize helped clients prevent isolation and uphold a schedule.

Prior to the pandemic, part of the structure of routine was maintained by the schedule and commute of therapy, which, as participants discussed, changed with the pandemic. Participant 11 described how early in the pandemic, when it was difficult to reach clients, the disruption in the therapy schedule contributed to the overall destruction of everyday routine. "For the patient it was like, 'oh what's happening everything is closing everywhere, and we don't have our weekly appointment. This routine is also part of the chaos that's going on'." On a different level, Participant 6 described how clients used the commute to therapy sessions to organize their thoughts and prepare for session. Meeting remotely reduced this element of the work. "When they were at home, their alarm would go off and they're like, 'oh, therapy,' and then just go sit in another chair. And so, they would get there and wouldn't be as prepared or as reflective." This quote demonstrates how the change in physical space alters the routine and the process, which is discussed more in the Changes in Therapeutic Processes theme, under the sub-theme: Physical Location.

Gender Identity. Participants shared multiple narratives regarding clients' engagement with gender identity. Some participants reported that work with gender took a more prominent place in clients' lives during the pandemic. Clinicians theorized that this may be a result of having greater opportunity to face inward and explore the self. Participant 5 explained, "I really think there have been a number of people who have taken advantage of not being constantly bombarded by the same expectations as usual, to investigate parts of themselves that they have not previously done." Connecting this to gender, Participant 5 said, "There's several people who, over the course of the pandemic, made the decision to come out, or to begin accessing transition-related care.” Similarly, in a focus group, a clinician reported the topic of gender occurred more frequently in therapy. “I have received an exponentially magnified number of requests for people exploring gender.” This clinician surmised that in the isolation of the pandemic, clients are “maybe exploring and evaluating in a way that's perhaps more immediate and more personal and they don't have access either to community-based resources or to groups where this can be normalized.” Another focus group participant discussed how the pandemic facilitated personal exploration: “I think there's definitely some people who have remarked on the conditions of the pandemic being conducive to self-discovery.” This was linked to having more space to consider gender. “I've heard from a bunch of clients who I'm talking about them with gender issues. More than one client who has been questioning since after the pandemic started, possibly for that reason.” Clinicians described how in the absence of social interactions clients faced fewer incidences of gender-related discrimination. This phenomenon was described in a focus group. “Brutal random encounters of negotiating the city as a visibly trans person aren't happening.”

In contrast, other participants reported that gender was less imminent for clients during the pandemic. Participant 7 described, “A lot of my clients who are questioning their gender identity, it has become, for some of them it's just become more of a non-issue because they are not being seen and there's not that mirroring happening to them.” Pondering reasons why, clinicians discussed how the lack of day-to-day interactions puts less emphasis on relational elements, like gender. So being gendered is less important in general, and additionally, people are not misgendered as often. Participant 7 stated, “They're not having a lot of misgendering happening or they're not having to be perceived in a certain way. And when they're misperceived, since it's not happening, there's not that painful dissonance that they experience.”

Participant 7 recalled a client saying, “We can put my gender identity work that we've been doing on a back burner because I'm not feeling as dysphoric because I'm not experiencing this mismatch with how I am and how the world sees me.” Similarly, a focus group participant reported that for clients where discovery of gender identity was previously a theme in therapy, gender exploration has “fallen into the background because they're like, ‘I'm not being seen, this is not on the forefront of my mind anymore.’” This act of being perceived by others was noted by clinicians as an important aspect mediating gender identity. The lack of interaction was also brought up in another focus group. “For some clients I've found that they've become kind of confused about it and not knowing what they want anymore and now knowing how they want to be read.” Another clinician in the focus group brought up other barriers to gender identity, as well as sexual orientation. “Clients who have been working on clarifying their gender identity and sexual orientations, they report regression on that because of not having social exposure enough and not being able to date.” This focus group clinician also brought up delays in gender-affirming medical care that many clients faced, which made it difficult to access hormones and surgery, citing “challenges with seeing doctors, hormones, and the body-image issues that come back with not receiving the hormones and other kinds of tests that they need, like thyroid.”

Gender-Affirming Medical Care. Access to medical gender affirming care was discussed by many participants. Already a complicated resource to access for trans and gender diverse people, the strain on the health care system during the pandemic delayed care and re-configured pathways to care. Clinicians reported that lack of access to hormones and surgeries had a tremendous negative impact on clients, making an already difficult system more challenging. Participant 5 summarized trans clients’ reports attempting to access various medical-based gender-affirming care. “I have difficulty accessing services because there are all these wait times, everything is moving more slowly and is a bit more chaotic. I don't understand the service delivery routes. The wait lists are crazy, and that's getting me down." In exploring access to gender-affirming medical care, a focus group participant asked, "To get access to hormones, how do you even see a doctor at this stage?" The discussion mapped out some of the repercussions that clients experienced, such as stress, increases in gender dysphoria, confusion, and difficulty waiting. "New prescription for hormones has been very difficult. Surgery was shut down for a while and I think people were stressing around that."

Finances and Work. Changes in financial security, money, and work, due to the pandemic context, were prevalent amongst participant accounts of client experiences. Clinicians documented the differences in experiences, noting that some clients' finances improved during periods of the pandemic, whereas others worsened significantly. Participants discussed the relationships between the unique intersections of a client's identities and contexts and financial security. "There was a variety of stories around the money and stability aspect of accessibility, depending on people's identities and financial resources and vulnerability that might intersect in different ways."

Participants reported that some clients were not able to work during the pandemic, due to closure of workplaces, and were thus financially strained. Participant 2 observed, "A lot of people spiraled. They lost their jobs, they lost their income, there was no longer any revenue and so then there was a huge adjustment on that level." Participant 3 described how for many clients, savings were depleted, and debt was acquired during periods of time where it was not possible to work. "Many people are dealing with much more poverty than they were pre-pandemic, and that's such a self-reinforcing cycle. I think a lot of people are also worried about, 'how do I get out of that?'" Participants also discussed how many options for work meant taking pandemic-related health risks as well as working in environments that were discriminatory (e.g., homophobic, transphobic), which contributed to worsening mental health.

Participants spoke about how their clientele were more vulnerable to risks of poverty or financial precarity, prior to the pandemic, due to societal discrimination towards variance in gender, sexuality, and other aspects of identity (e.g., race, disability, religion, language). Participant 3 explained: “Populations I'm working with are at several intersectionalities that almost always mean poverty or at the brink of poverty.” Participant 13 spoke about how barriers to financial stability made it difficult for sexual and gender diverse clients to access therapy. “I think also in the queer community, the money- that's why with [The Network] we have a low [session price] rate but also a sliding scale- they don’t have the money to work [in therapy] or to do long term work.” Even with sessions at $40 and sliding scales, this clinician noted that many clients cannot afford to attend therapy. Participant 12 described the perils of marginalization: “You don’t have much support and family doesn’t support you. You are discriminated [against], you don’t have good job opportunities or a well-paying job.” Participant 3 discussed the dearth of resources that are accessible across intersecting identities, citing how resources are rarely safe for queer or trans clients, and are often challenging to navigate for neurodivergent populations. Speaking about housing and food resources, Participant 3 said, “there's not enough [resources]. And some of the same problems in terms of accessing other services- it's not physically accessible, it's not cognitively accessible, right? It's not always so obvious how to access a food bank.” Clients facing several overlapping forces of discrimination experienced few, if any options, with diminishing access to resources during the pandemic, and worsening conditions. These examples illustrate some of the barriers that 2SLGBTQIA+ populations must overcome to have their basic needs met, due to societal discrimination.

While these populations face barriers to gain financial stability and at population levels see high rates of poverty, not all clients experienced financial precarity during the pandemic. Participants were reflective of some clients’ privilege, which allowed them to afford private therapy and not be mired in basic survival. Participant 2 illustrated, “I work privately, so they have the resources to be able to pay me. It's not like working in community where people are struggling with basic survival; the resources just aren't there for them to be able to benefit from that kind of support that people with money can access.” Similarly, focus group participants discussed populations with whom they work, and a clinician said, “I'm working with people who have access to resources and are quite privileged in their ability to pay for support.” Participant 13 also reflected how clients were able to continue working from home “The majority of my case load, their work was all back at home, so they didn’t have the stress financially.”

Clinicians discussed how work and finances improved for some clients during the pandemic. Governmental financial relief benefits, such as the Canadian Emergency Response Benefit (CERB), a monthly payment of $2,000 allotted to Canadian citizens who lost employment during the pandemic, supported some clients. Participant 8 reported that, “I think people having CERB really helped. I've found that the clients that I started with last year had the disposable income that they previously haven't had.” Many participants spoke about clients becoming more financially stable due to CERB. Participant 7 reflected, “some clients I have fared really well and the pandemic and staying home has actually given them a secure income for the first time in their life and given them more money than they've ever had.” Clinicians discussed how clients no longer had to face abusive work environments, as Participant 1 noted: “Some people were no longer working their shitty jobs in a way that felt good. And the toll that takes on people's mental health too, when they are working at jobs that don't feel good, shifted.”

The benefit of being financially stable and having free time was new to some clients and productive. Participant 12 said, “for some of my clients just getting this CERB gave them a bit of a space to step back and spend time to see what they want to do with their life.” Clinicians discussed how clients rested, developed skills, and focused on new care routines.

Another aspect of work was the attention paid to “Essential Workers” during the pandemic. Essential Workers was defined as those who work essential jobs which include “the functions performed by first responders, health care workers, critical infrastructure workers (e.g., hydro and natural gas), and workers who are essential to supply critical goods such as food and medicines” (*Guidance on essential services and functions in Canada during the COVID-19 pandemic*, 2020). In Canada, there were immigration allowances made for some migrants who were willing to take on the role of Essential Worker. Participant 11 explained the way it changed how clients felt and the ways clients were treated. “It shifted the fear that they are being seen differently socially. They're being called, ‘essential,’ ‘angels,’ things like that. So, they were feeling proud and for some people at the end it was an opportunity for immigration.” This clinician described the juxtaposition of messages clients received. On the one hand, these clients were struggling to be able to immigrate and facing discrimination clients felt othered and not accepted within society. On the other, they were being called “essential.” The participant noted that sadly, not all essential workers were granted immigration, even though all had worked during difficult and dangerous times to maintain functioning of the country.

Making Changes. Clinicians spoke about their perceptions of how clients made changes to improve their lives and to cope with the conditions of the pandemic. As Participant 2 said, “You can't automatically pilot through a pandemic. It requires actual changes and tweaks and thinking things through.” Participant 4 reflected on how queer and trans communities were already primed to think about how to adapt and did this with community in mind. Describing a trend stated among clients, Participant 4 reported, “We can't rely on the government or something to support us all financially, so we'll have to talk to each other and set up other ways of supporting each other and so on.” Participant 12 described adaptive change as an “act of resiliency” and detailed the process of change for clients, saying it started in resistance. “In the beginning it was freezing, was being angry, was sitting, and the heavy emotional package of it would give them a reason, a legitimate reason to not cope with it well.” Then the clinician described how the process moved to acceptance. “It became very long and chronic. At some point, they came to accept that they have to do something for themselves and there’s not much out there to do, so they became more creative.” This participant described how, with acceptance, clients could experiment and develop effective interventions. “I see them developing more independent strategies; that they can cope with problems more independently, becoming more pragmatic over time.”

Perception of time was an important element that contributed to positive changes. Clinicians reported clients benefited from shifting to a mindset where they are attending to the present moment. Participant 5 said, “I feel like some people have become a bit more focused on the day-to-day and it gives them a space to fret a bit less about the future in ways they would do that weren't very productive before.” Clinicians also discussed how conditions of the pandemic allowed clients to have more time, which has helped clients think more deeply about their lives. Participant 12 described how, “just a few months of not having to work 40, 45 hours in whatever job has been helping them to focus on their potentials and preparing themselves.” Similarly, Participant 11 mentioned how delays, while frustrating, allowed immigrants more time to adjust to new aspects of their lives. This was especially helpful for clients waiting for gender-affirming surgeries who needed to set up supports for recovery, as Participant 11 described, “they were ready for the surgery, but the environment was not quite there yet. For some people it’s like that. I think that was positive in a way. They will have more of a sense of how it works here.” The pace of life that changed during the pandemic was seen as beneficial to clients. Participant 14 reflected, “people are almost embracing the benefits of the pandemic, of being able to slow down and to connect and to engage in their creative projects in ways that would maybe not be possible otherwise.”

Engagement in Therapeutic Work. Clinicians explored how some clients were more engaged in therapy during the pandemic, due to having more time to spend on therapy, as well as having more therapeutic material surface. A focus group participant explained, “For many clients, the slowdown was an opportunity to do a lot of more in-depth inner work.” Slowing down was reflected on by other clinicians in individual interviews as well. Participant 9 explained, “there's a greater sense of calm for some people, and also more time to do the work…now that there isn't any of these social events or obligations to attend events in person; it's freed up a lot more time.” Similarly, Participant 13 described how having fewer distractions allows clients to face difficult emotional experiences. “We can have access more to the emotion because they're not always constantly doing other stuff that permits them not to be connected.” And Participant 2 spoke about how having fewer distractions allowed clients to reflect on patterns in their lives. “How they engage in relationships, for them, it's not something that they are necessarily consciously thinking about and in the context of this pandemic with everything slowed down and less noise around, there's opportunity to look at these themes.”

Participants explored a link between having more time and deeper engagement with more personal content arising in therapy. A focus group participant commented, “I've had some clients that I've worked with for years that, during the pandemic and during this process, the depth of the therapy had been accelerated and very profound.” Some participants reported that the slower pace of life and lack of activities during the pandemic allowed more emotions and material to surface. Participant 2 explained, “It's really stuff coming up, because there's just less noise, there's less distraction.” The additional time and space offered room for exploration of experiences, as captured in focus groups. “There's just more place and space for those experiences to express themselves. It's like everything has slowed down, so people are much better able to work mindfully with what arises and to pay attention and to be present for that.”

Perception of Client Relationships and Community

Relational factors were prevalent among participants’ depictions of their clients’ experiences. Clinicians spoke about barriers to relationships, such as governmental restrictions that did not account for client relationship structures, limited access to queer and trans community, discrimination within families, and hardships in dating. Additionally, participants spoke about the communities of care that were prominent among their clientele, which fostered supportive relationships and fostered client wellbeing.

Impact of Pandemic Restrictions. The governmental restrictions put in place to prevent spread of the COVID-19 were discussed as a barrier to connection and relationships, particularly for 2SLGBTQIA+ populations. Province-wide lockdowns mandated in Quebec at the time of the interviews and focus groups prohibited any in-person gatherings, including work, except necessary work activities to maintain essential services. Further an 8pm curfew was enforced that required people to stay indoors until 5am (see Appendix L for a timeline of Quebec closures and distancing mandates).

Many participants observed that 2SLGBTQIA+ populations were less likely to be reflected in the pandemic protocols and rules. Participant 5 described how the restrictions left clients much more isolated than heteronormative peers, due to the rules that limited contact with other households: “This can interact with LGBTQ relationship structures, where we're not all in a bungalow with our spouse and kids.” As Participant 5 explained, “there are lots of people who live with roommates and whose significant others live in another setup, and maybe also live with roommates.” Participant 4 discussed how clients needed to rearrange their home lives and relationships based on “government rules about what you're allowed to do and with whom and how and so on. I have multiple clients who are interested in chosen family or less conventional approaches to relationships.” Accordingly, in a focus group a participant said, regarding 2SLGBTQIA+ communities, “notions of family are different.” Another clinician added, “I work with a lot of under 30 [years old] queer folks and many of them live in collective houses, many of them are polyamorous and that created a number of challenges to negotiating the parameters of isolation.” This participant reported that most clients found ways to be connected to their loved ones, but also reported, “I have a few clients who are still struggling with how to negotiate with their roommates and partners and their roommates’ partners and their roommates’ important people, and it's been a real profound source of stress.” Clinicians offered examples of how clients safely engaged in their most important relationships. For instance, Participant 14 documented the use of “bubbles” or groups of people committed to respecting each other’s concepts of safety, to limit risk of spreading the virus while still being able to socialize with select people who are “in” the bubble; but noted the stress of this solution. “Navigating the different bubbles has been a colossal source of stress. Often an ongoing source of stress because navigating bubbles is complex. And everybody has their own understanding of what is the level of risk involved.”

The emotional impact of not being able to connect with friends and family was emphasized in focus groups. “They really want to feel their friends, or they want to feel their-, most of the time it's chosen family- where they're like ‘I need these people physically with me.’ And so, there's been a lot of despair around that.” Participant 5 also touched on some of the emotional consequences of the restrictions and paralleled the lack of attention to 2SLGBTQIA+ communities’ needs within other pandemics: “A lot of feeling of shame, or a lot of feeling of surveillance and being at risk of being surveyed and negatively commented on by others, or by the State, that looks a lot like the HIV epidemic.” Clinicians spoke about the difficulty of navigating restrictions while living with roommates and wanting to engage in other relationships, as well as about the challenges of living alone. A focus group participant said, “especially if living alone, the extra efforts to remain connected in some shape or form, that could be at times colossal, even now more recently with the curfew.” Participant 10 highlighted the interruption in relationships caused by restrictions. “Because of all the restrictions related to the pandemic specifically, they feel isolated, not being able to go out lunch, not being to see friends spontaneously, not being able to invite someone over for dinner, all of those things.” The limited sense of spontaneity and freedom was noted by clinicians, for instance, participant 14 remarked, “the curfew has been had a big impact on people's sense of freedom. That's really been another layer, this curfew.”

Isolation and Loss of Community. All participants brought up the ubiquitous isolation they perceived clients to be experiencing during the pandemic, due to limited opportunities to connect with others. A focus group clinician described, “They've lost the community resources that they had, like the bars or clubs or other places that they would get together with people and socialize. So those who I have worked with, many of them have been very isolated.” Participant

5 captured the toll of having few relational options: “Sometimes people have one other person in their life and that's not enough. And, also, they feel stressed about, ‘Am I relying on this other person too much? Are they going to get burnt out of me?’” Participant 8 described consequences of being without community: “I think that definitely speaks to the queer and trans community- not being able to access spaces that they know are safe and that community's going to be at.”

Participants also described the ways isolation affects clients. For instance, Participant 4 reflected on the ways in which isolation could evoke past memories of being alone and set apart from others, due to being marginalized based on identity. “Isolation strikes me as another thing that might have an echo for people in queer and trans communities that might be kind of specific.” This clinician shed light on how isolation could impact clients on several levels. “Rather than ‘oh, it's a little bit lonely,’ it might echo a loneliness of growing up in an environment where there aren't queer or trans role models or you're not able to see others.” Similarly, other participants described profound, reoccurring painful experiences of loneliness that were provoked for clients, when it was not possible to be with other people. A focus group participant recounted a client saying, “I can't talk to any other queer people, there's nowhere for me to find any. I am extremely lonely. I'm relying on one other person in my life, and I literally have no fashion in which to meet other people.”

Participants also noticed that seeking new relationships, or dating, was challenging during the pandemic. Participant 1 said, “People are really starting to talk about how inaccessible or difficult dating is. And I think the resource of sex and romance feels like it's far.” Participant 4 described a dilemma in responding to clients who wished they could date, “You can't say, ‘why don't you go date some new people or something,’ if it's maybe not that safe to be meeting strangers.” Participant 13 brought up the increase in difficulty level to meet someone new.

"Certain people are dating, and they find it hard. Dating is hard online. How do you have that connection?"

The heightened isolation for queer and trans clients was expressed through a lens of intersectionality, where isolation was augmented by other experiences and identities. As one participant who works with neurodiversity within queer and trans communities explained, isolation was not new for clients. "A lot of whom were already isolated before the pandemic, finding it difficult to leave the house, for lots of reasons, a lot of them sensory." This participant emphasized how some clients were more isolated during the pandemic than others. "Everyone is more isolated than they were before. With the folks I'm working with at the specific intersections they're at, this is folks that were already at significant risk of isolation." This clinician reported on the tremendous barriers to connection faced by clients who experience divergences from normative expectations in neurological functioning. "Especially making new social connection or trying to navigate socializing in new ways when it's already taken the better part of 20 or 25 or 30 years to parse how to do that when there's not a pandemic." The participant illustrated how difficulty with change is an integral feature of the neurological functioning of some neurodivergent clients, which made it more challenging to adapt in so many ways at once to the new and overwhelming context of the pandemic. "Having to, not start from scratch, obviously, but having to really shift things, which is already hard, I think for everyone to some degree, but, particularly hard for folks dealing with many ways of being neurodivergent." When imagining the future, this participant reflected on how neurodivergent people, who often need to build social skills to facilitate relationships, may struggle with long periods of isolation. "I do think that the rupture in connection and relationships is going to have long-term impacts. Again, I think for, for everyone. And I think in particular, and perhaps augmented ways for neurodivergent folks." The participant reflected on how clients' capacity to connecting with others might atrophy significantly, and how that could feel discouraging after working so hard to build that capacity.

Participants noticed that with the loss of community space, work, and social activities, to name a few, clients placed more emphasis on therapy and relied more heavily on therapists as a primary resource in their lives. As Participant 12 stated about clients: "Their main support system usually is their friends and their community, so it was difficult to socialize and get together with friends, and therapy is one of their main, if not the only space or support system." The isolation clients faced was pervasive and changed the ways clients engaged with therapy. Discussing isolation, Participant 3 said, "That's been something a lot of people are struggling with, in terms of not being connected. There's a number of people I'm working with where I'm the only person that they might speak to in a whole week." In parallel, Participant 9 spoke about the way people with fewer resources relied on therapy more heavily. "I am getting more requests for emergency meetings, and I believe that's because I've become more of the primary resource for them, for some of my clients. For these people that don't have many resources, COVID adds an extra layer." Participant 4 commented on the lack of other connective experiences that heightened the intensity and importance of therapeutic connections. "It's a strange thing because it's online, or remote, so there's those distancing effects, but in the pandemic context, that's the major connection."

Family. Participants reflected on myriad family relationship challenges during the pandemic. Participant 11 described aspects of enduring separation from family: "long-term border closed, family far, worried about the family." Other clinicians brought up the difficulties clients faced being with their families, due to homophobia and transphobia within families, and the lack of other social opportunities due to restrictions, leaving clients with few positive connections. Focus group participants described how pandemic restrictions forced some 2SLGBTQIA+ clients to become isolated within their families. “There are people who are stuck in places where they're not having access to safety because they're living with families.” Participant 5 illustrated the pervasiveness of this phenomenon for younger folks. “LGBTQ kids who are locked down and having to live with their unsupportive relatives and seeing them more often and not getting the release of spending time with friends or at school.” The conditions of the pandemic introduced relational risk for 2SLGBTQIA+ clients, in addition to precarity of basic needs, as Participant 3 demonstrated. “Not knowing if you're going to be able to pay next month's rent and keep having a place to live or, being worried that you might have to go back to live with abusive parents.” Being increasingly vulnerable to relational violence due to restrictions was discussed, as Participant 12 captured. “That was very difficult, getting stuck with families, there’s lots of violence there, it’s been very difficult.” This clinician brought to light the lack of resources available to navigate these scenarios. **“**They were coming from background that it's not easy for them to call 9-1-1 and kick out the person who is abusing them from home, and they had cope with the situation and de-escalate all the time the violence.”

Participants also addressed the ways in which restrictions hindered typically family-centric events, like holidays. Regarding Christmas, Participant 8 discussed how not connecting with family impacted some clients in the following months. “I think approaching the holiday break was a little bit tricky for people. People couldn't go home or see their loved ones, and now I definitely think we're in a deeper slump.” Similarly, Participant 13 said about 2SLGBTQIA+ clients, “a lot were sad because they would usually have a gathering with the chosen family.” On the other hand, participants also discussed how having a legitimate reason to opt out of family obligations was a relief. As Participant 13 described, “with Christmas it was mostly with family. It did take out some stress because they had an excuse to not go see their family and stuff like that.”

Social Media. An increase on relying on social media for connection within relationships was identified across clinicians. Participant 1 described: “the shift to how much of people's lives is online in this moment, and fucking Instagram, and people's fears around cancel culture; that being your main social space.” Clinicians identified the dangers of online connection, particularly for their clients. Participant 3 warned against “the realities of navigating social media as a queer and trans person. Even if you're neurotypical, it seems pretty awful being steeped in the fast-paced and often really, really nasty, if not violent stuff that can happen in spaces like Twitter.” This participant outlined the discrimination that clients can be exposed to within online communities. “Navigating that and trying really hard to build a community while having to wade through the transphobia and transmisogyny and misogynoir and all the various intersections of violence that people sling at each other on the Internet.” This participant noted the kind of psychological impact social media exerted on clients. “A lot of anxiety about needing community so desperately and trying to find that through social media, but also being terrified to say or do anything ‘wrong,’ and therefore lose access to what's feeling like quite literally, vital community.” Similarly, Participant 1 detailed isolated consequences of online interactions for a client. “Online having even more meaning, social meaning. I have clients who've been actively cancelled and that's been devastating. It's been another trauma.” Participants noted the use and importance of being able to connect online with others, and also saw the limits and detriments of these connections.

Social Movements. Participants spoke about changes in socio-political relationships and social justice movements that were happening during the pandemic, including Black Lives Matter, fascism and anti-fascism movements, climate justice, Indigenous reconciliation, and 2SLGBTQIA+ rights, as Participant 13 recalled. “With the different conversations that we're having more and more with the pandemic whether it's inequality, racism was more at the forefront, but also LGBTQ issues, and more maybe trans black women being more in the forefront.” Several clinicians identified a prevalence of clients within their practices already engaged in social change and activism, which made clients more aware and engaged in current issues, as noted by Participant 6. “Where my [queer] clients live and work, there were already things set up, there already was a lot of community oriented, collective organizing around things.” Participant 5 described how awareness of social movements encouraged people to become more engaged. “The Black Lives Matter movement last year, I think led to a huge amount of people becoming radicalized in positive ways that didn't seem likely before.” Participant 14 discussed how engaging in social change was an empowering act for clients and spoke about a client who decided to attend a Black Lives Matter event, as a process of coming to realize what was most important. “A pivotal moment of taking risk, but measured risk, with distance, with masks. Taking measured risk for what is meaningful.” Participants discussed how attention being paid to social issues inspired a sense of change and possibility, but did not promise change, as Participant 13 captured. “Those conversations might be hard right now but they're really important and it will be nice that it's not a performative element, not just passing. It will be really interesting if we can actually do the work.” Similarly, a focus group clinician said, “there was a lot of energy initially at the beginning of the pandemic about [how] we can make major changes really quickly in our society and people were finding that really hopeful, and I was finding that hopeful too.” Participants noticed that excitement about social change was juxtaposed with a sense of being limited or restricted. Participant 1 described a “simultaneous feeling of being able to be empowered and act in the world and being very disempowered and not able to act in the world right now.” As mentioned previously, the emphasis on online interactions due to pandemic restrictions introduced barriers to engaging in social change, as Participant 1 highlighted, “having a sense of social change, but also social precarity, but being at home and seeing it all play out online.” This participant described client experiences of engaging in social change online. “People also feel like their engagement is inauthentic in some ways or forced in other ways. And therefore, doesn't seem as meaningful, and I think people also experiencing other people's engagement as inauthentic and therefore is not as meaningful.”

Communities of Care. While participants cited many barriers to relationships and connection, clients’ engagement in caring relationships was also discussed. Participants described how enactments of care within relationships were more prevalent during the pandemic. Participant 1 noticed, “People made a different kind of effort to reach out, especially at the beginning of the pandemic. People were thinking about their people, being like, ‘what's happening?’ And reaching out and checking on them and seeing who needs support.” Similarly, Participant 14 described how “people have realized that there's a really conscious ongoing effort required to stay connected to others. At the beginning of the pandemic one of my clients would bring cookies to people. So, people have found really nice ways.” Participant 11 illustrated how, particularly for queer and trans migrants, the conversations in family relationships moved from expectations to explicit expressions of care. “So, a focus on ‘Hey are you safe there where you are?’ Instead of ‘Are you getting married?’ I think that was a positive experience.” Participant 9 reflected on the ways that being engaged in a caring, supportive relationships, predicted wellbeing in clients. “The biggest difference that I noticed in terms of how clients are doing, in terms of resilience factors, is, regardless of whether they're LGBT or not, those people that are able to come back to some kind of home base.”

Caring relationships were not uncomplicated. Participant 5 demonstrated the dilemma many clients faced in connecting with others without risking endangering themselves and others during the pandemic. “People who care about the pandemic and who care about others but are trying to balance that with their psycho-social needs and who find it really difficult to behave in the completely ideal ways.” Participant 4 articulated how clients spent time in therapy discussing how to navigate this dilemma. “I think there is quite a lot of negotiating of relationships and of when to see people, and how to see them and what relationships meant to my clients.”

The idea of being engaged in communities or networks of care was brought up in focus groups and interviews. As mentioned previously, participants noticed that membership within 2SLGBTQIA+ communities was linked to activism and engagement in social change. Participant 14 described a client with multiple marginalized identities who “co-started a new support group online during the pandemic.” In response to the client’s efforts, Participant 14 thought: “Isn’t that resilient!?” Participants found 2SLGBTQIA+ clients to be more readily participating in communities of care compared to clients without these identities. A focus group participant said, “My queer clients over my not queer clients seemed more quickly to be hooked into systems of mutual aid and to be participating in providing mutual aid to people or aware of what was available.” When asked to explain mutual aid, a participant described it as: “stems that were organized within communities to offer support to people who needed support that the government wasn't providing or wasn't able to provide.” Participant 4 surmised that previous experiences within 2SLGBTQIA+ communities offered knowledge about caring ways to cope as a community, during a pandemic. “The AIDS pandemic is one that has heavily affected queer and trans communities in a variety of different ways, some of it being very devastating and traumatic, but also other ways, like really speaking to mutual aid and support.” And furthermore, this participant reflected on how lack of governmental recognition of community needs spurred a sense of needing to provide support where none was offered. “There's more of an established idea of, ‘Well, things aren't necessarily going to be set up the way we need them to be, so we're just going to have to learn to do things for ourselves and each other.’” In parallel, or as a tenet of social change, focus groups discussed the inspirational hopes of igniting more broad, progressive change that comes with involvement in mutual aid, saying, “we can take all these dramatic measures to protect each other and pull together in this time of crisis. And that was exciting for a lot of my clients, especially the people who thought a lot about organizing society differently.”

Changes in Therapeutic Practices

Clinicians described needing to make changes to the way they worked to adapt to the pandemic as well as service delivery in virtual space. Participants adjusted to the omnipresent pandemic context, as well as working with technology, rather than face-to-face, which introduced differences and required clinical adaptations. Clinicians described how they worked through decisions, such as fielding hesitations about working with new clients and realizations that remote work facilitated writing letters to support gender-affirming care.

Clinician-Client Parallel Experiences. All participants described working during the pandemic as clinically unique, in that there were experiences of events related to the pandemic shared by the clinician and client. A focus group participant reflected on this new context, first, examining before the pandemic: “under normal circumstances either we don't share the clients’ experiences or else we do share them, but we have to decide whether or not we're gonna disclose that fact.” This clinician worked through how things had changed with the pandemic: “and in this case, it's the great, big, fat traumatic experience that everybody knows very well that we're all sharing in different ways, clearly, depending on our individual circumstances.” Many participants underlined the disruption to reality that they processed alongside clients, as Participant 1 succinctly stated, “it was a shocking experience for me and my clients.”

Clinicians spoke about the challenge of having similar difficult experiences as those clients were describing. Participant 8 described “really feeling the weight of the clients that I have and as they sink deeper into this situation of COVID, it definitely feels harder to keep that separate to my own feelings.” Similarly, in a focus group, a practitioner recounted, “it was very intense work in the beginning because you shared the same kind of anxiety in terms of being confined and socially isolated.” And another focus group participant reflected, “especially at the beginning, my anxiety mirrored my clients’ anxiety.” Participant 10 noted that it was not just the exacerbation of reliving your own distress in each session but doing so while supporting the client. “I had a few sessions where it felt like, ‘okay I feel exactly what you’re feeling, I’m feeling it too’, but I had to be there for them.” Participant 14 described working through shared feelings of isolation within clinical work. “I was trying to understand my countertransference and at one point I realized that I really wanted to see people in person, but that I was actually wanting to overcompensate for their isolation.” In realizing this motivation, the clinician shared being better able to help clients be empowered to address their isolation, which in turn was helpful in processing the clinician’s experience. Providing services without yet understanding what was unfolding was noted by most participants as truly difficult, which Participant 1 captured. “We were offering our services through an experience that we knew nothing about and we're also anxious and confused and depressed and scared and overwhelmed.” Many clinicians spoke about needing to find new ways to provide services in these conditions, some examples of which are detailed within subsequent sub-themes of this section.

Sharing Community During the Pandemic. In light of these pandemic parallels, another layer to the complexity of shared experience, is that most practitioners reported that they share social locations or identities with their clients. Predominately, participants declared membership within the 2SLGBTQIA+ umbrella and stated that working within their own community, to a certain degree, was an explicit part of their model or approach to therapy. Participant 7 disclosed, "I both am part of the community and work with the community." Similarly Participant 9 quoted, "I work with these clients but also, I'm part of the community myself and have been for 23 years now, so it touches me personally." Participants named their intentions of being able to help the communities to which they belong, to counteract the discrimination and neglect these communities have faced. Participant 1 explained: "I see myself as part of those communities, I went to therapy school after working as a community organizer for many years and observing the impact of mental health on those processes, and people's relationships with each other." Likewise, Participant 5 shared, "I'm a member of the LGBTQ community and I've been out since I was 16 and it's always been very important for me to work within my community." This clinician also spoke to the gap in care that working would help address. "Our communities have a lot of mental health care needs, both in general but also as a result of oppression and minority stress and trauma. We're also underserved, so we lack mental health care professionals who are competent to work with us."

Clinicians had reported that mental health outcomes and unmet care needs for 2SLGBTQIA+ populations were exacerbated by the conditions of the pandemic, when increase in service demand limited the available affirmative mental health care providers. Many participants reported wanting to close the gap in unmet service needs for 2SLGBTQIA+ populations as motivation for becoming clinicians. For example, Participant 4 described entering training thinking that: “it would be good if I were available to clients too, as a queer person” and recounted difficult personal experiences accessing health care. “I wasn't sure each time if the practitioner would be queer friendly or if it would be awkward or what I would be able to expect from a practitioner.” Participant 3 brought in an important view, illustrating how it is at the intersection of multiple minority identities where clients have the fewest resources. “There are very few mental health providers who are offering ‘by and for’ services to queer and trans neurodivergent communities.” This was even more true during the pandemic. This participant named the potential for harm to come to clients who end up with clinicians who lack knowledge about client identities and experiences. Participants also recognized the plurality of communities within 2SLGBTQIA+ communities, as captured by Participant 14. “I'm not directly in certain communities. But I'm aware of different communities and can appreciate them.” This clinician and others spoke to the importance of training to complement lived experience and to advance clinical expertise.

Clinicians reported that identifying and working within smaller communities, like queer and trans communities, prepared clinicians to be able to work with the parallels of shared experiences that came from the pandemic. Participant 1 spoke about how having experiences in common with clients was integral to working within one’s community. “My practice is already probably the most explicitly acknowledging of some shared experiences, a shared community. I've worked a lot with overlap, I work a lot with people who are not that many degrees away from me.” Having this framework guided participants in navigating the unavoidable shared experiences that arose. However, the pandemic also augmented the amount of shared experience between clients and clinicians. Participants noted the profound difference in sharing the unfolding experiences of the pandemic. Participant 3 said: “there was enough sameness before, coming up in the work, but I think now even more so, because there's this overarching factor.” This practitioner shed light on the intensity of sharing experiences of identity, community, and the pandemic, all at once and delineated that this is likely to be different for those who do not share community. “Anyone working within their own sub-populations, there's particular ways in which we're affected by the work that doesn't necessarily happen for people working alongside, or as allies.” Previous shared experiences with clients beneficially primed clinicians’ work during the pandemic, but at times, clinicians noticed that the amount of shared experienced reached a critical limit.

Evolving Therapeutic Approaches. Participants described ways in which they coped with sharing in the unfolding pandemic alongside clients while continuing to offer support and therapeutic intervention. Many participants described wanting and needing to find new ways to work; for example, Participant 3 spoke about “trying to figure out what to do with increasing frequency of people speaking to some of the stuff that I'm also experiencing. Because like you said, we're all going through this pandemic.” Focus group participants discussed not knowing how to practice, initially. “How do I respond to this therapeutically instead of just being like, ‘oh my G-d, what the #%!-?’ Which was how I was feeling.” Clinicians reported learning how to respond, with time. Participant 1 exemplified, “and so that evolved. My ability to be in it with them, but also to be therapeutic, is a skill that I'm sure we're all developing.” An example offered in a focus group was using context to help clients understand the warranted difficult feelings that were provoked during the pandemic. “It's magnifying the inequalities in our society and taking that systemic approach. Often, it's weird to think saying there is a horrible plague ravishing the land would make somebody feel better, but it does." In general, practitioners described interventions in the initial stages of the pandemic as less directive and more experiential, such as validating clients' experiences and staying present with emotions, as well as drawing from approaches for grief. Later, practitioners moved into more directive strategies that were goal-oriented, for instance, guiding clients to set up routines, to find ways to connect to others, or to limit social media usage.

In Each Other's Homes. A phenomenon of remote therapy that participants discussed was the new perspective into their clients' lives that resulted from video sessions. Participants reported seeing into clients' homes, meeting pets and family members, and having less control over the space where therapy takes place. Focus groups discussed the insertion of new actors into the therapy: "We do see lots of peoples' pets. And sometimes family members get introduced and things like that." In another focus group conversation, a clinician said, "it brought some opportunities to see where they live, to show me some of their family, their children." Clinicians detailed how everyday life was woven into sessions: "The way we share space with our clients now, which is that we are in each other's homes and our pets are present and interrupting and interacting." Therapy was no longer in a separate, protected space, where life could be reflected on from a distance. Therapy was subjected to the disruptions of life, including pets, doorbells, people, and phone calls. Participant 6 recalled, "the doorbell would ring and your life as a therapist intrudes on the space in a way that's different from the containment of an office."

Participants spoke about the positive aspects of obtaining more collateral information about clients and thus knowing their clients more intimately. A focus group member explained, "They wanted their kids to come and talk and things like that. And that was quite a nice experience. And that was the good part too, that they share more of their environment."

Participants also spoke about how transference, or ways that clients feel about clinicians, played out in remote spaces. For example, in a focus group, a practitioner shared an experience with a client who was feeling disorganized and “wishing that some kind aunt figure would come over and help them organize their life. And then the following week they appeared in their living room with items all around them saying ‘I'm trying to organize things.’” This clinician wondered: “Am I the aunt who's coming here to help sort through items?” Similarly, Participant 6 spoke about using clients’ observations to understand clients better. “Clients could see my bookshelves and would make comments. There's a lot more opportunity for working on the transference and countertransference.” Clinicians also spoke about enjoying the experience, as an enthusiastic focus group member noted: “So many cats! It was fantastic!” Seeing into clients’ homes was another layer of sharing that brought closeness during the pandemic. Participant 14 shared an interpretation of these encounters as a sign that connection was possible, despite the technology and distance. “A client’s cat came up to me on Zoom and I felt that was the moment when, ‘OK we're connecting on Zoom now.’ So, symbolically when the client’s cat was coming to see me on Zoom, that really felt good.” Seeing into homes was described as intimate, and this was ultimately a change in the therapeutic process, as well as the therapeutic relationship.

Personal Disclosures. Participants reported a difference in the way therapy felt due to the extent of overt, shared experiences with clients, which prompted more personal disclosures from therapists, thus changing the relational dynamic of therapy to be more bidirectional. Clinicians spoke about being asked about their personal lives more than usual. For instance, in a focus group a participant shared, “my clients, anyways, and it seems yours too, are much more concerned about me. They ask about me more, you know, ‘how are you doing in all of this?’” Clinicians needed to make decisions about how to respond to these inquiries, and most indicated that they were more forthcoming than they would be typically, and even shared personal coping strategies with clients. A focus group participant explained that “depending on the relationship, I'll share a little bit more and say, ‘I have had that also. Here's one of the things that's helped me.’” This was discussed as an intentional, strategic way of responding that invested in the therapeutic relationship, but also changed the typical dynamic between client and clinician by offering more personal information from the clinician. One focus group participant agreed that disclosure impacted the relationship and added, “it's been interesting to have this parallel experience and to see how that's changed the relational aspect a little bit.” Another participant responded enthusiastically, “Yeah, I totally agree with you on that sense of being able to disclose more for the therapeutic purpose.” Participant 14 reflected on how personal disclosures about the pandemic felt different. “Because it is a shared experience, that's been an interesting way to maybe connect differently with your clients or connect more informally, while keeping healthy boundaries. And that might be more in an expression rather than it's not necessarily a specific disclosure.” Disclosures altered the way therapy felt for therapists, as a focus group clinician stated, “It’s a shared experience and that created almost a new type of intimacy.” Another focus group participant suggested that the power dynamic in the therapy session had changed: “It's more equal. The hierarchy, I feel, is not as much present as it was.” Participant 6 fleshed this idea out during an interview, stating therapeutic work felt deeper and wondering if this was because the therapist was less shielded by anonymity. “There's this very explicit awareness that you're experiencing a similar thing.”

Humour was also mentioned as a way for clinicians to reflect the shared experience with clients. A focus group clinician explained connecting through humour: “The thing about gallows humour is that you have to also be on the gallows otherwise you're part of the executioner party.”

Using this type of humour as a therapeutic intervention emphasized shared experience. This participant continued, elaborating on “why it becomes so useful and so potent in being able to diffuse some of what we're going through is literally because we share that experience and that gets felt on a pretty deep level.” Humour was also discussed as a way of coping with the high levels of collective despair.

The idea of disclosure as a relational and therapeutic event was further reinforced by participants’ experiences of sharing with each other, which was reported as therapeutic for clinicians. Speaking to other clinicians was the main resource that participants described as helping them to cope personally during the pandemic, and to evolve their therapeutic process in response to the pandemic. Some of the focus group members had attended other clinician meetings prior to this research project where they discussed work challenges, concerns, and adaptations. Referencing those meetings a focus group participant said, “I thought that [meeting] was really, really appreciated; that we could express our own anxieties.” In a similar way, participants noted that it personally felt good to share with clients. “I think that's a different way of bonding, different way of connecting on a therapeutic relationship level, which I've liked.”

Physical Space. Changes to physical space were necessary in remote work. Clinicians reported checking in with clients regularly about attending sessions remotely, as Participant 9 illustrated: “we had conversations around how they were feeling about being online.” Clinicians said check-ins helped clients speak up about obstacles faced with remote therapy. For example, a focus group participant shared: “I checked in and I found that they can't. They live in a big house, but the family are pretty into overhearing and actually monitoring, so a very high level of control is in the family.” This clinician reported finding ways to adapt to privacy concerns for clients, which included having the clinician speak more than the client, trying to add description to the limited narratives shared by the client, offering options for the client to choose from, and using analogies.

Clinicians named client distraction as one of the consequences that came with having less control over the physical space. Participant 8 reported “having to be a bit more vigilant about phones and things like that.” Participants expressed frustration with new scenarios that were arising, such as clients being distracted by their surroundings, as described in focus groups. “I'd be working with somebody, and they'd get up and they would be like making a smoothie or making their toast and I would be like, ‘What are you doing? You're making me dizzy.’” This participant voiced needing to set parameters for online work, which had not been an issue at the office. Other focus group clinicians had similar experiences and one added: “I remember at one point, one situation, saying, ‘are you texting?’ Because they've got all their devices there, so the distraction element is very present.” Focus group participants also shared how to refocus clients, for instance: “I would say ‘you seem to be distracted, maybe we can close that down.’”

Participants described losing information by not sharing physical space with clients and needing to devise ways to compensate. One strategy was by making information that was previously implicit, explicit. Participant 11 reported doing this by asking more questions and added that it was necessary to ask for visual cues when none were available. “I feel like what I don’t see, I can ask about.” Clinicians described needing information about clients’ physical responses, which were not always visible in remote work. Participant 9 described an example of this. “I'm missing the micro expressions if the camera is blurry or the connection is off, so I ask a lot more questions. So, I've had to adapt the style of how I catch those micro expressions by checking in.” The clinician linked this kind of intervention to trauma work and references the higher rates of trauma that exists within 2SLGBTQIA+ communities, due to prejudice and discrimination. “In the LGBT community, if there's work with trauma, there's this element of dissociation and catching those micro expressions to be able to focus in on what's happening for someone emotionally. I probably miss some that I wouldn't miss, live.” The clinician lamented how some moments in therapy may not receive due attention, but stated that overall, virtual work is very effective. Other participants also spoke to the utility of asking clients questions about their physicality and found that it helped integrate self-awareness into the clients’ repertoire, particularly when clinicians worked with trauma using somatic approaches. A focus group clinician shared how “not being able to see the full body language was more challenging and I had to really remember to be more explicit and ask more menu questions.” The clinician described how this explicit questioning transferred to the client with time. “They would have to be mindful of themselves and describe it to me.” The practitioner spoke about how this new way of accessing information changed the client-clinician dynamic. “I think that it ended up being a lot more active online in a sense, a lot more active and directive for me and with the clients, like the clients would also direct me more.” Overall, it was reported as a therapeutic gain, in that clients were able to do some of the work for themselves independently.

Clinicians reported other kinds of adaptations that were necessary to accommodate for being in different locations. Participant 14 said being able to discuss separation was a helpful intervention. “When people would struggle with being virtual, really leaving a space to talk about that, on a regular basis, as needed.” An art therapist described not being able to know in advance what clients would be able to accomplish in their own homes, depending on space, materials, and privacy. The clinician mentioned that typically clients would leave clinical artwork at the office, due to its potentially challenging emotional significance. Client and therapist had to collaborate to find creative solutions to make storing work comfortable for clients. Similarly, another clinician described adapting the “empty chair” exercise. This intervention involves imagining someone in your life is physically present in the therapy room, sitting in an empty chair, to process a conversation that has not been possible yet in life (or never will be). The therapist felt it was not therapeutic for clients to be faced with the empty chair in their own home after the session. As Participant 6 recalled, “they would leave the session and they would look at that chair all day. So, the chair stays with them, their mother stays with them, they can't leave it in my office or leave it with me.” The clinician tried using role-play to solve this dilemma. “What I started to do with clients is that I would ask them to give it to me, the thing that they need to leave in the office.” Having clients imagine storing what was too heavy to shoulder alone in the therapy office, or at times, even miming the safe-keeping of clients’ emotional experiences, was an adaptive technique that participants used successfully.

Location. Clinicians brought attention to a dimension lost with virtual work: travelling to and from the clinic office. Participant 9 recounted discussions with clients about the commute to therapy. "We had this conversation about the coming and going to the therapy, they said that there isn't much difference.” Some clients indicated that not commuting made it easier to engage in therapy, and more comfortable to go into difficult topics. As Participant 9 reported: “Maybe, even that they're more comfortable being at home in being able to open up or access deeper emotions, knowing that they're not going to have to go out into the world afterwards.” Yet, Participant 9 also captured a loss element: “But they said that there was a lack, in the sense that they weren't preparing for the meetings in the same way.” This was echoed by other participants’ reports of client experiences. Focus group participants described an idea of an expansion of the therapy hour that included the therapeutic commute. “For some clients, the ritual of getting to the office, and they would already be getting into a therapeutic space and turning inwards to themselves and what they wanted to talk about." And others agreed. "True, actually, that whole ritual, that whole component of preparing, setting the space, having time to reflect and collect when you go in and when you leave and the container. All of those dimensions are gone online." Similarly, Participant 6 reflected on how the commute and shared physical space of sessions could be seen as a "ritual" of therapy. "I've been really feeling more strongly about the sense of ritual around therapy and that's part of the frame and part of the containment in terms of physical space, but also an internal shift in being prepared for a session."

Clinicians changed their process by speaking to clients about the transition into and out of therapy that was missing in remote work. A focus group participant said: "We would talk about how they can, in their own space, come to a session the way they would when it's not online. Walk around the block first or walk around their house and get into the space of therapy." One clinician described guiding questions to help clients think about how to end therapy. "So, when we close the screen, what are you thinking you're going to do?" Clinicians felt that working with clients to set up transitional space contributed to the therapeutic process. Importantly, not all clients benefitted from travelling to and from the therapy office. Some found the commute difficult, and at times, a barrier to attending therapy. Yet, the realization of the ritual of transitioning into and out of therapy that was illuminated may still benefit those who suffered travelling, but in an adapted form.

The environmental cues associated with physical locations was also discussed in terms of different psychological states evoked for clients. Participant 6 brought up the grounding effect of physical space for some clients who have experienced trauma. "I work with a lot of trauma. So, there is already a lot of fragmentation in the day, and everything just kind of bleeds, or can just bleed from the before session, in session, and after session." This clinician described how the physical space and time of therapy acted as an “anchor” for clients, particularly clients who experience symptoms of trauma such as dissociation. Clients may experience changes in space as cues that can help focus attention and evoke certain thoughts. “The use of different spaces to ground and to shift mental states in a way that keeps folks from fragmenting or dissociating.” This clinician noted the ease of staying at home for therapy. “Being in your pyjamas, cozy and comfortable; that's one thing.” Yet, the participant felt something important happened when travelling to and from the office and described the effect: “But then the shift after the session, there is a sense of when you're in the office you actually do need to pull your defences, in a healthy way, back up.” Location may be particularly important for people who experience dissociative symptoms of trauma, as Participant 6 said: “clients who have that [dissociative] experience regularly need to have a lot of anchors in their day.” The clinician reported that it was helpful to have clients notice this and recreate physical differences for sessions, even if they could not go to the office. “With a lot of my clients I would suggest to have a space, if they could, where they would go to session. They would only sit in that chair for their therapy sessions.” The clinician also recommended taking walks before and after sessions for these clients.

New Clients. Clinicians reported that starting therapy remotely with new clients felt different to beginning in-person. Participants spoke about waiting to bring new clients into their practice until they gained more experience working remotely. Participant 14 shared, “Starting with new clients was extremely difficult at first. At one point when I saw that I didn't have the level of comfort to start with new clients, I waited; I continued to work with my existing clients.” This was discussed in focus groups too: “I have similar hesitations to bring on new clients.” And one focus group clinician mentioned the difficulty of doing evaluations remotely. “Evaluating new cases has been very challenging, particularly evaluating asylum seekers and for court letters or things that require building trust and bonding super quickly because you don't have many sessions to evaluate." Further, this clinician reported challenges of working with others (e.g., interpreters, social workers) in addition to the client, during evaluation. "Over the screen is very difficult. And working with interpreter, I found it more challenging working with the team, with social workers. And the client found it more challenging." Building alliance was also considered a more challenging task, virtually, by this clinician, as well as others. "Mostly for new clients regardless of the background, the evaluation and the building relationships and rapport, I found it more difficult." Another clinician in the focus group wondered if a client who quit therapy early on, would have stayed if sessions could have been in-person. "My sense is, we would have managed to move into a stronger alliance in the room then we were able to on Zoom." This clinician described the frustration of not being able to connect to the client while being distanced by technology. "I definitely felt like I didn't have like my full roster of tools. I could feel myself tying to climb into the screen, basically, and I just can't, so."

Summary of Results

Analyses of results reflected participant perspectives regarding their experiences of working with 2SLGBTQIA+ clients during the first year of the COVID-19 pandemic. Illustrating the ways clinicians understood and adapted to pandemic related changes, I organized results within two domains: 1) Evolution of Service Delivery, which portrays how clinicians set up their work, both remotely and in person, during the pandemic, and 2) Changes in Therapeutic Processes, which discusses how clinicians perceived change in clients' lives, as well as adaptations clinicians made to their clinical approaches and processes. In the next chapter I will discuss results in context with other research, explore the implications of findings, and make suggestions for future research.

Chapter Five: Discussion

The aim of this research project is to understand the unique experiences of mental health clinicians working with 2SLGBTQIA+ clientele during the first year of the pandemic. Results from this study have illustrated how clinicians viewed the evolution of their services to offer remote care, the impact of the pandemic on the lives of 2SLGBTQIA+ clients, and clinical adaptations to therapeutic processes.

Provision of Remote Mental Health Care

Pandemic-related mental health research has captured the mass move to remote care as a revolutionary change in service delivery (Wind et al., 2020). For the first time ever, most mental health care practitioners engaged in offering remote care (Wind et al., 2020). Research conducted during the pandemic reinforced a long history of literature demonstrating the effectiveness of remote therapies (Lal & Adair, 2014; Stoll et al., 2020; Witteveen et al., 2022). In an umbrella review of 38 systematic reviews of remote mental health care, Witteveen and colleagues (2022) reported widespread and successful use of synchronous services during the pandemic, such as videoconferencing, to replicate previously offered services. In addition, scholars documented other forms of remote mental health care that has recently become more available, such as internet-based asynchronous tools, like self-guided cognitive-behavioral therapy modules (Appleton et al., 2021; Siegel et al., 2021; Witteveen et al., 2022). These newer forms of services question what mental health care entails, by expanding format and modes of interacting. However, in this study, participants reported primarily engaging in remote care via synchronous service provision that was analogous to the in-person therapies used prior to the pandemic.

Research regarding the shift to remote services has reflected that many practitioners felt they were not adequately trained and did not have enough information to transition to remote therapy, despite many trainings becoming available (Ceniti et al., 2022; Witteveen et al., 2022). In this study, one of the difficulties clinicians faced in adapting to remote service delivery was finding applicable information to guide their work. Participants reported lacking necessary information to setup remote practices and lacking training to provide remote interventions. Some clinicians reported that their particular work was not reflected in the information offered (e.g., social workers or art therapists in private practice), or, that their clients were not represented by the resources provided. Further, participants described the additional burden of needing to quickly transition to remote services while experiencing feelings of overwhelm and fatigue in response to the pandemic, which were exacerbated by organizing new ways of working with little time to prepare, during a global crisis. Some participants reported that there was not enough time or energy to engage in new training during this transition. Findings from this study reflects calls from broader literature to integrate remote care into graduate training programs and has illustrated that education in the digitalization of care (e.g., use of digital technologies, data security, privacy concerns) is lacking and thus needed for most practitioners (Appleton et al., 2021; Siegel et al., 2021; Witteveen et al., 2022).

Unique to this study was the explicit use of community-based knowledge mobilization amongst clinicians to guide their transition to remote care. The most widely endorsed resource that helped guide clinicians in setting up and adapting their practices, was speaking with each other. By sharing information as well as experiences of what does and does not work, clinicians were able to collaboratively figure out how to set up remote offices as well as deliver remote services. Clinicians reported that engaging in this research project, which facilitated intra-group discussions, contributed to their understanding of their work. Some participants shared that initially they were not convinced that they had useful reflections to share as research; however, at the end of data collection, they were surprised by how much they knew. One hypothesis is that the stressful circumstances of the pandemic obscured clinicians' sense of confidence in their experiences. Yet, by engaging in research and sharing with others, participants learned from each other about an otherwise confusing and mostly isolated period.

Research has indicated that most clinicians grew more confident in their capabilities to provide remote care over time, which in return fostered interest in continuing to offer remote services, even when it was no longer necessary (Ceniti et al., 2022; Witteveen et al., 2022). Similarly, participants in this study reported gaining remote clinical skills over the course of the first year of the pandemic. As comfort with and confidence in providing remote therapy grew, some participants indicated that in the future they would like to maintain hybrid practices that offer in-person and remote modalities; other research studies have also reported similar findings across other practitioners (AlRasheed et al., 2022; Ceniti et al., 2022). Practitioners in this study imagined collectively navigating future decisions about hybrid service delivery and wondered how these decisions may impact their work.

Findings from this study emphasized integrating the needs and preferences of clinicians, as well as clients, when making decisions about long term remote care. Research examining remote synchronous mental health care during the pandemic has reflected how widespread use of technology did not result in more accessible services for *all* service users, but rather accessibility of services depended on many factors including client's access to technology and space, relationship with the therapist, mental health conditions, and so on (Ceniti et al., 2022; Witteveen et al., 2022). An idiosyncratic understanding of accessibility was reflected by participants in this study, who reported on different ways remote therapy aided or hindered therapeutic experiences, depending on the therapist, client, and their contexts.

In this study, many clinicians reported preferring remote service delivery and finding it to be a more accessible modality from a worker's perspective. For some, working from home was more comfortable and more conducive to meeting physical needs, as well as attending to home chores. Being in full control of the space was advantageous for clinicians with chronic pain, disabilities, sensory processing issues, and social anxiety. These advantages may contribute to being more able to attune to clients and be fully present in therapy. Further, working from home meant cancellations were less bothersome, and clinicians reported being more flexible in their schedules, as they did not need to coordinate office space. Clinicians also felt they had more free time with less time spent commuting. Across the remote care literature, flexibility in schedule and convenience of working at home were most often reported as gains for clinicians due to remote work (Ceniti et al., 2022; Witteveen et al., 2022).

On the other hand, results from this study showed that working at home was not preferential for clinicians who missed the social interactions throughout the day, including being able to connect with other service providers. Working at the office also provided separation between work and home, which could facilitate attention and presence, as well as work-life balance. It was also easier for some parents to practice at the office, away from any potential family interruptions or family bandwidth-sharing issues. Many clinicians found remote work more tiring and more difficult, and some clinicians described missing a sense of richness that was integral to in-person work. The benefits of working in-person reported in this study were also cited in the broader literature (Appleton et al., 2021; Ceniti et al., 2022; Witteveen et al., 2022). Interestingly, in this study, some clinicians reported that remote work provoked migraines; research has noted how remote services are not indicated for clients with migraines (Appleton et al., 2021), however few studies mentioned clinicians (Tolland & Drysdale, 2023).

Notably, clinicians in this study considered accessibility in terms of clinicians, as well as service users, whereas broader literature tends to focus on client accessibility (Witteveen et al., 2022).

Clinicians reported that many clients found remote service to be more accessible than in-person. Being able to choose between video, chat, and phone met a variety of different needs and could improve access to therapy for clients. For instance, use of the chat feature could facilitate ease for clients who struggle with verbal communication. Use of phone instead of video could be useful for clients struggling to be seen (e.g., due to body image issues or gender dysphoria; however, use of voice via the phone could be challenging for some dysphoric clients). Additionally, for many clients, no longer commuting to therapy was beneficial. It saved time for clients and meant fewer uncomfortable scenarios were experienced en route to therapy (e.g., avoids sensory overload, discrimination, anxiety provoking scenarios). For clients acutely struggling, the commute to therapy can be a barrier to being able to attend sessions. Additionally, some clinicians reported that clients were able to be more open when working remotely. It was hypothesized that the physical distance as well as the comfort of being in one’s own home made it easier to be vulnerable for some clients. This phenomenon has been reported in other studies as well (Ceniti et al., 2022). Lastly, working remotely also allowed clinicians to reach clients in areas with fewer clinicians, such as rural regions of Canada. This was particularly helpful for 2SLGBTQIA+ clients who can cast a wider net to find service providers specialized in gender and sexuality. The convenience and ease of remote services for clients were reported across most studies (Witteveen et al., 2022).

However, for some clients, working remotely was not accessible, as it requires access to private space as well as digital technologies. Lack of private space to attend therapy was a particular concern for clients living with families that did not support sexual and/or gender identities. It was also challenging for low-income clients and clients without housing or a place to access remote therapy. Further, clinicians explained how safety was jeopardized by therapy for clients at risk for domestic violence. Clinicians also remarked that some clients were apprehensive about sharing over the internet, due to technological privacy concerns. Spatial and technological barriers to remote therapy have been well-documented in the broader research (Witteveen et al., 2022). Research has also documented difficulties accessing therapy for specific client populations, such as clients with schizophrenia diagnoses and older clients (Appleton et al., 2021), as well as difficulty staying engaged in online therapy, particularly for younger clients (AlRasheed et al., 2022).

Overwhelmingly, research has indicated that remote synchronous therapy is effective, from client and provider perspectives, however not consistently across all clients and contexts (Ceniti et al., 2022; Witteveen et al., 2022). Participants' reports from this study were in accordance with the literature: clinicians were convinced that remote therapy was effective, when clients could reliably access services. Participants noted the need for more research that thoroughly investigates the implications of remote service delivery across client characteristics and contexts, to better predict which delivery modalities are best adapted to client specificity. This need for more research was voiced across most studies examining remote service delivery (AlRasheed et al., 2022; Appleton et al., 2021; Ceniti et al., 2022; Witteveen et al., 2022). Widespread implementation during the pandemic was an opportunity for many clinicians and clients to experience remote therapy. Now, there is an imperative to understand remote service provision with more detail, to understand the parameters that indicate when it will be most or least effective, and to bring awareness to long-term effects.

2SLGBTQIA+ Client Contexts

Growing research illustrates the interconnected and multifaceted disparities faced by 2SLGBTQIA+ communities due to structural discrimination and oppression (Higgins et al., 2021). Scholars have traced the multiple forms of hardships 2SLGBTQIA+ communities have faced during the pandemic, including limited access to medical care, economic precarity, housing instability, food insecurity, in addition to loss of community, all of which contributed to worsened mental health outcomes (Anderson & Knee, 2021; Duguay et al., 2022l; Egale, 2020; van der Miesen et al., 2020). As mentioned previously, mental illness rates are generally higher within 2SLGBTQIA+ communities, compared to their cisgender heterosexual peers (Kidd et al., 2016; Meyer, 2015). During the pandemic, research indicated that this trend continued, and mental health outcomes for sexual and gender minoritized populations deteriorated (Combden et al., 2022; Slemon et al., 2022). Research indicated that overall, negative mental health outcomes rose as isolation and lack of social connectedness worsened (Combden et al., 2022; Slemon et al., 2022). However, one area that contradicts this trend was evidence of reduced rates of certain types of substance use: those that occur socially (Vo et al., 2022), such as substance use at parties (Palamar & Acosta, 2021), or, during sexual encounters, also known as “chem sex” (Starks et al., 2020).

In this study, participants linked experiences of oppression to worsened mental health outcomes, while also demonstrating how privilege and stability contributed to mental wellbeing. Clinicians noted that clients who experienced the least amount of uncertainty during the pandemic (e.g., had stable work, secure housing, access to food), as well as positive, enduring relationships, were the least negatively impacted by pandemic tribulations, as well as the most likely to find resilient ways to cope. Clinicians reported that clients facing many difficulties at once (e.g., immigration delays, abusive families, ablism, financial precarity, instability, food and housing insecurity, in addition to mental health challenges), who were also likely to be socially excluded, were overloaded with multiple worsening contexts and struggled more intensely.

Participants reported exacerbated mental health outcomes during the pandemic for clients with pre-existing mental health conditions. This finding is reflected in research examining mental health during the pandemic, across general populations and within minoritized groups (Frounfelker et al., 2022; Jenkins et al., 2021; Slemon et al., 2022). For instance, clinicians observed that clients with symptoms of depression experienced heightened symptoms, often having episodes of depression in response to adverse phases of the pandemic. One caveat found in this study, was that at times when the pandemic halted most societal functioning, some clients with depression felt a sense of relief that the world matched their own, slowed pace. Similarly, research looking at silver-linings of the pandemic noted that "slower pace of life" was an appreciated consequence that some people experienced during the pandemic (Kowalski et al., 2022).

This sense of relief was found in other areas well. Interestingly, there were some difficult symptoms and experiences that clinicians reported had lessened for clients during the pandemic. For instance, participants discussed how some clients with social anxiety experienced prolonged periods of relief, due to limited possibility of social engagements. This allowed clients to inhabit a new internal state never previously held, one without constant social anxiety. This unique experience has not been highlighted in other research, which tends to focus on how social anxiety is comorbid with other mental health symptoms and for many, worsened during the pandemic (Kindred & Bates, 2023). Further, dominant theories regarding social anxiety purport that experiential avoidance, which restrictions necessarily reinforced, contributes to worsening social anxiety (Moscovitch et al., 2009). Contemporary best practices for treating social anxiety utilize exposure to anxiety-provoking scenarios to diminish symptoms and illustrate how avoiding exposure can worsen anxiety (Moscovitch et al., 2009). In attempt to reconcile this well-evidenced understanding of social anxiety and effective treatments, it has been theorized that connecting with others via technology could be useful as a type of gradual exposure for people experiencing social anxiety, as there are more ways to control the environment, coupled with reduced physical exposure, allowing people to experience connection without being overwhelmed (Bortolan, 2023). However, if this remained the only form of connection to others, it would be considered a form of avoidance or a "safety behavior" within social anxiety literature and would contribute to maladaptive beliefs that would contribute to ongoing anxieties about social experiences (Moscovitch et al., 2009).

Clinicians also reported similar reduced symptoms for clients with sensory processing difficulties, who were less often overwhelmed by the lights, noise, and other sensations that are unavoidable in public, but more controllable within one's own personal space. Stay-at-home orders reduced exposure to difficult sensory information and allowed for relief. Other studies have also reported reduction of sensory and social overload, particularly with Autistic adults, resulting in relief (Oomen et al., 2021). In another vein, participants described how some clients were able to avoid facing some forms of discrimination, by no longer going to work or public events. This offered a break from some of the psychological burden of predicting and experiencing discrimination. Other studies have also documented the refuge from some forms of discriminations that stay-at-home orders fostered (O'Handley & Courtice, 2022).

However, results from this study indicated there were limits to these experiences of reprieve. Social anxieties endured in other forms, as clients struggled to find ways to connect online with new social formalities. And, consistent with social anxiety literature, participants reported that clients feared returning to socializing, and shared predictions with clinicians that they may have decreased tolerance for social experiences (Moscovitch et al., 2009). Further, avoiding discrimination or sensory overload was only possible for few clients in very limited ways.

Research has documented the link between positive, affirming relationships and wellbeing within 2SLGBTQIA+ populations, and on the other hand, the detrimental mental health outcomes linked to relational rejection (Blair & Holmberg, 2008l; Meyer, 2003; Ryan et al., 2009; Ryan et al., 2010). Clinicians in this study demonstrated their awareness of how clients were discriminated against based on their identities within interpersonal relationships, as well as relationally within organizations, institutions, and societally. A prominent example participants discussed was how the lives and experiences of many sexual and gender minoritized clients were not reflected in the design of pandemic-related social distancing measures, which were designed for a "normative" subject who would be likely living within a home with other family members. Other scholars have also commented on the lack of attention to minoritized populations in pandemic policy and have pointed to the prioritization of physical health over mental health and social connection (Brennan et al., 2020; Lewis, 2022).

Participants named myriad ramifications that resulted from pandemic restrictions including clients enduring domestic violence as well as homelessness. Clinicians reported that some clients were forced to return home during the pandemic, often due to loss of employment, and were trapped living with abusive families. The circumstances were aggravated by the lack of opportunity for social connection. Further, the closure of community spaces was detrimental particularly for 2SLBGTQIA+ clients, who may have few if any other opportunities to be in affirmative spaces or connect with others who shared their identities. These findings were reinforced within broader literature. For instance, research has documented high rates of family violence towards 2SLGBTQIA+ populations, which worsened during the pandemic (Abramovich et al., 2022; Kourti et al., 2021). Consequentially, homelessness rates, which are already heightened among 2SLGBTQIA+ youth due to identity-based family violence, were exacerbated during the pandemic (Abramovich et al., 2022).

In this study, clinicians reported that some clients resourcefully found ways to navigate the risks and uncertainties of the pandemic by creating bubbles, wherein they negotiated varying perspectives on safety across networks of relationships to stay connected. However, this kind of pathway to social connection was very resource-intensive and required high-level planning, communication skills, networks that are already in place, and relationships that can tolerate negotiation. Many clients were not in positions to be well connected during the pandemic and were severely impacted by restriction measures. It was noted that clients with multiple intersecting minoritized identities (e.g., trans, neurodiverse, and experiencing financial precarity, or racialized, refugee, lingual minority, and sexual minority) were more likely to experience barriers to relationships and resources, in several ways at once.

Clinicians mapped out some of the complexities of care experienced by their sexual and gender minoritized clients. While these clients may be less likely to have positive relationships with their families, they are also more likely to be embedded into community-built systems of care, than their cisgender, heterosexual peers. Several clinicians commented that their 2SLGBTQIA+ clients were more likely to be engaged in activism, and thus more immersed in networks of mutual aid and care. These are known trends across these communities (Irving & Raj, 2014; Tremblay, 2015; Warner, 2002). Sexual and gender minoritized populations are vulnerable to pervasive discrimination that limits, corrupts, and eradicates care across most realms, however at the same time, these are also populations that have normalized self-advocacy and solidarity with others, as forms of care. Clinicians identified a trend of "do it yourself" (DIY) initiatives among their 2SLGBTQIA+ clients, whose needs were otherwise not served by institutionalized systems. Participants commented how institutional care was rarely designed with these populations in mind. Prior to, and in response to the pandemic, scholars have called for more comprehensive governmental support for these communities (Goldberg, 2020; Higgins et al., 2021; Mulé et al., 2009; Salerno et al., 2020; Tremblay, 2015).

Therapeutic Processes

The growing body of literature dedicated to examining remote mental health care during the pandemic has primarily focused on the accessibility and effectiveness of care, in addition to necessary resources to support remote care (Witteveen et al., 2022). Fewer studies have examined adaptations to therapeutic processes that have resulted from working remotely during the pandemic; even fewer have discussed therapeutic adaptations when working with minoritized clients. In this study, an overarching theme spanning the clinical approaches clinicians discussed was the use of a systemic lens when thinking of clients, symptoms, and mental health care. Integrating a systemic lens allowed clinicians to understand clients as individuals within many systems, affecting and affected by those systems. Further, clinicians saw themselves as actors within systems, analyzing their roles within the therapeutic relationship, community, and larger mental health care systems. Unique to this study was the exploration of participants who worked together as a team of independent practitioners. Participants were part of a team, or system, that connected clinicians to each other and through these connections, fostered support, learning, growth and collective means of working.

Systemic theories analyze the impact of context in our lives; understanding context as a web of interrelated systems that influence each other (Dallos & Draper, 2015). Like the social justice epistemology guiding this study, different system levels (e.g., micro, meso, macro) are useful in examining the ways in which we are interacting with systems and how we are impacted by our surrounding contexts. Employing a systemic lens was adaptive during the pandemic, during which there were tremendous systemic implications, due to disruptions of nearly all human relational processes. Participants illustrated their understandings of the multifaceted impacts of the pandemic, particularly within clients' lives, by tracing the effects of events through many systems, examining impact across levels: the individual, the interpersonal, the organizational, and the societal.

One of the fundamental ways clinicians employed a systemic lens was by understanding mental health beyond the individual experience, examining how socio-political contexts can shape and hinder mental health. This kind of systemic analysis is considered integral to comprehensive mental health care with 2SLGBTQIA+ populations (Mulé et al., 2009; O'Shaughnessy & Speir, 2018). Clinicians also demonstrated understanding pathways to recovery through a systemic lens, for instance, recognizing the structural barriers clients may face in life, as well as in accessing in mental health care. Further, clinicians developed ways to meet client needs at varying system-levels: person-to-person, communally, organizationally, and societally. This was done by interacting with mental health care systems at multiple levels, within the therapeutic room, as well as beyond: taking into account access to therapy, training for adequate therapy, and practitioner needs to provide care. Importantly, clinicians understood themselves as within these systems, and spoke to their own experiences during the pandemic.

Overall, research has demonstrated that mental health disparities worsened for 2SLGBTQIA+ populations during the pandemic (with exacerbated severity for individuals facing multiple intersections of marginalization) and has called for attention and resources to respond to these perils (Slemon et al., 2022). In accordance with the research, clinicians in this study connected the forces of oppression (e.g., transphobia, homophobia, racism, classism, ablism) to the context of clients' lives (e.g., barriers to accessing stable housing, employment, community organizations, discrimination from family, fewer opportunities to connect with others to make lasting social bonds, vulnerable to internalized stigma) and drew links to mental health and well-being (e.g., potential for chronic states of stress, low self-esteem, lack of hope). Further, clinicians understood clients' experiences of oppression as having potential to cause traumatic impact and result in traumatic symptoms; an idea that is best captured by systemic trauma, or the understanding that trauma can result from systemic oppression and discrimination (Holmes et al., 2016). Systemic trauma is well documented within trauma literature, yet not well integrated into mental health care; for instance, systemic trauma is not captured within mental health diagnostic manuals, such as the Diagnostic Statistical Manual (Goldsmith et al., 2014). Consequently, there is inadequate attention addressing systemic trauma, and thus fewer resources mobilized to contribute to prevention, treatment, and recovery. Hence, it is unique to their specialized training that participants in this study have a strong analysis of the detrimental impact of oppression.

Ongoing learning was one of the ways that participants demonstrated high levels of commitment to the provision of mental health care for 2SLGBTQIA+ communities. Further, becoming trained and training other clinicians are examples of systemic interventions for 2SLGBTQIA+ population wellbeing. Being able to access mental health care that is affirmative, that is, care that celebrates and honours diverse genders and sexualities and recognizes the inequities faced by these communities due to societal discrimination, is essential for the wellbeing of these communities (O'Shaughnessy & Speir, 2018; Singh & dickey, 2017). However, adequate mental health care is a resource many 2SLGBTQIA+ individuals are denied, as most mental health care practitioners have not received training regarding diverse genders and sexualities (McIntyre et al., 2011). The Network organizes regular trainings in 2SLGBTQIA+ mental health care, and in addition, members offer each other support, share resources, and engage in peer supervision. The Network also provides consultations for clinicians outside of the team. By offering free training, consultation, and support, this Network strives to close the educational gap contributing to inadequate services by training as many clinicians as possible in best practices for working with 2SLGBTQIA+ populations. As the Network is comprised of many independent clinicians working in different settings, members are embedded in multiple systems, and thus the reach of training is far: the group can bring aspects of 2SLGBTQIA+ affirmative practices into hospitals, clinics, schools, organizations, and private practices. This model also brings incredibly diverse knowledge back to the group, by having practitioners from diverse organizational contexts contribute to knowledge sharing with each other.

There is little research examining the characteristics of clinicians who decide to seek training and specialize in working with 2SLGBTQIA+ clients (Rutherford et al., 2012). Yet advocating for care that does not pathologize diverse gender and sexuality has been necessary for 2SLGBTQIA+ communities to be treated ethically within mental health systems (Higgins et al., 2021). In this study, participants named their reasons for working with and caring for 2SLGBTQIA+ clientele. Predominately, clinicians were interested in addressing systemic issues these communities faced, due to personal investment within these communities. Many clinicians shared that they are members of sexual and gender minoritized communities and were personally invested in providing excellent mental health care to 2SLGBTQIA+ communities. Participants reflected on the incredible personal meaning inherent in providing care to 2SLGBTQIA+ clients. Clinicians were motivated by their own values and care for community, and this was sustaining, particularly during the pandemic, when work required more effort and for many was more difficult. Clinicians described the benefits they received from their work, including connection, growth, identity exploration, and a sense of contribution to community. The reciprocity of investing in care for others demonstrated how through enacting care, one could receive personal meaning, value, and a returning sense of care.

A feature of working within one's own communities, is that clinicians experienced many parallels with their clients. The advantages, challenges, and skills needed to navigate working within one's own community are reflected within literature regarding working in small communities, such as care in rural, deaf and hard of hearing, and 2SLGBTQIA+ communities (Schank et al., 2010). Consistent with broader literature, participants reported that generally sharing experiences with clients was clinically useful and personally rewarding (Schank et al., 2010). However, during the pandemic, the pervading sharing of many difficult experiences with clients blurred the edges of work and life and made it challenging to distinguish personal and professional boundaries. This was heightened for clinicians who shared multiple identities with clients (e.g., neurodiverse and queer). While participants felt they could rely on their prior experience navigating professional/personal boundaries, due to previously working within their communities, the pandemic was a new level of challenge, that posed new difficulties for clinicians.

More generally, the mental health and wellbeing of mental health care providers is known to be under-researched, despite the vulnerabilities to mental health challenges this population faces, such as burnout, vicarious trauma and compassion fatigue (Green et al., 2014; Hobaica et al., 2021; Pope & Tabachnick, 1994; Tay et al., 2018; Victor et al., 2022). During the pandemic, clinician mental illness rates were associated with pandemic severity. For instance, a study conducted in Quebec during the May and June of 2020 indicated that mental health care workers experienced more psychological distress when they were situated in regions where COVID-19 infections were highest (Brillon et al., 2022). From a systemic vantage point, considering these risk factors (i.e., compassion fatigue, vicarious trauma, pandemic severity), the known mental health perils associated with minoritized identities and with the pandemic, mental health care providers who are marginalized and working within marginalized communities, during the pandemic, were vulnerable to mental health risks. While this study did not focus on quantifying clinician mental health outcomes, participants reported on professional circumstances that fostered their wellbeing, as well as challenges that contributed to symptoms of burn out, such as fatigue and limited resources to carry out their work (McCormack et al., 2018). This study has shed light on the need for intersectional research that explores factors that promote or hinder clinician wellbeing, taking into consideration clinician and client characteristics and contexts of clinical work.

One of the ways that clinicians could delineate boundaries between professional and personal worlds, was by using the therapeutic frame. Conceptually, the frame aids clinicians in being able to provide attentive, attuned services, and is designed to foster security for clients by offering a reliable context in which to explore psychological concerns. The therapeutic frame is described as a set of consistent parameters that define the therapeutic space, environmentally as well as relationally (Charura & Paul, 2014). These parameters, or the setting of therapy, were changed drastically during the pandemic, as many services became remote. The therapeutic frame was one of the prominent ideas that participants worked with to navigate changes prompted by the pandemic.

Participants discussed how having the clinician and client in disparate spaces brought new dimensions into clinical work. For instance, practitioners working remotely no longer provided the physical space, thus having less control over consistency and confidentiality to meet with clients. Rather, clinicians had to work collaboratively with clients to find new ways to establish the environmental aspects of the therapeutic frame, as well as consider the effects the new frame had on the client, the clinician, and the therapy. Clinicians discussed how the need to foster a more collaborative approach to setting the frame decreased the power held by the therapist in deciding parameters of physical space. Broader remote care literature has also captured the need to establish therapeutic setting parameters with remote service users (Appleton et al., 2021).

Changes to the frame also permitted new kinds of information into sessions, available via video conference, as clients could see into clinician' space and clinicians into clients' space. Some clinicians found that peering into personal space elicited new transference and countertransference, concepts referring to the ways in which of previous relational experiences are evoked and worked with in therapy (Charura & Paul, 2014). Participants also reported that the ability for clinicians and clients to see into each other's homes invited more intimacy, authenticity, and connection into the therapeutic relationship. For instance, clinicians said they enjoyed meeting pets and family members. Another dimension of video sessions was to be able to pragmatically engage in problem-solving real life client issues, such as filling out paperwork or strategizing how to organize household items. A new frontier in therapy was the chat function available on many video platforms. This offered an entirely new venue for therapy to take place.

Clinicians commented on the usefulness of this feature, in navigating difficulties with hearing, speaking, or when there was a lack of confidential space.

However, video, phone, and chat also lack information that is available when sessions are in person. Clinicians wondered what their clients' bodies look like and described the bizarre juxtaposition of knowing someone intimately without ever having had met. In a clinical paper regarding remote therapy, Padfield (2021) commented on the experience of working online and wondering about basic client details. "How tall are they, what do their bodies look like, how do they hold themselves, what does it feel like to be with them in a room?" (p. 221). This author described the experience of trying to fill in the gaps where information is lacking as "draining" and part of the strange subjectivity of being "there-but-not-there" (Padfield, 2021, p. 221). Similarly, many clinicians in this study describe remote work as draining, fatiguing, and lacking information.

Physical signs of emotion were difficult to see on screen, slightly delayed due to digital connections, or absent entirely, due to being beyond the camera lens. Many participants commented on the difficulty of staying attuned to emotion, as they could not see the full set of client physical emotional expression, which includes changes to facial expression, body movements, posture, changes in muscle tension, breath, and skin tone. Review studies of remote care have reported on the difficulties of discerning emotional response when working virtually (Witteveen et al., 2022), and many have also reported on the loss of richness and intimacy that was available in person (Appleton et al., 2021). More research is needed to understand how lacking physical information and shared space may impact the depth of the therapeutic relationships, and which theoretical orientations, as well as clinical problems, may be most impacted by working in person or remotely.

Changes in the frame were also discussed in relation to trauma-work. Participants described the importance of the environmental setting as a physical cue for specific mental states. For example, arriving to the therapy office cued moving into a state of being where a client would talk about the self and past experiences, and then leaving the therapeutic space would cue leaving this state and the content that was evoked. This was described as important for clients who experience dissociation, a symptom of complex trauma that is described as a disconnection from one's thoughts, memories, feelings, actions, and context (Drescher, 2022). Finding ways to help clients cue the therapeutic frame in their own home (e.g., creating a special spot only used for therapy), was used to be able to work with traumatic material, so that clients would be able to physically and psychically leave evoked material behind, and cue a new mental state. In a recently published book on complex trauma, Stubley (2021) also speaks of the loss of the transitional space travelling to and from therapy, as well as the physical container of the therapeutic room. In a similar way, the commute to and from therapy was also seen as a cue for psychological transition in general, not only for trauma work. Clinicians shared how clients used commuting to therapy to get into the mindset of therapy and commuting from therapy to consolidate and reflect after session. Clinicians reported that they made suggestions for clients to replicate these transitions into and out of therapy, for instance by going on walks before and after therapy. The loss of shared physical space fundamentally changed therapy and what was possible within therapy; at the same time, participants found creative ways to make their remote work as viable as possible.

Another element of the therapeutic frame discussed by participants is financial compensation. Working with systemic ideas of economic privilege and marginalization, participants demonstrated awareness of the financial challenges clients faced. It is well documented 2SLGBTQIA+ populations are at risk for financial inequities; pervasive societal discrimination contributes to workplace discrimination, which results in high rates of being unemployed, underemployed, under salaried, and living in poverty (Appiah et al., 2021; Waite, 2021; Waite et al., 2019). Often, these communities are forced to choose between experiencing discrimination at work or not working at all (Waite, 2021). During the pandemic, financial precarity worsened for many minorized groups, and specifically, gender and sexual minoritized groups (Combden et al., 2022; Egale, 2020). For instance, early on in the pandemic, 53% of 2SLGBTQIA+ households experienced layoffs or reduced hours compared to 39% of overall Canadian households (Egale, 2020).

Clinicians involved in this study were dedicated to economic justice, which included offering financially accessible mental health care. In addition to recognizing how economic inequities contributed to mental health challenges, clinicians provided therapy at reduced fees. Each member of the Network offered at least one client sessions at $40/session (the average session cost in Quebec is $120-$180; (Québec, 2020), and offered sessions fees according to clients' financial capacity, along sliding scales. Further, many participants reported changing fee structures to accommodate clients who lost work during the pandemic. In this way, providers were forfeiting a portion of their own salary to meet the needs of these communities.

In another vein, the concept of a sliding scale engages clients into a communal care system with unknown others, wherein higher fees of some clients contribute to supporting the lower fees of others, in addition to clinicians agreeing to work for lower overall financial compensation. By offering sliding care, clinicians recognized and responded directly to the systemic inequities that clients face, providing an alternative route to care that is more accessible than standardized care. The tendency to work with others to form collectives of care, and to design needed resources that do yet exist, paralleled between clients and clinicians.

Best practice guidelines for working with low income and economic marginalization places emphasis on understanding how economic precarity and ensuing stigma and discrimination negatively impacts mental health (Juntunen et al., 2022). Further, guidelines call for clinicians to engage in action that seeks economic justice (Juntunen et al., 2022). This group of clinicians has collectively normalized offering reduced fee sessions as a means of reducing (or not further contributing to) disparities faced by their clients.

Implications and Future Directions

This study explored clinician experiences providing mental health care services to 2SLGBTQIA+ populations during the first year of the COVID-19 pandemic in Montreal, Quebec. The implications regarding service delivery modalities emerging from this study, as well as others, indicate that there are benefits as well as impediments to remote mental health care, which are idiosyncratic to the unique characteristics of clients and clinicians involved in a specific treatment (Appleton et al., 2021; Witteveen et al., 2022). This study highlights the need for precise understanding of how in-person, remote, or hybrid approaches may impact clients differently, depending on myriad factors including mental health concerns, access to technology and space, personal preference, disability, schedules, and location. In addition to how remote work may impact clients, this study emphasized the importance of how remote work impacts clinicians. Further, findings indicate that establishing more thorough procedures and adaptations for remote interventions would be useful, particularly for physical therapeutic approaches such as art therapy, somatic therapy, and drama therapy. Research is also needed for comprehensive understanding of how shared physical space (or lack thereof) may impact the therapeutic relationships and the depth of emotional processes in therapy. This is crucial when working with trauma. In addition to more comprehensive research regarding impact and delivery of remote care, this study and others have clearly demonstrated that clinicians need more training in working remotely, including ongoing up-to-date training on digital security (Witteveen et al., 2022). Accordingly, remote service provision should be integral to all graduate training programs.

This study has illustrated that clinicians working with 2SLGBTQIA+ populations have specialized knowledge and understanding of these communities, which can contribute to research on therapeutic practices. While more research is needed to develop best practices for working with 2SLGBTQIA+ populations, it may prove useful to consult with clinicians who have expertise in this realm. Participants in this study have indicated the importance of attending to the stigma and discrimination these populations face and finding ways to support clients in navigating inequities. Further, clinicians have shown the use of employing a systemic lens to understand client lives and make impactful interventions. Importantly, future research and work dedicated to best therapeutic practices should be attentive to look at distinct populations subsumed within the 2SLGBTQIA+ umbrella, as well as to employ intersectional approaches to capture differences of experiences of gender and sexuality across social locators (e.g., race, age, class, disability). More research examining the impact of oppression, marginalization and discrimination is needed, in addition to developing strategic interventions to mitigate and buffer against these impacts, and to make changes to the structures that undergird inequitable conditions. In addition, more available trainings and clinical experiences working with 2SLGBTQIA+ populations are needed within graduate programs to help reduce knowledge gaps and decrease unmet service needs.

This study also brought attention to clinicians' experiences. The personal toll of working during the pandemic was evident, as well as the ways in which working was a meaningful task and a protective factor for clinicians. Further, clinicians working collaboratively in teams may benefit from peer support, professional development, and knowledge sharing, which are likely to facilitate better clinical outcomes and reduce burnout. This study evokes important future research endeavors to examine how clinical work impacts clinician mental health. As an understudied area (Victor et al., 2022), there are many avenues that lack attention. It would be useful to explore the how different kinds of clinical work effect provider mental health, across diverse clinicians and work environments, as well as the ways in which clinical work can foster wellbeing.

Strengths and Limitations

A strength of drawing from interpersonal phenomenological analytical methods was to be able to pull in participants' subjectivity and allow for understandings of individual experiences by researcher and participant to be integral in the research process. With this inclusion, participants' processes of making meaning are necessarily involved in interpretation. One hope was that participants gained personally from participating in the research, which many participants reported they did. Further it was evident that engaging in this project was a catalyst in shaping ideas to become explicitly realized for participants, as well as in eliciting new ideas and understandings of experiences. Participants also commented that sharing with other participants was illuminating, connective, and conducive of mobilizing knowledge. If nothing else, this project has served its participants.

This research adds to the limited body of work dedicated to understanding mental health care for sexual and gender minoritized communities. Careful attention was paid to avoid hyper focusing on the risks associated with these populations, as well as pigeonholing subjects as simply resilient to these challenges, and without other dimensions. Rather, the intention was to capture authentic experiences within context. Employing a social justice epistemology facilitated individual, interpersonal, organizational, and societal analyses, which helped see beyond the therapeutic dyad to other levels of impact. This illuminated the ways that participants' interventions ranged from therapeutic to structural. It also traced the impact of intersectional discrimination on wellbeing.

One of the unfortunate limitations of this work, was the fatigue and isolation felt by clinicians and clients, as well as researchers. There were limits to the efficiency and speed of processing this research. This research may have been better served if it had been conducted with more community involved in steering the project. At the time of creation, that did not seem feasible due to the enormity of the pandemic, the vast uncertainties, and the need to limit time spent online.

This work is also stunted by an ongoing conundrum in gender and sexuality research, wherein projects tend to reach for inclusivity (e.g., all sexualities and genders), which lacks specificity, or reach for precision (e.g., a specific identity, such as, 'trans women'), which risks categorization that does not represent reality and leaves many identities excluded from research altogether (e.g., gender identities that do not fall within trans or nonbinary categories). This research was able to shed light on the multiplicities of intersecting identities, social locations, and contexts among clinicians, clients, and communities, highlighting the vast differences amongst clinicians, as well as drawing out the heterogeneity within 2SLGBTQIA+ populations, who are often represented as a unified and homogenous group. The complexly distinct experiences represented in this work reinforced the need for in-depth, qualitative research that lifts out of categorical limitations to offer pertinent and nuanced understandings of real-life experiences. This research cannot provide highly generalizable results, but at the same time, it is not without useful meaning and patterns that can be transferable to new contexts, and which can contribute to the overarching body of knowledge regarding mental health, service provision, and care for and within minoritized groups, such as sexual and gender diverse communities. While this work does not offer an intricate detangling of the diverse experiences and identities subsumed within gender and sexuality under the 2SLGBTQIA+ umbrella, this research does offer detail in that it reflects the experiences of a specific group of clinicians, connected via their dedication to working affirmatively with 2SLBGTQIA+ clientele, during a specified period, in a localized place. This level of detail recognizes the contextual, cultural, and relational factors that influence social locations such as gender and sexuality, as well as mental health and wellbeing.

However, with specificity comes limitations. For instance, diversity across participants was limited in this study, particularly in racial diversity and gender diversity, which are key social locations to inform this work. This was in part due to the participant pool, a network of clinicians which was at the time, limited in some aspects of diverse identity representation. There are many hypotheses regarding contributors to homogeneity within the group. For instance, the requirements to become a mental health professional, such as attending higher education, imply privileges that would make it possible to succeed (e.g., stable housing, food, shelter, financial support, previous positive education experiences, absence of carceral record). In addition to the barriers to even apply to graduate school, discrimination for those who do attend is rampant. Minoritized students are subjected to a lack of heterogeneity in graduate school admissions, coupled with vulnerability to oppressive experiences within graduate training (Callahan et al., 2018; Sarr et al., 2022; Stewart et al., 2017). This makes it less likely for there to be diversity within student bodies. It follows that professional populations are likely to more homogenous around majority identity locations (e.g., white, middle class, cisgender, Canadian). Further, membership within community organizations, such as The Network, requires additional time and energy. Bandwidth to engage is another privilege that not all can afford. However, it is also important to note that many organizations for sexual and gender minorities have not been inclusive, and have many times reflected normative societal values that prioritize certain social locations (e.g., white, middle class, able bodied) at the detriment to others (Labelle, 2019, 2021; Ward, 2008). This work would be improved with the contributions of more diverse voices.

Conclusion

In this study, experiences of mental health care service providers who worked with 2SLGBTQIA+ communities in Montreal, Canada during the first year of COVID-19 pandemic shed light on the evolution of service provision to provide remote care, as well as subsequent changes in therapeutic processes. Results from this study offer insight on how the pandemic impacted remote therapy, approaches to practice, new clinical experiences, professional development, and 2SLGBTQIA+ populations.

References

Abramovich, A., Pang, N., & Moss, A. (2022). Experiences of family violence among 2SLGBTQ+ youth at risk of, and experiencing, homelessness before and during the COVID-19 pandemic. *Journal of Gay & Lesbian Mental Health, 26*(3), 265-288. https://doi.org/https://doi.org/10.1080/19359705.2022.2076759

Abreu, R. L., Gonzalez, K. A., Arora, S., Sostre, J. P., Lockett, G. M., & Mosley, D. V. (2021). "Coming together after tragedy reaffirms the strong sense of community and pride we have:" LGBTQ people find strength in community and cultural values during the COVID-19 pandemic. *Psychology of Sexual Orientation and Gender Diversity, 10*(1), 140-149. https://doi.org/https://doi.org/10.1037/sgd0000516

Aghili, S. M., & Arbabi, M. (2020). The COVID-19 pandemic and the health care providers; what does it mean psychologically? *Advanced Journal of Emergency Medicine, 4*(2s), e63. https://doi.org/https://doi.org/10.22114/ajem.v4i2s.419

Ali, R. M. C. (2014). *A transpositive approach to therapy with transgender clients: An exploration of therapists' subjective experiences* [Masters, The University of Western Ontario]. Ontario, Canada. https://ir.lib.uwo.ca/etd/1979

Alleman, J. R. (2002). Online counseling: The Internet and mental health treatment. *Psychotherapy: Theory, Research, Practice, Training, 39*(2), 199. https://doi.org/https://doi.org/10.1037/0033-3204.39.2.199

AlRasheed, R., Woodard, G. S., Nguyen, J., Daniels, A., Park, N., Berliner, L., & Dorsey, S. (2022). Transitioning to telehealth for COVID-19 and beyond: Perspectives of community mental health clinicians. *The Journal of Behavioral Health Services & Research, 49*(4), 524-530. https://doi.org/https://doi.org/10.1007/s11414-022-09799-z

Anderson, A. R., & Knee, E. (2021). Queer isolation or queering isolation? Reflecting upon the ramifications of COVID-19 on the future of queer leisure spaces. *Leisure Sciences, 43*(1-2), 118-124. https://doi.org/https://doi.org/10.1080/01490400.2020.1773992

Andersson, G., Titov, N., Dear, B. F., Rozental, A., & Carlbring, P. (2019). Internet-delivered psychological treatments: From innovation to implementation. *World Psychiatry, 18*(1), 20-28. https://doi.org/https://doi.org/10.1002/wps.20610

Appiah, A., Brennan, K., Halpenny, C., Pakula, B., & Waite, S. (2021). *Building the evidence base about economic, health, and social inequities faced by LGBTQ2S+ individuals in Canada*. T. S. R. a. D. Corporation. https://www.researchgate.net/profile/Basia-Pakula-2/publication/353886974_Building_the_evidence_base_about_economic_health_and_social_inequities_faced_by_LGBTQ2S_individuals_in_Canada_Phase_2_Final_Report/links/611690641e95fe241acd4878/Building-the-evidence-base-about-economic-health-and-social-inequities-faced-by-LGBTQ2S-individuals-in-Canada-Phase-2-Final-Report.pdf

Appleton, R., Williams, J., Vera San Juan, N., Needle, J. J., Schlief, M., Jordan, H., Sheridan Rains, L., Goulding, L., Badhan, M., & Roxburgh, E. (2021). Implementation, adoption, and perceptions of telemental health during the COVID-19 pandemic: Systematic review. *Journal of Medical Internet Research, 23*(12), e31746. https://doi.org/https://doi.org/10.2196/31746

Arnberg, F. K., Linton, S. J., Hultcrantz, M., Heintz, E., & Jonsson, U. (2014). Internet-delivered psychological treatments for mood and anxiety disorders: A systematic review of their efficacy, safety, and cost-effectiveness. *Plos One, 9*(5), e98118. https://doi.org/https://doi.org/10.1371/journal.pone.0098118

Asakura, K., & Craig, S. L. (2014). “It gets better”… but how? Exploring resilience development in the accounts of LGBTQ adults. *Journal of Human Behavior in the Social Environment, 24*(3), 253-266. https://doi.org/https://doi.org/10.1080/10911359.2013.808971

Bai, Y., Lin, C.-C., Lin, C.-Y., Chen, J.-Y., Chue, C.-M., & Chou, P. (2004). Survey of stress reactions among health care workers involved with the SARS outbreak. *Psychiatric Services, 55*(9), 1055-1057. https://doi.org/https://doi.org/10.1176/appi.ps.55.9.1055

Banks, J. (2021). *Psychotherapists' approaches to transgender affirmative psychotherapy* [Masters thesis, The University of Western Ontario]. Ontario, Canada. https://ir.lib.uwo.ca/etd/7781

Barbisch, D., Koenig, K. L., & Shih, F.-Y. (2015). Is there a case for quarantine? Perspectives from SARS to Ebola. *Disaster Medicine and Public Health Preparedness, 9*(5), 547-553. https://doi.org/https://doi.org/10.1017/dmp.2015.38

Bauer, G. R., Pyne, J., Francino, M. C., Hammond, R., Dorais, M., & Chamberland, L. (2013). Suicidality among trans people in Ontario: Implications for social work and social justice. *Service Social, 59*(1), 35-62. https://doi.org/https://doi.org/10.7202/1017478ar

Bennett, G. G., & Glasgow, R. E. (2009). The delivery of public health interventions via the Internet: Actualizing their potential. *Annual Review of Public Health, 30*, 273-292. https://doi.org/https://doi.org/10.1146/annurev.publhealth.031308.100235

Berryhill, M. B., Culmer, N., Williams, N., Halli-Tierney, A., Betancourt, A., Roberts, H., & King, M. (2019). Videoconferencing psychotherapy and depression: A systematic review. *Telemedicine and e-Health, 25*(6), 435-446. https://doi.org/https://doi.org/10.1089/tmj.2018.0058

Betancourt, G. (2020). Code blue! Implementing a COVID-19 emergency response, supported by an HIV community program: Communities without borders, a Spanish-Speaking intervention in Toronto, Canada. *Journal of HIV/AIDS & Social Services, 19*(2), 188-191. https://doi.org/https://doi.org/10.1080/15381501.2020.1768194

Blair, K. L., & Holmberg, D. (2008). Perceived social network support and well-being in same-sex versus mixed-sex romantic relationships. *Journal of Social and Personal Relationships, 25*(5), 769-791. https://doi.org/https://doi.org/10.1177/0265407508096695

Bortolan, A. (2023). Healing online? Social anxiety and emotion regulation in pandemic experience. *Phenomenology and the Cognitive Sciences*, 1-20. https://doi.org/https://doi.org/10.1007/s11097-023-09886-2

Bouchard, S., Paquin, B., Payeur, R., Allard, M., Rivard, V., Fournier, T., Renaud, P., & Lapierre, J. (2004). Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. *Telemedicine Journal and e-Health, 10*(1), 13-25. https://doi.org/https://doi.org/10.1089/153056204773644535

Bowman, S., & Fox, R. (2020). Virtually caring: A qualitative study of internet-based mental health services for LGBT young adults in rural Australia. *Rural and Remote Health, 20*(1), 5448-5448. https://doi.org/https://doi.org/10.22605/RRH5448

Bränström, R. (2017). Minority stress factors as mediators of sexual orientation disparities in mental health treatment: A longitudinal population-based study. *Journal of Epidemiology & Community Health, 71*(5), 446-452. https://doi.org/https://doi.org/10.1136/jech-2016-207943

Brennan, D. J., Card, K. G., Collict, D., Jollimore, J., & Lachowsky, N. J. (2020). How might social distancing impact gay, bisexual, queer, trans and two-spirit men in Canada? *AIDS* *and Behavior, 24*(9), 2480-2482. https://doi.org/https://doi.org/10.1007/s10461-020-02891-5

Brillon, P., Philippe, F. L., Paradis, A., Geoffroy, M. C., Orri, M., & Ouellet-Morin, I. (2022). Psychological distress of mental health workers during the COVID-19 pandemic: A comparison with the general population in high-and low-incidence regions. *Journal of Clinical Psychology, 78*(4), 602-621. https://doi.org/https://doi.org/10.1002/jclp.23238

Bristol, T., & Fern, E. F. (1996). Exploring the atmosphere created by focus group interviews: Comparing consumers' feelings across qualitative techniques. *Market Research Society Journal, 38*(2), 1-9. https://doi.org/https://doi.org/10.1177/147078539603800208

Brooks, S. K., Dunn, R., Amlôt, R., Rubin, G. J., & Greenberg, N. (2018). A systematic, thematic review of social and occupational factors associated with psychological outcomes in healthcare employees during an infectious disease outbreak. *Journal of Occupational and Environmental Medicine, 60*(3), 248-257. https://doi.org/https://doi.org/10.1097/JOM.0000000000001235

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. *The Lancet*. https://doi.org/https://doi.org/10.1016/S0140-6736(20)30460-8

Buchanan, N. T., Perez, M., Prinstein, M. J., & Thurston, I. B. (2021). Upending racism in psychological science: Strategies to change how science is conducted, reported, reviewed, and disseminated. *American Psychologist, 76*(7), 1097-1112. https://doi.org/https://doi.org/10.1037/amp0000905

Callahan, J. L., Smotherman, J. M., Dziurzynski, K. E., Love, P. K., Kilmer, E. D., Niemann, Y. F., & Ruggero, C. J. (2018). Diversity in the professional psychology training-to-workforce pipeline: Results from doctoral psychology student population data. *Training and Education in Professional Psychology, 12*(4), 273-285. https://doi.org/https://doi.org/10.1037/tep0000203

Camargo, E. L. S., de Oliveira, B. I. A., Siffoni, I. F., de Sousa, A. R., Teixeira, J. R. B., Mendes, I. A. C., & de Sousa, Á. F. L. (2021). Low psychological well-being in men who have sex with men (MSM) during the shelter-in-place orders to prevent the COVID-19 spread: Results from a nationwide study. *Sexuality Research and Social Policy, 19*, 391-400. https://doi.org/https://doi.org/10.1007/s13178-021-00550-5

Camic, P. M., Rhodes, J. E., & Yardley, L. E. (2003). *Qualitative research in psychology: Expanding perspectives in methodology and design*. American Psychological Association. https://doi.org/https://doi.org/10.1037/10595-000

Campbell, A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. *Forensic Science International: Reports, 2*, 100089. https://doi.org/https://doi.org/10.1016/j.fsir.2020.100089

Canadian COVID-19 Intervention Timeline. (2022). Canadian Institute for Health Information. Retrieved October 25 from https://www.cihi.ca/en/canadian-covid-19-intervention-timeline

Canvin, L., Twist, J., & Solomons, W. (2022). How do mental health professionals describe their experiences of providing care for gender diverse adults? A systematic literature review. *Psychology & Sexuality, 13*(3), 717-741. https://doi.org/https://doi.org/10.1080/19419899.2021.1916987

Ceniti, A. K., Abdelmoemin, W. R., Ho, K., Kang, Y., Placenza, F., Laframboise, R., Bhat, V., Foster, J. A., Frey, B. N., & Lam, R. W. (2022). “One degree of separation”: A mixed-methods evaluation of Canadian mental health care user and provider experiences with remote care during COVID-19. *The Canadian Journal of Psychiatry, 67*(9), 712-722. https://doi.org/https://doi.org/10.1177/07067437211070656

Chaiton, M., Musani, I., Pullman, M., Logie, C. H., Abramovich, A., Grace, D., Schwartz, R., & Baskerville, B. (2021). Access to mental health and substance use resources for 2SLGBTQ+ youth during the COVID-19 pandemic. *International journal of Environmental Research and Public Health, 18*(21), 11315. https://doi.org/https://doi.org/10.3390/ijerph182111315

Charura, D., & Paul, S. (2014). *The therapeutic relationship handbook: Theory and practice* (D. Charura & S. Paul, Eds.). McGraw Hill Education/Open University Press.

Chew, Q. H., Wei, K. C., Vasoo, S., Chua, H. C., & Sim, K. (2020). Narrative synthesis of psychological and coping responses towards emerging infectious disease outbreaks in the general population: Practical considerations for the COVID-19 pandemic. *Singapore Medical Journal*. https://doi.org/https://doi.org/10.11622/smedj.2020046

Chiari, G., & Nuzzo, M. L. (1996). Psychological constructivisms: A metatheoretical differentiation. *Journal of Constructivist Psychology, 9*(3), 163-184. https://doi.org/https://doi.org/10.1080/10720539608404663

Choi, K., Denice, P., Haan, M., & Zajacova, A. (2020). Studying the social determinants of COVID-19 in a data vacuum. *UCLA CCPR Population Working Papers*. https://doi.org/https://doi.org/10.31235/osf.io/yq8vu

Christensen, H., Griffiths, K., & Evans, K. (2002). *e-Mental health in Australia: Implications of the Internet and related technologies for policy* (0642821860).

Cochran, S. D., Björkenstam, C., & Mays, V. M. (2017). Sexual orientation differences in functional limitations, disability, and mental health services use: Results from the 2013–2014 National Health Interview Survey. *Journal of Consulting and Clinical Psychology, 85*(12), 1111-1121. https://doi.org/https://doi.org/10.1037/ccp0000243

Colpitts, E., & Gahagan, J. (2016). The utility of resilience as a conceptual framework for understanding and measuring LGBTQ health. *International Journal for Equity in Health, 15*(1), 60. https://doi.org/https://doi.org/10.1186/s12939-016-0349-1

Combden, S., Forward, A., & Sarkar, A. (2022). COVID-19 pandemic responses of Canada and United States in first 6 months: A comparative analysis. *The International Journal of Health Planning and Management, 37*(1), 50-65. https://doi.org/https://doi.org/10.1002/hpm.3323

CORD-19. (2020). Retrieved May 1, 2020 from https://www.semanticscholar.org/cord19/get-started

Coronavirus disease (COVID-19): Prevention and risks. (2020). Government of Canada. Retrieved May 1, 2020 from https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks.html

COVID-19 Member Messages. (2020). Canadian Psychological Association. https://cpa.ca/category/covid19members/

Cronin, T. J., Pepping, C. A., Halford, W. K., & Lyons, A. (2021). Minority stress and psychological outcomes in sexual minorities: The role of barriers to accessing services.

Journal of Homosexuality, 68(14), 2417-2429. https://doi.org/https://doi.org/10.1080/00918369.2020.1804264

Cwikel, J., & Friedmann, E. (2019). E-therapy and social work practice: Benefits, barriers, and training. *International Social Work*. https://doi.org/https://doi.org/10.1177/0020872819847747

Dallos, R., & Draper, R. (2015). *Ebook: An introduction to family therapy: Systemic theory and practice*. McGraw-Hill Education (UK).

Denier, N., & Waite, S. (2017). Sexual orientation wage gaps across local labour market contexts: Evidence from Canada. *Relations industrielles/Industrial Relations, 72*(4), 734-762. https://doi.org/https://doi.org/10.7202/1043174ar

Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences, 5*(4), 565-575. https://doi.org/https://doi.org/10.3390/bs5040565

Drescher, J. (2022). *What are dissociative disorders?* American Psychiatric Association. https://www.psychiatry.org/patients-families/dissociative-disorders/what-are-dissociative-disorders

Drescher, J., Shidlo, A., & Schroeder, M. (2002). *Sexual conversion therapy: Ethical, clinical and research perspectives*. Haworth Medical Press. https://doi.org/https://doi.org/10.1201/9781315272955

Duguay, S., Trépanier, A.-M., & Chartrand, A. (2022). The hottest new queer club: investigating Club Quarantine's off-label queer use of Zoom during the COVID-19 pandemic. *Information, Communication & Society*, 1-17. https://doi.org/https://doi.org/10.1080/1369118X.2022.2077655

Dunne, E. A., & Quayle, E. (2001). The impact of iatrogenically acquired hepatitis C infection on the well-being and relationships of a group of Irish women. *Journal of Health Psychology, 6*(6), 679-692. https://doi.org/https://doi.org/10.1177/135910530100600606

Dyck, K. G., & Hardy, C. (2013). Enhancing access to psychologically informed mental health services in rural and northern communities. *Canadian Psychology/Psychologie Canadienne, 54*(1), 30-37. https://doi.org/https://doi.org/10.1037/a0031280

Earle, E. A., Davies, H., Greenfield, D., Ross, R., & Eiser, C. (2005). Follow-up care for childhood cancer survivors: A focus group analysis. *European Journal of Cancer, 41*(18), 2882-2886. https://doi.org/https://doi.org/10.1016/j.ejca.2005.08.028

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (Vol. 179, pp. 194). SAGE. https://doi.org/https://dx.doi.org/10.4135/9781848607927.n11

Edelman, E. J., Aoun-Barakat, L., Villanueva, M., & Friedland, G. (2020). Confronting another pandemic: Lessons from HIV can inform our COVID-19 response. *AIDS and Behavior, 24*, 1977-1979. https://doi.org/https://doi.org/10.1007/s10461-020-02908-z

Egale, I. (2020). *Impact of COVID-19 Canada's LGBTQ12S Community in Focus*. https://egale.ca/wp-content/uploads/2020/04/Impact-of-COVID-19-Canada%E2%80%99s-LGBTQI2S-Community-in-Focus-2020-04-06.pdf

Enns, C. Z. E., & Sinacore, A. L. (2005). *Teaching and social justice: Integrating multicultural and feminist theories in the classroom*. American Psychological Association. https://doi.org/https://doi.org/10.1037/10929-000

Fergus, S., & Zimmerman, M. A. (2005). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annual Review of Public Health, 26*, 399-419. https://doi.org/https://doi.org/10.1146/annurev.publhealth.26.021304.144357

Ferlatte, O., Salway, T., Rice, S., Oliffe, J. L., Rich, A. J., Knight, R., Morgan, J., & Ogrodniczuk, J. S. (2019). Perceived barriers to mental health services among Canadian sexual and gender minorities with depression and at risk of suicide. *Community Mental Health Journal, 55*, 1313-1321. https://doi.org/https://doi.org/10.1007/s10597-019-00445-1

Filice, E., & Meyer, S. B. (2018). Patterns, predictors, and outcomes of mental health service utilization among lesbians, gay men, and bisexuals: A scoping review. *Journal of Gay & Lesbian Mental Health, 22*(2), 162-195. https://doi.org/https://doi.org/10.1080/19359705.2017.1418468

Frounfelker, R. L., Li, Z. Y., Santavicca, T., Miconi, D., & Rousseau, C. (2022). Latent class analysis of COVID-19 experiences, social distancing, and mental health. *American Journal of Orthopsychiatry, 92*(1), 1-12. https://doi.org/https://doi.org/10.1037/ort0000593

Gagné-Julien, A.-M. (2022). Medicalization, contributory injustice, and mad studies. *Kennedy Institute of Ethics Journal, 32*(4), 401-434. https://doi.org/https://doi.org/10.1353/ken.2022.0023

Gahagan, J., & Colpitts, E. (2017). Understanding and measuring LGBTQ pathways to health: A scoping review of strengths-based health promotion approaches in LGBTQ health research. *Journal of Homosexuality, 64*(1), 95-121. https://doi.org/https://doi.org/10.1080/00918369.2016.1172893

Garcia, J., Vargas, N., Clark, J. L., Magaña Álvarez, M., Nelons, D. A., & Parker, R. G. (2020). Social isolation and connectedness as determinants of well-being: Global evidence mapping focused on LGBTQ youth. *Global Public Health, 15*(4), 497-519. https://doi.org/https://doi.org/10.1080/17441692.2019.1682028

Ghabrial, M. A., Scheim, A. I., Chih, C., Santos, H., Adams, N. J., & Bauer, G. R. (2021). Change in finances, peer access, and mental health among trans and non-binary people in Canada during COVID-19. *medRxiv*, 1-30. https://doi.org/https://doi.org/10.1101/2021.12.13.21267077

Gibb, J. K., DuBois, L. Z., Williams, S., McKerracher, L., Juster, R.-P., & Fields, J. (2020). Sexual and gender minority health vulnerabilities during the COVID-19 health crisis. *American Journal of Human Biology, 32*(5), e23499. https://doi.org/https://doi.org/10.1002/ajhb.23499

Giwa, S., & Greensmith, C. (2012). Race relations and racism in the LGBTQ community of Toronto: Perceptions of gay and queer social service providers of color. *Journal of Homosexuality, 59*(2), 149-185. https://doi.org/https://doi.org/10.1080/00918369.2012.648877

Glassgold, J. M., Beckstead, L., Drescher, J., Greene, B., Miller, R. L., Worthington, R. L., & Anderson, C. W. (2009). *Report of the American Psychological Association Task Force on appropriate therapeutic responses to sexual orientation*. https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

Goldberg, S. B. (2020). COVID-19 and LGBT rights. In K. Pistor (Ed.), *Law in the time of COVID-19* (pp. 99-108). Columbia Law School. https://scholarship.law.columbia.edu/faculty_scholarship/2687

Goldsmith, R. E., Martin, C. G., & Smith, C. P. (2014). Systemic trauma. *Journal of Trauma & Dissociation, 15*(2), 117-132. https://doi.org/https://doi.org/10.1080/15299732.2014.871666

Gonzalez, K. A., Abreu, R. L., Arora, S., Lockett, G. M., & Sostre, J. (2021). "Previous resilience has taught me that I can survive anything:" LGBTQ resilience during the COVID-19 pandemic. *Psychology of Sexual Orientation and Gender Diversity, 8*(2), 133-144. https://doi.org/https://doi.org/10.1037/sgd0000501

Graham, R., Berkowitz, B., Blum, R., Bockting, W., Bradford, J., de Vries, B., & Makadon, H. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. T. N. A. Press.

Green, A. E., Albanese, B. J., Shapiro, N. M., & Aarons, G. A. (2014). The roles of individual and organizational factors in burnout among community-based mental health service providers. *Psychological Services, 11*(1), 41-49. https://doi.org/https://doi.org/10.1037/a0035299

Greteman, A. (2021). Queer resilience. In *Oxford research encyclopedia of education*. Oxford University Press. https://doi.org/https://doi.org/10.1093/acrefore/9780190264093.013.1397

Greytak, E., Gill, A., Conron, K., & Herman, J. (2014). *Best practices for asking questions to identify transgender and other gender minority respondents on population-based surveys*. U. T. W. Institute. https://escholarship.org/uc/item/3qk7s1g6

Griffiths, F., Lindenmeyer, A., Powell, J., Lowe, P., & Thorogood, M. (2006). Why are health care interventions delivered over the internet? A systematic review of the published literature. *Journal of Medical Internet Research, 8*(2), e10. https://doi.org/https://doi.org/10.2196/jmir.8.2.e10

Guest, G., Namey, E., Taylor, J., Eley, N., & McKenna, K. (2017). Comparing focus groups and individual interviews: Findings from a randomized study. *International Journal of Social Research Methodology, 20*(6), 693-708. https://doi.org/https://doi.org/10.1080/13645579.2017.1281601

Guidance on essential services and functions in Canada during the COVID-19 pandemic. (2020). Public Safety Canada. https://www.publicsafety.gc.ca/cnt/ntnl-scrt/crtcl-nfrstrctr/esf-sfe-en.aspx

Guta, A., & Newman, P. A. (2021). Virality, desire and health assemblages: Mapping (dis) continuities in the response to and management of HIV and COVID-19. *Culture, Health & Sexuality, 23*(11), 1516-1531. https://doi.org/https://doi.org/10.1080/13691058.2021.1981453

Halcomb, E. J., Gholizadeh, L., DiGiacomo, M., Phillips, J., & Davidson, P. M. (2007). Literature review: Considerations in undertaking focus group research with culturally and linguistically diverse groups. *Journal of Clinical Nursing, 16*(6), 1000-1011. https://doi.org/https://doi.org/10.1111/j.1365-2702.2006.01760.x

Hamza Shuja, K., Aqeel, M., Jaffar, A., & Ahmed, A. (2020). COVID-19 pandemic and impending global mental health implications. *Psychiatria Danubina, 32*(1), 32-35. https://doi.org/https://doi.org/10.24869/psyd.2020.32

Hardy, Z. B. C. (2022). Indigenous LGBTQ and Two-Spirit health. In E. K. Amy Bourns, Allan Peterkin, Cathy Risdon (Ed.), *Caring for LGBTQ2S People: A Clinical Guide* (2nd ed., pp. 465-490). University of Toronto Press. https://doi.org/https://doi.org/10.3138/9781487515249-015

Hargreaves, J., Davey, C., Auerbach, J., Blanchard, J., Bond, V., Bonell, C., Burgess, R., Busza, J., Colbourn, T., & Cowan, F. (2020). Three lessons for the COVID-19 response from pandemic HIV. *The Lancet HIV, 7*(5), e309-e311. https://doi.org/https://doi.org/10.1016/S2352-3018(20)30110-7

Haritaworn, J. (2020). # NoGoingBack: Queer leaps at the intersection of protest and COVID-19. *Journal of Environmental Media, 1*(1), 12.11-12.17. https://doi.org/https://doi.org/10.1386/jem_00033_1

Harrison, B. F., & Michelson, M. R. (2022). LGBTQ scholarship: Researcher identity and ingroup positionality. *PS: Political Science & Politics, 55*(4), 759-763. https://doi.org/https://doi.org/10.1017/S1049096522000038

Hatzenbuehler, M. L. (2009). How does sexual minority stigma “get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707-730. https://doi.org/https://doi.org/10.1037/a0016441

Hatzenbuehler, M. L., & Pachankis, J. E. (2021). Does stigma moderate the efficacy of mental- and behavioral-health interventions? Examining individual and contextual sources of treatment-effect heterogeneity. *Current Directions in Psychological Science, 30*(6), 476-484. https://doi.org/https://doi.org/10.1177/09637214211043884

Haworth, B. T. (2022). The importance of queer community resilience. *The Australian Journal of Emergency Management, 37*(1), 31-32.

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress

Model. *Professional Psychology: Research and Practice, 43*(5), 460. https://doi.org/https://doi.org/10.1037/a0029597

Higgins, R., Hansen, B., Jackson, B. E., Shaw, A., & Lachowsky, N. J. (2021). At-a-glance-Programs and interventions promoting health equity in LGBTQ2+ populations in Canada through action on social determinants of health. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice, 41*(12), 431. https://doi.org/https://doi.org/10.24095/hpcdp.41.12.04

HIV/AIDS. (2019). World Health Organization. Retrieved May 1 2020 from https://www.who.int/news-room/fact-sheets/detail/hiv-aids

Hobaica, S., Szkody, E., Owens, S. A., Boland, J. K., Washburn, J. J., & Bell, D. J. (2021). Mental health concerns and barriers to care among future clinical psychologists. *Journal of Clinical Psychology, 77*(11), 2473-2490. https://doi.org/https://doi.org/10.1002/jclp.23198

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., Ballard, C., Christensen, H., Silver, R. C., & Everall, I. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: A call for action for mental health science. *The Lancet Psychiatry*, 547-560. https://doi.org/https://doi.org/10.1016/S2215-0366(20)30168-1

Holmes, S. C., Facemire, V. C., & DaFonseca, A. M. (2016). Expanding criterion a for posttraumatic stress disorder: Considering the deleterious impact of oppression. *Traumatology, 22*(4), 314. https://doi.org/https://doi.org/10.1037/trm0000104

How it spreads. (2020). BC Centre for Disease Control. Retrieved May 1 2020 from http://www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid-19/how-it-spreads

Hoy-Ellis, C. P., Ator, M., Kerr, C., & Milford, J. (2016). Innovative approaches address aging and mental health needs in LGBTQ communities. *Generations, 40*(2), 56-62.

Humphreys, K., Winzelberg, A., & Klaw, E. (2000). Psychologists' ethical responsibilities in the Internet-based groups: Issues, strategies, and a call for dialogue. *Professional Psychology: Research and Practice, 31*(5), 493-496. https://doi.org/https://doi.org/10.1037/0735-7028.31.5.493

Hunt, S. (2016). *An introduction to the health of Two-Spirit people: Historical, contemporary and emergent issues*. National Collaborating Centre for Aboriginal Health Prince George, BC.

Huremović, D. (2019). *Psychiatry of pandemics: A mental health response to infection outbreak*. Springer. https://doi.org/https://doi.org/10.1007/978-3-030-15346-5

Irving, D., & Raj, R. (2014). *Trans activism in Canada: A reader*. Canadian Scholars' Press.

Jacmin-Park, S., Rossi, M., Dumont, L., Lupien, S. J., & Juster, R.-P. (2022). Mental health and social support of sexual and gender diverse people from Québec, Canada during the COVID-19 crisis. *LGBT health, 9*(3), 151-160. https://doi.org/https://doi.org/10.1089/lgbt.2021.0255

Jenkins, E. K., McAuliffe, C., Hirani, S., Richardson, C., Thomson, K. C., McGuinness, L., Morris, J., Kousoulis, A., & Gadermann, A. (2021). A portrait of the early and differential mental health impacts of the COVID-19 pandemic in Canada: Findings from the first wave of a nationally representative cross-sectional survey. *Preventive Medicine, 145*, 106333. https://doi.org/https://doi.org/10.1016/j.ypmed.2020.106333

Juntunen, C. L., Pietrantonio, K. R., Hirsch, J. K., Greig, A., Thompson, M. N., Ross, D. E., & Peterman, A. H. (2022). Guidelines for psychological practice for people with low-income and economic marginalization: Executive summary. *American Psychologist, 77*(2), 291. https://doi.org/https://doi.org/10.1037/amp0000826

Kahn, S., Alessi, E., Woolner, L., Kim, H., & Olivieri, C. (2017). Promoting the wellbeing of lesbian, gay, bisexual and transgender forced migrants in Canada: Providers' perspectives. *Culture, Health & Sexuality, 19*(10), 1165-1179. https://doi.org/https://doi.org/10.1080/13691058.2017.1298843

Karyotaki, E., Ebert, D. D., Donkin, L., Riper, H., Twisk, J., Burger, S., Rozental, A., Lange, A., Williams, A. D., & Zarski, A. C. (2018). Do guided internet-based interventions result in clinically relevant changes for patients with depression? An individual participant data meta-analysis. *Clinical Psychology Review, 63*, 80-92. https://doi.org/https://doi.org/10.1016/j.cpr.2018.06.007

Kassan, A., & Moodley, R. (2021). *Diversity and social justice in counseling, psychology, and psychotherapy: A case study approach*. Cognella Academic Publishing.

Kcomt, L., Gorey, K. M., Barrett, B. J., & McCabe, S. E. (2020). Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. *SSM-Population Health, 11*, 100608. https://doi.org/https://doi.org/10.1016/j.ssmph.2020.100608

Kennedy, A. M., Black, S., Watt, S., Vitkin, N., Young, J., Reeves, R., & Salway, T. (2022). Health provider and sexual and gender minority service user perspectives on provision of mental health services during the early phase of the COVID-19 pandemic in British Columbia, Canada. *medRxiv*. https://doi.org/https://doi.org/10.1101/2022.02.18.22271151

Kidd, J. D., Jackman, K. B., Barucco, R., Dworkin, J. D., Dolezal, C., Navalta, T. V., Belloir, J., & Bockting, W. O. (2021). Understanding the impact of the COVID-19 pandemic on the mental health of transgender and gender nonbinary individuals engaged in a longitudinal cohort study. *Journal of Homosexuality, 68*(4), 592-611. https://doi.org/https://doi.org/10.1080/00918369.2020.1868185

Kidd, P. S., & Parshall, M. B. (2000). Getting the focus and the group: Enhancing analytical rigor in focus group research. *Qualitative Health Research, 10*(3), 293-308. https://doi.org/https://doi.org/10.1177/104973200129118453

Kidd, S. A., Howison, M., Pilling, M., Ross, L. E., & McKenzie, K. (2016). Severe mental illness in LGBT populations: A scoping review. *Psychiatric Services, 67*(7), 779-783. https://doi.org/https://doi.org/10.1176/appi.ps.201500209

Kidd, S. A., Veltman, A., Gately, C., Chan, K. J., & Cohen, J. N. (2011). Lesbian, gay, and transgender persons with severe mental illness: Negotiating wellness in the context of multiple sources of stigma. *American Journal of Psychiatric Rehabilitation, 14*(1), 13-39. https://doi.org/https://doi.org/10.1080/15487768.2011.546277

Kincheloe, J. L., & McLaren, P. (2005). Rethinking critical theory and qualitative research. *Bold Visions in Educational Research, 32*, 285-326. https://doi.org/https://doi.org/10.1007/978-94-6091-397-6_23

Kindred, R., & Bates, G. W. (2023). The Influence of the COVID-19 pandemic on social anxiety: A systematic review. *International Journal of Environmental Research and Public Health, 20*(3), 2362. https://doi.org/https://doi.org/10.3390/ijerph20032362

Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness, 16*(1), 103-121. https://doi.org/https://doi.org/10.1111/1467-9566.ep11347023

Kourti, A., Stavridou, A., Panagouli, E., Psaltopoulou, T., Spiliopoulou, C., Tsolia, M., Sergentanis, T. N., & Tsitsika, A. (2021). Domestic violence during the COVID-19 pandemic: A systematic review. *Trauma, Violence, & Abuse*, 15248380211038690. https://doi.org/https://doi.org/10.1177/15248380211038690

Kowalski, R. M., Carroll, H., & Britt, J. (2022). Finding the silver lining in the COVID-19 crisis. *Journal of Health Psychology, 27*(6), 1507-1514. https://doi.org/https://doi.org/10.1177/1359105321999088

Kroll, T., Barbour, R., & Harris, J. (2007). Using focus groups in disability research. *Qualitative Health Research, 17*(5), 690-698. https://doi.org/https://doi.org/10.1177/1049732307301488

Krueger, R., & Casey, M. (2000). *Focus groups: A practical guide for applied research* (3rd Edition ed.). Sage Publications

Labelle, A. (2019). Intersectional praxis from within and without: Challenging whiteness in Québec's LGBTQ movement. In *Intersectionality in feminist and queer movements* (pp. 202-218). Routledge. https://doi.org/https://doi.org/10.4324/9780429289859-13

Labelle, A. (2021). Why participate? An intersectional analysis of LGBTQ people of color activism in Canada. *Politics, Groups, and Identities, 9*(4), 807-825. https://doi.org/https://doi.org/10.1080/21565503.2019.1674671

Lal, S., & Adair, C. E. (2014). E-mental health: A rapid review of the literature. *Psychiatric Services, 65*(1), 24-32. https://doi.org/https://doi.org/10.1176/appi.ps.201300009

Lev, A. I. (2015). Resilience in lesbian and gay couples. In *Couple resilience* (pp. 45-61). Springer. https://doi.org/https://doi.org/10.1007/978-94-017-9909-6_3

Levitt, H. M. (2015). Interpretation-driven guidelines for designing and evaluating grounded theory research: A constructivist-social justice approach. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: Foundations, process, and outcome* (1 ed., pp. 455-483). Springer. https://doi.org/https://doi.org/10.1007/978-3-7091-1382-0_22

Lewis, S. (2022). *Abolish the family: A manifesto for care and liberation*. Verso Books.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* Sage. https://doi.org/https://doi.org/10.1016/0147-1767(85)90062-8

Logie, C. H., & Turan, J. M. (2020). How do we balance tensions between COVID-19 public health responses and stigma mitigation? Learning from HIV research. *AIDS and Behavior, 24*, 2003-2006. https://doi.org/https://doi.org/10.1007/s10461-020-02856-8

Marjanovic, Z., Greenglass, E. R., & Coffey, S. (2007). The relevance of psychosocial variables and working conditions in predicting nurses' coping strategies during the SARS crisis: An online questionnaire survey. *International Journal of Nursing Studies, 44*(6), 991-998. https://doi.org/https://doi.org/10.1016/j.ijnurstu.2006.02.012

McBeath, A. G., Du Plock, S., & Bager-Charleson, S. (2020). The challenges and experiences of psychotherapists working remotely during the Coronavirus* pandemic. *Counselling and Psychotherapy Research, 20*(3), 394-405. https://doi.org/https://doi.org/10.1002/capr.12326

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause(s) of burnout among applied psychologists: A systematic review. *Frontiers in Psychology, 9*, 1897. https://doi.org/https://doi.org/10.3389/fpsyg.2018.01897

McInroy, L. B., Beaujolais, B., Leung, V. W., Craig, S. L., Eaton, A. D., & Austin, A. (2022). Comparing asexual and non-asexual sexual minority adolescents and young adults: Stressors, suicidality and mental and behavioural health risk outcomes. *Psychology & Sexuality, 32*(2), 387-403. https://doi.org/https://doi.org/10.1080/19419899.2020.1806103

McIntyre, J., Daley, A., Rutherford, K., & Ross, L. (2011). Systems-level barriers in accessing supportive mental health services for sexual and gender minorities: Insights from the provider's perspective. *Canadian Journal of Community Mental Health, 30*(2), 173-186. https://doi.org/https://doi.org/10.7870/cjcmh-2011-0023

Melendez, S. I. (2021). *Improving mental health professional training: The collaborative development of a trans health teaching and testing tool* [Master thesis, Queen's University]. https://qspace.library.queensu.ca/bitstream/handle/1974/29017/Melendez_Sofia_I_202108_MED.pdf?sequence=3

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697. https://doi.org/https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 209. https://doi.org/https://doi.org/10.1037/sgd0000132

MHCC, M. H. C. o. C. (2012). *Changing directions, changing lives: The mental health strategy for Canada [Internet]*. http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf.

Moody, C., Fuks, N., Peláez, S., & Smith, N. G. (2015). "Without this, I would for sure already be dead": A qualitative inquiry regarding suicide protective factors among trans adults. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 266-280. https://doi.org/https://doi.org/10.1037/sgd0000130

Morris, E. R., Lindley, L., & Galupo, M. P. (2020). "Better issues to focus on": Transgender microaggressions as ethical violations in therapy. *The Counseling Psychologist, 48*(6), 883-915. https://doi.org/https://doi.org/10.1177/0011000020924391

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250. https://doi.org/https://doi.org/10.1037/0022-0167.52.2.250

Moscovitch, D. A., Antony, M. M., & Swinson, R. P. (2009). Exposure-based treatments for anxiety disorders: Theory and process. In M. M. Antony & M. B. Stein (Eds.), *Oxford handbook of anxiety and related disorders* (pp. 461-475). Oxford University Press. https://doi.org/https://doi.org/10.1093/oxfordhb/9780195307030.013.0035

Mulé, N. J. (2015). Much to be desired: LGBT health inequalities and inequities in Canada. In J. Fish & K. Karban (Eds.), *Lesbian, gay, bisexual and trans health inequalities: International perspectives in social work* (pp. 27-43). Policy Press Scholarship Online. https://doi.org/https://doi.org/10.1332/policypress/9781447309673.003.0001

Mulé, N. J., Ross, L. E., Deeprose, B., Jackson, B. E., Daley, A., Travers, A., & Moore, D. (2009). Promoting LGBT health and wellbeing through inclusive policy development. *International Journal for Equity in Health, 8*(18), 1-11. https://doi.org/https://doi.org/10.1186/1475-9276-8-18

Murphy, L., MacFadden, R., & Mitchell, D. (2008). Cybercounseling online: The development of a university-based training program for e-mail counseling. *Journal of Technology in Human Services, 26*(2-4), 447-469. https://doi.org/https://doi.org/10.1080/15228830802102081

Nobles, J., Martin, F., Dawson, S., Moran, P., & Savovic, J. (2020). *The potential impact of COVID-19 on mental health outcomes and the implications for service solutions* 0). N. I. f. H. Research. https://arc-w.nihr.ac.uk/research-and-implementation/covid-19-response/potential-impact-of-covid-19-on-mental-health-outcomes-and-the-implications-for-service-solutions/

O'Handley, B. (2023). *Vulnerability and resilience: A longitudinal examination of minority stress and coping processes in a sample of LGBTQ+ individuals during the COVID-19 pandemic* (Publication Number 29399341) [Masters thesis, Trent University]. ProQuest Dissertations Publishing. https://proxy.library.mcgill.ca/login?url=https://www.proquest.com/dissertations-theses/vulnerability-resilience-longitudinal-examination/docview/2741041719/se-2?accountid=12339

O'Neill, B., Swan, T. A., & Mulé, N. J. (2015). *LGBTQ people and social work: Intersectional perspectives*. Canadian Scholars' Press.

O'Shaughnessy, T., & Speir, Z. (2018). The state of LGBQ affirmative therapy clinical research: A mixed-methods systematic synthesis. *Psychology of Sexual Orientation and Gender Diversity, 5*(1), 82. https://doi.org/https://doi.org/10.1037/sgd0000259

O’Handley, B., & Courtice, E. L. (2022). Mental well-being, social support, and the unique experiences of transgender and nonbinary people during the COVID-19 pandemic. *The*

Canadian Journal of Human Sexuality, 31(2), 163-175. https://doi.org/https://doi.org/10.3138/cjhs.2022-0024

Obasi, S. N., King, R. E., Holt, N. R., Mocarski, R., Hope, D. A., & Woodruff, N. (2023). Educational preparedness to care for transgender and gender diverse adults: Perspectives of mental health professionals. *Journal of Gay & Lesbian Social Services, 35*(2), 204-217. https://doi.org/https://doi.org/10.1080/10538720.2022.2056782

Oh, H., Rizo, C., Enkin, M., & Jadad, A. (2005). What is eHealth (3): A systematic review of published definitions. *Journal of Medical Internet Research, 7*(1), e1. https://doi.org/https://doi.org/10.2196/jmir.7.1.e1

Oomen, D., Nijhof, A. D., & Wiersema, J. R. (2021). The psychological impact of the COVID-19 pandemic on adults with autism: A survey study across three countries. *Molecular Autism, 12*, 1-21. https://doi.org/https://doi.org/10.1186/s13229-021-00424-y

Pachankis, J. E., Soulliard, Z. A., Seager van Dyk, I., Layland, E. K., Clark, K. A., Levine, D. S., & Jackson, S. D. (2022). Training in LGBTQ-affirmative cognitive behavioral therapy: A randomized controlled trial across LGBTQ community centers. *Journal of Consulting and Clinical Psychology, 90*(7), 582. https://doi.org/https://doi.org/10.1037/ccp0000745

Padfield, L. R. (2021). On disembodiment, dissonance and deprivation–Why remote psychotherapy in the time of COVID-19 is so taxing. *Psychoanalysis, Self and Context, 16*(3), 218-229. https://doi.org/https://doi.org/10.1080/24720038.2021.1933986

Pakula, B., Shoveller, J., Ratner, P. A., & Carpiano, R. (2016). Prevalence and co-occurrence of heavy drinking and anxiety and mood disorders among gay, lesbian, bisexual, and heterosexual Canadians. *American Journal of Public Health, 106*(6), 1042-1048. https://doi.org/https://doi.org/10.2105/AJPH.2016.303083

Palamar, J. J., & Acosta, P. (2021). Virtual raves and happy hours during COVID-19: New drug use contexts for electronic dance music partygoers. *International Journal of Drug Policy, 93*, 102904. https://doi.org/https://doi.org/10.1016/j.drugpo.2020.102904

Palmer, M., Larkin, M., de Visser, R., & Fadden, G. (2010). Developing an interpretative phenomenological approach to focus group data. *Qualitative Research in Psychology, 7*(2), 99-121. https://doi.org/https://doi.org/10.2105/AJPH.2016.303083

Pfefferbaum, B., & North, C. S. (2020). Mental health and the COVID-19 pandemic. *New England Journal of Medicine*. https://doi.org/https://doi.org/10.1056/NEJMp2008017

Phillips, E., Montague, J., & Archer, S. (2016). Worlds within worlds: A strategy for using interpretative phenomenological analysis with focus groups. *Qualitative Research in Psychology, 13*(4), 289-302. https://doi.org/https://doi.org/10.1080/14780887.2016.1205692

Pope, K. S., & Tabachnick, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25*(3), 247. https://doi.org/https://doi.org/10.1037/0735-7028.25.3.247

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390. https://doi.org/https://doi.org/10.1037/0022-006X.51.3.390

Prokopenko, E., & Kevins, C. (2020). *Vulnerabilities related to COVID-19 among LGBTQ2+ Canadians*. https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00075-eng.pdf

Pujolar, G., Oliver-Anglès, A., Vargas, I., & Vázquez, M.-L. (2022). Changes in access to health services during the COVID-19 pandemic: A scoping review. *International Journal of*

Environmental Research and Public Health, 19(3), 1749. https://doi.org/https://doi.org/10.3390/ijerph19031749

Québec, O. d. p. d. (2020). *How much will it cost?* Ordre des psychologues de Québec. https://www.ordrepsy.qc.ca/web/english/how-much-will-it-cost-#:~:text=A%20psychologist%20in%20private%20practice,region%20where%20they%20are%20working.

Quinn, K. G., Walsh, J. L., John, S. A., & Nyitray, A. G. (2021). "I feel almost as though I've lived this before": Insights from sexual and gender minority men on coping with COVID-19. *AIDS and Behavior, 25*(1), 1-8. https://doi.org/https://doi.org/10.1007/s10461-020-03036-4

Råheim, M., Magnussen, L. H., Sekse, R. J. T., Lunde, Å., Jacobsen, T., & Blystad, A. (2016). Researcher–researched relationship in qualitative research: Shifts in positions and researcher vulnerability. *InternationalJjournal of Qualitative Studies on Health and Well-being, 11*(1), 30996. https://doi.org/https://doi.org/10.3402/qhw.v11.30996

Raskin, J. D. (2002). Constructivism in psychology: Personal construct psychology, radical constructivism, and social constructionism. *American Communication Journal, 5*(3), 1-25.

Robinson, M. (2022). Recent insights into the mental health needs of Two-Spirit people. *Current Opinion in Psychology, 104*(6), 10-14. https://doi.org/https://doi.org/10.1016/j.copsyc.2022.101494

Rosa, W. E., Shook, A., & Acquaviva, K. D. (2020). LGBTQ+ inclusive palliative care in the context of COVID-19: Pragmatic recommendations for clinicians. *Journal of Pain and*

Symptom Management. https://doi.org/https://doi.org/10.1016/j.jpainsymman.2020.04.155

Rotondi, N., Bauer, G., Scanlon, K., Kaay, M., Travers, R., & Travers, A. (2011). Prevalence of and risk and protective factors for depression in female-to-male transgender ontarians: Trans PULSE project. *Canadian Journal of Community Mental Health, 30*(2), 135-155. https://doi.org/https://doi.org/10.7870/cjcmh-2011-0021

Rotondi, N., Bauer, G., Travers, R., Travers, A., Scanlon, K., & Kaay, M. (2011). Depression in male-to-female transgender ontarians: Results from the trans PULSE project. *Canadian Journal of Community Mental Health, 30*(2), 113-133. https://doi.org/https://doi.org/10.7870/cjcmh-2011-0020

Runyan, A. S. (2018). What is intersectionality and why is it important? *Academe, 104*(6), 10-14.

Rutherford, K., McIntyre, J., Daley, A., & Ross, L. E. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education, 46*(9), 903-913. https://doi.org/https://doi.org/10.1111/j.1365-2923.2012.04272.x

Rutkowska, E. (2022). Ethical dilemmas in online psychotherapy-A review of selected ethical codes and recommendations of psychotherapeutic and psychological associations. *Archives of Psychiatry & Psychotherapy, 24*(3). https://doi.org/https://doi.org/10.12740/APP/144246

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346-352. https://doi.org/https://doi.org/10.1542/peds.2007-3524

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205-213. https://doi.org/https://doi.org/10.1111/j.1744-6171.2010.00246.x

Saewyc, E. M., Li, G., Gower, A. L., Watson, R. J., Erickson, D., Corliss, H. L., & Eisenberg, M. E. (2020). The link between LGBTQ-supportive communities, progressive political climate, and suicidality among sexual minority adolescents in Canada. *Preventive Medicine, 139*, 106191. https://doi.org/https://doi.org/10.1016/j.ypmed.2020.106191

Salerno, J. P., Williams, N. D., & Gattamorta, K. A. (2020). LGBTQ populations: Psychologically vulnerable communities in the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S239. https://doi.org/https://doi.org/10.1037/tra0000837

Sanders, C., Usipuik, M., Crawford, L., Koopmans, E., Todd, N., & Jones, T. (2021). What mental health supports do people with intersex variations want, and when?: Person-centred trauma-informed life-cycle care. *Psychology of Sexualities Review, 12*(1), 5-19. https://doi.org/https://doi.org/10.53841/bpssex.2021.12.1.5

Sarr, F., Knight, S., Strauss, D., Ouimet, A. J., Cénat, J. M., Williams, M. T., & Shaughnessy, K. (2022). Increasing the representation of Black, Indigenous, and People of Colour as students in psychology doctoral programmes. *Canadian Psychology/Psychologie Canadienne, 63*(4), 479. https://doi.org/https://doi.org/10.1037/cap0000339

Scanlon, K., Travers, R., Coleman, T., Bauer, G., & Boyce, M. (2010). Ontario’s trans communities and suicide: Transphobia is bad for our health *Trans PULSE e-Bulletin, 1*(2), 1-2. http://transpulseproject.ca/wp-content/uploads/2010/11/E2English.pdf

Schank, J. A., Helbok, C. M., Haldeman, D. C., & Gallardo, M. E. (2010). Challenges and benefits of ethical small-community practice. *Professional Psychology: Research and Practice, 41*(6), 502. https://doi.org/https://doi.org/10.1037/a0021689

Schellenberg, M., Hatcher, S., Thapliyal, A., & Mahajan, S. (2014). *E-Mental health in Canada: Transforming the mental health system using technology*. https://www.mentalhealthcommission.ca/sites/default/files/MHCC_E-Mental_Health-Briefing_Document_ENG_0.pdf

Schudson, Z. C. (2021). Psychology's stewardship of gender/sex. *Perspectives on Psychological Science, 16*(6), 1105-1112. https://doi.org/https://doi.org/10.1177/17456916211018462

Seeman, M. V. (2015). Sexual minority women in treatment for serious mental illness: A literature review. *Journal of Gay & Lesbian Mental Health, 19*(3), 303-319. https://doi.org/https://doi.org/10.1080/19359705.2015.1026016

Shalev, D., & Shapiro, P. A. (2020). Epidemic psychiatry: The opportunities and challenges of COVID-19. *General Hospital Psychiatry, 64*, 68-71. https://doi.org/https://doi.org/10.1016/j.genhosppsych.2020.03.009

Siegel, A., Zuo, Y., Moghaddamcharkari, N., McIntyre, R. S., & Rosenblat, J. D. (2021). Barriers, benefits and interventions for improving the delivery of telemental health services during the coronavirus disease 2019 pandemic: A systematic review. *Current Opinion in Psychiatry, 34*(4), 434-443. https://doi.org/https://doi.org/10.1097/YCO.0000000000000714

Simeonov, D., Steele, L. S., Anderson, S., & Ross, L. E. (2015). Perceived satisfaction with mental health services in the lesbian, gay, bisexual, transgender, and transsexual communities in Ontario, Canada: An internet-based survey. *Canadian Journal of*

Community Mental Health, 34(1), 31-44. https://doi.org/https://doi.org/10.7870/cjcmh-2014-037

Sinacore, A. L. (2022). A legacy of counselling psychology and social justice: Understanding and promoting mental health through consultation and systemic change. In J. J. W. Andrews, S. R. Shaw, J. F. Domene, & C. McMorris (Eds.), *Mental health assessment, prevention, and intervention* (pp. 285-303). Springer. https://doi.org/https://doi.org/10.1007/978-3-030-97208-0_14

Singer, M. (2009). *Introduction to syndemics: A critical systems approach to public and community health*. John Wiley & Sons.

Singh, A. A., & dickey, l. m. (2016). Implementing the APA guidelines on psychological practice with transgender and gender nonconforming people: A call to action to the field of psychology. *Psychology of Sexual Orientation and Gender Diversity, 3*(2), 195-200. https://doi.org/http://dx.doi.org/10.1037/sgd0000179

Singh, A. A., & dickey, l. m. (2017). *Affirmative counseling and psychological practice with transgender and gender nonconforming clients* (First edition. ed.). American Psychological Association. https://doi.org/https://doi.org/10.1037/14957-000

Slemon, A., Richardson, C., Goodyear, T., Salway, T., Gadermann, A., Oliffe, J. L., Knight, R., Dhari, S., & Jenkins, E. K. (2022). Widening mental health and substance use inequities among sexual and gender minority populations: Findings from a repeated cross-sectional monitoring survey during the COVID-19 pandemic in Canada. *Psychiatry Research, 307*, 114327. https://doi.org/https://doi.org/10.1016/j.psychres.2021.114327

Smith, J., Davies, S. E., Feng, H., Gan, C. C., Grépin, K. A., Harman, S., Herten-Crabb, A., Morgan, R., Vandan, N., & Wenham, C. (2021). More than a public health crisis: A feminist political economic analysis of COVID-19. *Global Public Health, 16*(8-9), 1364-1380. https://doi.org/https://doi.org/10.1080/17441692.2021.1896765

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain, 9*(1), 41-42. https://doi.org/https://doi.org/10.1177/2049463714541642

Smith, J. A., & Shinebourne, P. (2012). *Interpretative phenomenological analysis*. American Psychological Association. https://doi.org/https://doi.org/10.1037/13620-005

Starks, T. J., Jones, S. S., Sauermilch, D., Benedict, M., Adebayo, T., Cain, D., & Simpson, K. N. (2020). Evaluating the impact of COVID-19: A cohort comparison study of drug use and risky sexual behavior among sexual minority men in the USA. *Drug and Alcohol Dependence, 216*, 108260. https://doi.org/https://doi.org/10.1016/j.drugalcdep.2020.108260

Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2017). LGBT identity, untreated depression, and unmet need for mental health services by sexual minority women and trans-identified people. *Journal of Women's Health, 26*(2), 116-127. https://doi.org/https://doi.org/10.1089/jwh.2015.5677

Sternheim, L., Konstantellou, A., Startup, H., & Schmidt, U. (2011). What does uncertainty mean to women with anorexia nervosa? An interpretative phenomenological analysis. *European Eating Disorders Review, 19*(1), 12-24. https://doi.org/https://doi.org/10.1002/erv.1029

Stewart, C. E., Lee, S. Y., Hogstrom, A., & Williams, M. (2017). Diversify and conquer: A call to promote minority representation in clinical psychology. *The Behavior Therapist, 40*(3), 74-79.

Stiles, W. B. (2014). Theory building, enriching, and fact gathering: Alternative purposes of psychotherapy research. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: Foundations, process, and outcome* (pp. 159-179). Springer. https://doi.org/https://doi.org/10.1007/978-3-7091-1382-0_8

Stoll, J., Müller, J. A., & Trachsel, M. (2020). Ethical issues in online psychotherapy: A narrative review. *Frontiers in Psychiatry, 10*, 993. https://doi.org/https://doi.org/10.3389/fpsyt.2019.00993

Stryker, S. D., Pallerla, H., Yockey, R. A., Bedard-Thomas, J., & Pickle, S. (2022). Training mental health professionals in gender-affirming care: A survey of experienced clinicians. *Transgender Health, 7*(1), 68-77. https://doi.org/https://doi.org/10.1089/trgh.2020.0123

Stubley, J. (2021). Complex trauma in a time of crisis: The COVID-19 pandemic. In *Complex Trauma* (pp. 266-277). Routledge. https://doi.org/https://doi.org/10.4324/9781003227182-20

Tami, A., Ferguson, T., Bauer, G. R., & Scheim, A. I. (2022). Avoidance of primary healthcare among transgender and non-binary people in Canada during the COVID-19 pandemic. *Preventive Medicine Reports, 27*, 101789. https://doi.org/https://doi.org/10.1016/j.pmedr.2022.101789

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of Clinical Psychology, 74*(9), 1545-1555. https://doi.org/https://doi.org/10.1002/jclp.22614

Tjepkema, M. (2008). Health care use among gay, lesbian and bisexual Canadians. *Health Reports, 19*(1), 53-64. http://thebridgebrant.com/wp-content/uploads/2014/03/Health-care-among-LGBT-Canada-stats-Can.pdf

Tolland, H., & Drysdale, E. (2023). Clinical psychologists' well-being and experiences of home working during COVID-19. *The Journal of Mental Health Training, Education and Practice, 18*(1), 78-93. https://doi.org/https://doi.org/10.1108/JMHTEP-08-2021-0098

Toombs, E., Kowatch, K. R., Dalicandro, L., McConkey, S., Hopkins, C., & Mushquash, C. J. (2020). A systematic review of electronic mental health interventions for Indigenous youth: Results and recommendations. *Journal of Telemedicine and Telecare*. https://doi.org/https://doi.org/10.1177/1357633X19899231

Topooco, N., Riper, H., Araya, R., Berking, M., Brunn, M., Chevreul, K., Cieslak, R., Ebert, D. D., Etchmendy, E., Herrero, R., Kleiboer, A., Krieger, T., García-Palacios, A., Cerga-Pashoja, A., Smoktunowicz, E., Urech, A., Vis, C., & Andersson, G. (2017). Attitudes towards digital treatment for depression: A European stakeholder survey. *Internet Interventions, 8*, 1-9. https://doi.org/https://doi.org/10.1016/j.invent.2017.01.001

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *International Journal of Social Psychiatry, 66*(4), 0020764020915212. https://doi.org/https://doi.org/10.1177/0020764020915212

Torous, J., Myrick, K. J., Rauseo-Ricupero, N., & Firth, J. (2020). Digital mental health and COVID-19: Using technology today to accelerate the curve on access and quality tomorrow. *JMIR Mental Health, 7*(3), e18848. https://doi.org/https://doi.org/10.2196/18848

Tremblay, M. (2015). *Queer mobilizations: Social movement activism and Canadian public policy*. UBC Press.

van der Miesen, A. I., Raaijmakers, D., & van de Grift, T. C. (2020). “You have to wait a little longer”: Transgender (mental) health at risk as a consequence of deferring gender-affirming treatments during COVID-19. *Archives of Sexual Behavior, 49*(5), 1395-1399. https://doi.org/https://doi.org/10.1007/s10508-020-01754-3

Veenstra, G. (2011). Race, gender, class, and sexual orientation: Intersecting axes of inequality and self-rated health in Canada. *International Journal for Equity in Health, 10*(1), 3. https://doi.org/https://doi.org/10.1186/1475-9276-10-3

Veltman, A., & Chaimowitz, G. (2014). Mental health care for people who identify as lesbian, gay, bisexual, transgender, and (or) queer. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 59*(11), 1-7. https://doi.org/https://doi.org/10.2196/mental.9769

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31*(3), 253-272. https://doi.org/https://doi.org/10.1177/0011000003031003001

Victor, S. E., Devendorf, A. R., Lewis, S. P., Rottenberg, J., Muehlenkamp, J. J., Stage, D. R. L., & Miller, R. H. (2022). Only human: Mental-health difficulties among clinical, counseling, and school psychology faculty and trainees. *Perspectives on Psychological Science, 17*(6), 1576-1590. https://doi.org/https://doi.org/10.1177/17456916211071079

Vis, C., Mol, M., Kleiboer, A., Bührmann, L., Finch, T., Smit, J., & Riper, H. (2018). Improving implementation of eMental health for mood disorders in routine practice: Systematic review of barriers and facilitating factors. *JMIR Mental Health, 5*(1), e20. https://doi.org/https://doi.org/10.2196/mental.9769

Vo, A. T., Patton, T., Peacock, A., Larney, S., & Borquez, A. (2022). Illicit substance use and the COVID-19 pandemic in the United States: A scoping review and characterization of research evidence in unprecedented times. *International Journal of Environmental Research and Public Health, 19*(14), 8883. https://doi.org/https://doi.org/10.3390/ijerph19148883

Wada, K., McGroarty, E. J., Tomaro, J., & Amundsen-Dainow, E. (2019). Affirmative career counselling with transgender and gender nonconforming clients: A Social justice perspective. *Canadian Journal of Counselling & Psychotherapy/Revue Canadienne de Counseling et de Psychothérapie, 53*(3). https://cjc-rcc.ucalgary.ca/article/view/61246

Waite, S. (2021). Should I stay or should I go? Employment discrimination and workplace harassment against transgender and other minority employees in Canada's federal public service. *Journal of Homosexuality, 68*(11), 1833-1859. https://doi.org/https://doi.org/10.1080/00918369.2020.1712140

Waite, S., & Denier, N. (2019). A research note on Canada's LGBT data landscape: Where we are and what the future holds. *Canadian Review of Sociology / Revue Canadienne de Sociologie, 56*(1), 93-117. https://doi.org/https://doi.org/10.1111/cars.12232

Waite, S., Ecker, J., & Ross, L. E. (2019). A systematic review and thematic synthesis of Canada's LGBTQ2S+ employment, labour market and earnings literature. *Plos One, 14*(10). https://doi.org/https://doi.org/10.1371/journal.pone.0223372

Ward, J. (2008). White normativity: The cultural dimensions of whiteness in a racially diverse LGBT organization. *Sociological Perspectives, 51*(3), 563-586. https://doi.org/https://doi.org/10.1525/sop.2008.51.3.563

Warmerdam, L., Smit, F., van Straten, A., Riper, H., & Cuijpers, P. (2010). Cost-utility and cost-effectiveness of internet-based treatment for adults with depressive symptoms: Randomized trial. *Journal of Medical Internet Research, 12*(5), e53. https://doi.org/https://doi.org/10.2196/jmir.1436

Warner, T. E. (2002). *Never going back: A history of queer activism in Canada*. University of Toronto Press. https://doi.org/https://doi.org/10.3138/9781442677623

Watson, R. J., Wheldon, C. W., & Puhl, R. M. (2020). Evidence of diverse identities in a large national sample of sexual and gender minority adolescents. *Journal of Research on Adolescence, 30*, 431-442. https://doi.org/https://doi.org/10.1111/jora.12488

Watts, K. J., & Thrasher, S. S. (2023). The Impact of Community Belongingness on Mental Health and Well-Being Among Black LGBTQ Adults. *Race and Social Problems*, 1-17. https://doi.org/https://doi.org/10.1007/s12552-023-09396-5

Wilkinson, S., Joffe, H., & Yardley, L. (2004). Qualitative data collection: Interviews and focus groups. In D. F. Marks & L. Yardley (Eds.), *Research Methods for Clinical and Health Psychology* (pp. 39-55). Sage. https://doi.org/https://doi.org/10.4135/9781849209793.n3

Williams, M. T., Khanna Roy, A., MacIntyre, M.-P., & Faber, S. (2022). The Traumatizing Impact of Racism in Canadians of Colour. *Current Trauma Reports*, 1-18.

Wind, T. R., Rijkeboer, M., Andersson, G., & Riper, H. (2020). The COVID-19 pandemic: The 'black swan'for mental health care and a turning point for e-health. *Internet Interventions*. https://doi.org/https://doi.org/10.1016/j.invent.2020.100317

Witteveen, A., Young, S., Cuijpers, P., Ayuso-Mateos, J., Barbui, C., Bertolini, F., Cabello, M., Cadorin, C., Downes, N., & Franzoi, D. (2022). Remote mental health care interventions during the COVID-19 pandemic: An umbrella review. *Behaviour Research and Therapy*, 104226. https://doi.org/10.1016/j.brat.2022.104226

Wu, P., Fang, Y., Guan, Z., Fan, B., Kong, J., Yao, Z., Liu, X., Fuller, C. J., Susser, E., & Lu, J. (2009). The psychological impact of the SARS epidemic on hospital employees in China: Exposure, risk perception, and altruistic acceptance of risk. *The Canadian Journal of Psychiatry, 54*(5), 302-311. https://doi.org/https://doi.org/10.1177/070674370905400504

Wu, P., Liu, X., Fang, Y., Fan, B., Fuller, C. J., Guan, Z., Yao, Z., Kong, J., Lu, J., & Litvak, I. J. (2008). Alcohol abuse/dependence symptoms among hospital employees exposed to a SARS outbreak. *Alcohol & Alcoholism, 43*(6), 706-712. https://doi.org/https://doi.org/10.1093/alcalc/agn073

Xue, J., Chen, J., Chen, C., Hu, R., & Zhu, T. (2020). The hidden pandemic of family violence during COVID-19: Unsupervised learning of tweets. *Journal of Medical Internet Research, 22*(11), e24361. https://doi.org/https://doi.org/10.2196/24361

Yardley, L. (2015). Demonstrating Validity in Qualitative Psychology. In J. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (3rd ed., pp. 257-272). Sage Publications Inc.

Appendix A: Informed Consent - Focus Group and Questionnaire

INFORMED CONSENT TO PARTICIPATE IN RESEARCH
Mental Health Care with LGBTQ2IA+ Clients during COVID-19

Principal Investigator:
Jann Tomaro, Doctoral Candidate, McGill University, Montreal, QC, Canada
Email: jann.tomaro@mail.mcgill.ca

This study is supported by funding from Fonds de Recherche du Québec - Société et Culture (FRQSC)

The principal investigator of this study is a doctoral student, Jann Tomaro, and the work will be supervised by Professor Ada L. Sinacore, director of the Social Justice and Diversity Research Lab at McGill University. All research activities will be approved by the McGill Research Ethics Board before the research process begins.

Purpose of the Study

You are being asked to participate in a study that aims to work with service-providers within the Pride Therapy Network of Montreal about providing mental health services to LGBTQ2IA+ clients during the COVID-19 pandemic. This information will be used to gain understanding of the aforementioned experiences and will contribute to a growing body of literature about mental health care and service provision for LGBTQ2IA+ communities.

Procedure of the Study

You are being asked to participate in a focus group to speak about your experiences as a mental health care service provider for LGBTQ2IA+ clients during the COVID-19 pandemic. Focus groups will be formed based on availability of participants.

Online focus groups will be led by Jann Tomaro via the Zoom video conferencing platform, with video and audio and will be audio recorded, then professionally transcribed, wherein all names will be removed. Zoom sessions will use private entry links, require a password entry and will be locked before sessions begin. If you consent to participate in this study, you will be able to indicate your availability for a focus group session and will be emailed through the LimeSurvey platform to confirm your focus group time and you will be given a secure Zoom link to the session.

The focus group topics will explore working with LGBTQ2IA+ clients in Montreal, Canada during the time of the COVID-19 pandemic and will focus on: 1) experiences of mental health service provision during COVID-19; 2) understanding of client experiences as a result of COVID-19. Focus groups will begin by reviewing consent to participate and will last 60-90 minutes, including a 10-minute break.

Additionally, you will be given a link to an open form online questionnaire following the focus group where you can provide any additional commentary in a written format. You will have two weeks following the focus group to add any additional information. You will be able to access and amend your answers as many times as you like within the two-week time frame.

Withdrawal from the Study

Your participation in the focus group is completely voluntary. There is no obligation to participate in this study and it will not affect your membership within The Pride Therapy Network should you choose, for whatever reason, to engage or not to engage with this study. Your decision to participate or not will not affect your relationship with the PI, Jann Tomaro. Other members of The Pride Therapy Network will not be informed of your participation or lack thereof in this research study.

You do not have to answer any questions asked and you may stop and or leave the focus group at any time for any reason. Participation in the online questionnaire is optional. You will be able to withdraw from the study at any time.

If you choose to withdraw during or after the focus group session, all information obtained up until that point will be destroyed unless you specify otherwise at the time of withdrawal. Once data from the focus groups has been combined for publication, it may not be possible to withdraw your data in its entirety. We can only remove your dataset from analysis and from use in future publications.

Risks and Benefits

There are limited risks associated with this study. It may require time and energy to participate in this study. Participation in this study may bring awareness to aspects of your clinical practice that were previously unknown. There is potential that by participating in focus groups, you could disagree or share different views with participants that may impact your perceptions of each other. It is important to acknowledge that decisions around participating as well as participation could impact the way power is felt in relationships between participants, between team members, and between participants and the researcher. The Principal Investigator will make all efforts to ensure that this research study does not impact relationships with team members, regardless of participation or lack thereof in this study.

Although all precautions will be taken, there is always the possibility of third-party interception when using communications through the internet.

Please note that although the data will be collected to ensure confidentiality, with focus groups there is no way to ensure that people will not discuss focus groups outside of the focus group. All efforts will be made to ask people to keep focus group conversations confidential, but there is risk that this data will be discussed.

All data will be de-identified, however the identities of participants or third parties may be recognized in focus groups or online questionnaires. Participant are asked to omit identifying details of themselves and absent third parties, to protect anonymity

There are no direct potential benefits of participating in this study, but it is hoped that this study may contribute to a personal understanding of your experiences as well as other mental health service providers. Moreover, the intention is to contribute to a growing body of literature speaking to the needs and care of LGBTQ2IA+ communities and the clinicians working with these communities.

Compensation

Compensation of $50 will be given for the time and effort of participating in the focus group portion of this study. Compensation will be electronically transferred to participants by the principal investigator, Jann Tomaro.

Your confidentiality will be secured in the following ways:

- In all data, identifying information (your name) will be replaced by a code and only the PI will have access to those codes.
- The codes will be password protected and stored in a separate file from the data.
- Any identifying information of participants or others will be removed from data, results, and publications of any kind, to protect against deductive disclosure of identity.
- Participants will be asked to ensure anonymity of themselves and absent third parties by omitting identifying information.
- All data will be password protected and stored on a hard drive in the Social Justice and Diversity office at McGill University. Audio recordings will be deleted once data is transcribed and analyzed.
- De-identified, aggregated results from this study may be discussed with The Pride Therapy Network to benefit the understanding of the team and its members.
- Analyses and results from this study may be disseminated via doctoral thesis manuscripts, professional conferences and scholarly journals. Throughout the process of communicating these results, participant confidentiality will be safeguarded.

Signing below means that you have read the information in this agreement and have had a chance to ask any questions you have about the study. It also means that you agree to participate in the study and have been told that you can withdraw at any time.

Please sign below if you have read the above information and consent to participate in this study. Agreeing to participate in this study does not waive any of your rights or release the researchers from their responsibilities. A copy of this consent form will be given to you and the researcher will keep a copy.

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Research Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca

Date: ___________________________________

Participant Name: **Signature *(click here to sign this consent form)*:**

Do you agree to be contacted to participate in an open form online questionnaire following the focus group?
YES/NO

Appendix B: Informed Consent - Individual Interview

INFORMED CONSENT TO PARTICIPATE IN RESEARCH
Mental Health Care with LGBTQ2IA+ Clients during COVID-19

Principal Investigator:
Jann Tomaro, Doctoral Candidate, McGill University, Montreal, QC, Canada
Email: jann.tomaro@mail.mcgill.ca

This study is supported by funding from Fonds de Recherche du Québec - Société et Culture (FRQSC)

The principal investigator of this study is a doctoral student, Jann Tomaro, and the work will be supervised by Professor Ada L. Sinacore, director of the Social Justice and Diversity Research Lab at McGill University. All research activities will be approved by the McGill Research Ethics Board before the research process begins.

Purpose of the Study

You are being asked to participate in a study that aims to work with service-providers within the Pride Therapy Network of Montreal about providing mental health services to LGBTQ2IA+ clients during the COVID-19 pandemic. This information will be used to gain understanding of the aforementioned experiences and will contribute to a growing body of literature about mental health care and service provision for LGBTQ2IA+ communities.

Procedure of the Study

You are being asked to participate in an interview to speak about your experiences as a mental health care service provider for LGBTQ2IA+ clients during the COVID-19 pandemic.

Interviews will be conducted by Jann Tomaro via the Zoom video conferencing platform using video and audio, and will be audio recorded, then professionally transcribed, wherein all names will be removed. Zoom sessions will use private entry links, require a password entry and will be locked before sessions begin. If you consent to participate in this study, you will be able to indicate your availability for an interview and will be emailed through the LimeSurvey platform to confirm your interview time and you will be given a secure Zoom link to the session.

The interview topics will explore working with LGBTQ2IA+ clients in Montreal, Canada during the time of the COVID-19 pandemic and will focus on: 1) client experiences as a result of COVID-19 and 2) personal experiences as a mental health care provider during the COVID-19 pandemic. Interviews will begin by reviewing consent and will take 30-60 minutes of your time.

Participants will have the option to verify initial analyses of data.

Withdrawal from the Study

Your participation in this study is completely voluntary. There is no obligation to participate in this study and it will not affect your membership within The Pride Therapy Network should you choose, for whatever reason, not to engage with this study. If you choose not to participate, it will not affect your relationship with the PI, Jann Tomaro. Other members of The Pride Therapy Network will not be informed of your participation or lack thereof in this research study.

You do not have to answer any questions asked and you may stop and or leave the interview at any time for any reason. You will be able to withdraw from the study at any time.

If you choose to withdraw during or after the interview, all information obtained up until that point will be destroyed unless you specify otherwise at the time of withdrawal. Once data from the interview has been combined for publication, it may not be possible to withdraw your data in its entirety. We can only remove your dataset from analysis and from use in future publications.

Risks and Benefits

There are limited risks associated with this study. It may require time and energy to participate in this study. Participation in this study may bring awareness to aspects of your clinical practice that were previously unknown. It is important to acknowledge that decisions around participating as well as participation could impact the way power is felt in relationships between participants, between team members, and between participants and the researcher. The Principal Investigator will make all efforts to ensure that this research study does not impact relationships with team members, regardless of participation or lack thereof in this study.

Although all precautions will be taken, there is always the possibility of third-party interception when using communications through the internet.

All data will be de-identified, however the identities of absent third parties may be recognized by the researcher during interviews. Participant are asked to omit identifying details of absent third parties, to protect anonymity

There are no direct potential benefits of participating in this study, but it is hoped that this study may contribute to a personal understanding of your experiences as well as other mental health service providers. Moreover, the intention is to contribute to a growing body of literature speaking to the needs and care of LGBTQ2IA+ communities and the clinicians working with these communities.

Compensation

Compensation of $50 will be given for the time and effort of participating in the interview portion of this study. Compensation will be electronically transferred to participants by the principal investigator, Jann Tomaro.

Your confidentiality will be secured in the following ways:

- Identifying information (your name) will be replaced by a code and only the PI will have access to those codes.
- The codes will be password protected and stored in a separate file from the data.
- Participant are asked to omit identifying details of absent third parties, to protect anonymity
- Any identifying information of participants or others will be removed from results and publications of any kind, to protect against deductive disclosure of identity.
- All data will be password protected and stored on a hard drive in the Social Justice and Diversity office at McGill University. Audio recordings will be deleted once data is transcribed and analyzed.
- De-identified, aggregated results from this study may be discussed with The Pride Therapy Network to benefit the understanding of the team and its members.
- Analyses and results from this study may be disseminated via doctoral thesis manuscripts, professional conferences and scholarly journals. Throughout the process of communicating these results, participant confidentiality will be safeguarded.

Signing below means that you have read the information in this agreement and have had a chance to ask any questions you have about the study. It also means that you agree to participate in the study and have been told that you can withdraw at any time.

Please sign below if you have read the above information and consent to participate in this study. Agreeing to participate in this study does not waive any of your rights or release the researchers from their responsibilities. A copy of this consent form will be given to you and the researcher will keep a copy.

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Research Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca

Date: ________________________________

Participant Name: **Signature** ***(click here to sign this consent form)*****:**

________________________________ ________________________________

Do you agree to be contacted to verify initial analyses of data?
YES/NO

Appendix C: Demographic Form

Mental Health Care with LGBTQ2IA+ Clients during COVID-19

Principal Investigator:
Jann Tomaro, McGill University, Montreal, QC, Canada
Email: jann.tomaro@mail.mcgill.ca

Please answer all of the following questions as they apply.

Name:____

Year of birth: ____

Languages spoken (please check all that apply):
French: _______
English: _______
Others: ____

Religion: ____
Gender: ____
Sexual orientation: ____
Ethnicity: ____
Race:____
Country of Birth: ____
If you were born outside of Canada, please indicate the year that you arrived at Canada: _______
Status in Canada:
Canadian Citizen: _____________________
Permanent Resident: ___________________
Work Permit Holder: ___________________
Other: ________________________________

Profession title: ____

Certification and licenses: ____

Years working as a mental health care professional: ____________________________________

Educational background, check all the apply:

Associates:	Major/Focus:	University:
Bachelor:	Major/Focus:	University:
Masters:	Major/Focus:	University:
PHD:	Major/Focus:	University:

Appendix D: Focus Group Questions

I'm interested in understanding your experiences providing mental health care during the coronavirus pandemic. I'll ask about the services you provide and the LGBTQ2IA+ clients you serve, and your personal experiences.

1. Could you please describe the evolution of your mental health care services in response to COVID-19?
Listen for/prompts:
Please describe any
Alterations you've made to your practice and why
Changes in your experience providing services
Differences/similarities to practice before the pandemic
Challenges you have faced
Benefits you have seen
What has made things easier/worse?
Descriptions of changes to service delivery over time?

2. Could you please describe client experiences as you understand them, as a result of the pandemic?
Listen for/prompts:
Please describe any
Clinical issues that have arose as a result of the pandemic.
Challenges clients have faced
Acts of resiliency
Benefits resulting from the pandemic
Changes in the experience of therapy
Long-term effects due to the pandemic that you suspect will influence your clients

3. Please describe any training experiences that have helped you navigate the pandemic as a mental health professional

4. Are there training experiences that you wish you had before the pandemic?

5. Are there any things we haven't talked about yet that you would like to discuss?

6. Are there any questions that were not asked that you wish had been asked?

Appendix E: Interview Questions

1. I'm interested in understanding your work as a mental health practitioner. Could you please tell me your professional title, and describe the mental health care services you provide?
Listen for/prompts:
What setting do you work in?
What kinds of clients do you see (range of pathology and populations)?
What kinds of professional specialties do you have?
What is your approach to practice, theoretical orientation?
What values are inherent to your practice?

2. I'm interested in understanding your connection to LGBTQ2IA+ communities. Could you please describe your experiences with LGBTQ2IA+ communities?
Listen for/prompts:
Is the participant a member of LGBTQ2IA+ communities?
Family members of people in LGBTQ2IA+ communities?
Do clinicians have experience working/volunteering in organizations serving LGBTQ2IA+ communities?
Do clinicians have professional training in LGBTQ2IA+ communities?
Do clinicians consume LGBTQ2IA+ media?

3. Could you please describe salient client experiences, as you understand them, that are as a result of the pandemic?
Listen for/prompts:
Please describe any-
Clinical issues that have arose as a result of the pandemic.
Challenges clients have faced
Acts of resiliency
Benefits resulting from the pandemic
Changes in the experience of therapy
Long-term effects due to the pandemic that you suspect will influence your clients

4. Please describe your personal experiences as a mental health care provider for LGBTQ2IA+ clients during the pandemic.
Listen for/prompts:
Please describe how it feels to be practicing during the pandemic
Please describe any similarities/differences of your personal experiences providing mental health care during the pandemic
Please describe any challenges/benefits you have faced

Appendix F: Online Questionnaire

Thank you for participating in a focus group for the Mental Health Care with LGBTQ2IA+ Clients During COVID-19 study. Your contributions to this research are very valuable and I appreciate your efforts and engagement.

While research shows that focus groups can facilitate greater ease in sharing experiences than individual interviews, at times, it can also be challenging to speak about your own experiences in a group setting. It may also be that since the time of the focus group, you have reflected on some of the questions asked and have more to say. If there are any additional pieces of information that were missed during the focus group, I would like to invite you to share them with me now.

You do not need to repeat information that you have already stated during the focus group.

All data will be de-identified, however the identities of participants or third parties may be recognized in online questionnaires by the researcher. Participant are asked to omit identifying details of themselves and absent third parties, to protect anonymity

You will have two weeks following the focus group to add any additional information. You will be able to access and amend your answers as many times as you like within the two-week time frame. After this, the survey will be closed and you will no longer be able to access your survey response. When you are finished, click the "Finished" button to submit your answers.

As a reminder, these are the topics we have covered in the focus group:
Your clinical experiences due to the coronavirus including the evolution of your practice and client experiences.

Your confidentiality will be secured in the following ways:

- In all data, identifying information (your name) will be replaced by a code and only the PI will have access to those codes.
- The codes will be password protected and stored in a separate file from the data.
- Any identifying information of participants or others will be removed from data, results, and publications of any kind, to protect against deductive disclosure of identity.
- Participants will be asked to ensure anonymity of absent third parties by omitting identifying information.
- All data will be password protected and stored on a hard drive in the Social Justice and Diversity office at McGill University.
- De-identified, aggregated results from this study may be discussed with The Pride Therapy Network to benefit the understanding of the team and its members.
- Analyses and results from this study may be disseminated via doctoral thesis manuscripts, professional conferences and scholarly journals. Throughout the process of communicating these results, participant confidentiality will be safeguarded.

Comments:

Appendix G: Invitation to Join Study

Dear Members of the Pride Therapy Network of Montreal,

This is an invitation to participate in a research project examining clinician experiences providing services during the coronavirus pandemic to LGBTQ2IA+ communities.

The first round of data collection for this study will be through online focus groups with members of the Pride Therapy Network of Montreal. Following the focus groups there will be an option to add any additional information missed during the focus group via an open form online questionnaire. There will be a $50 compensation for your participation in a focus group.

After focus group data collection, online individual interviews will be conducted. There will be an additional $50 compensation for your participation in an interview. Participation in focus groups as well as interviews is encouraged, but optional.

The principal investigator of this study is Jann Tomaro, a doctoral student in counselling psychology and the work will be supervised by Professor Ada L. Sinacore, director of the Social Justice and Diversity Research Lab at McGill University. All research activities will be approved by the McGill Research Ethics Board before the research process begins.

If you are interested in learning more about participating in this study, please follow **this** link to a consent form detailing the focus group and written portion, and this link to a consent form for the interviews.

If you have any questions or concerns about the study, or your participation in the study, please let us know:
jann.tomaro@mail.mcgill.ca
ada.sinacore@mail.mcgill.ca

Thank you,

Jann
--
Jann Tomaro, M.A.
Ph.D. Candidate
Counselling Psychology
Social Justice and Diversity Research Lab
McGill University

Appendix H: Invitation to Join Online Questionnaire

Thank you for participating in a focus group for the Mental Health Care with LGBTQ2IA+ Clients During COVID-19 study. Your contributions to this research are very valuable and I appreciate your efforts and engagement.

While research shows that focus groups can facilitate greater ease in sharing experiences than individual interviews, at times, it can also be challenging to speak about your own experiences in a group setting. It may also be that since the focus group, you have reflected on some of the questions asked and have more to say. If there are any additional pieces of information that were missed during the focus group, this is an opportunity to share them.

You do not need to repeat information that you have already stated during the focus group.

As a reminder, these are the topics we have covered in the focus group:
Your experiences due to the coronavirus including the evolution of your practice and client experiences.

Here is a **link** to the online questionnaire.
Please fill this in within two weeks. If you need more time, or if you have any questions or concerns, please contact me: jann.tomaro@mail.mcgill.ca

Thank you,

Jann
--
Jann Tomaro, M.A.
Ph.D. Candidate
Counselling Psychology
Social Justice and Diversity Research Lab
McGill University

Appendix I: Transcription Service Confidentiality Agreement

This is an agreement between ________________________and the Principal Researcher, Jann Tomaro with regards to transcribing audio-files for her research.

The Parameters of the Agreement are as follows:

1. ________________ (to be referred as the transcriber) has agreed to transcribe audio-files.
2. Roles and Responsibilities:
    a) Transcriber understands that data is extremely sensitive and will treat it with the utmost of care and confidentiality consistent with Ethical Requirements of the Tri-Council Policy Statement 2 (TCPS2).
    b) The sole owner of the data is Jann Tomaro (Principal Researcher) and transcriber understands that she/he/they is not to keep any data on her/his/their computer or to use it for purposes other than transcription. She/he/they will not make any copies of the data or use it for her/his/their own purpose.
    c) No other individual should hear the recordings, read the transcripts or have any interaction with the data without the written permission of Jann Tomaro. No discussion about the data should occur with anyone other than those mentioned above.

I have read the agreement and understand the conditions therein and agree of my own free will without coercion to all of the above conditions.

________________________________	________________________________
Transcriber	Principal Researcher- Jann Tomaro

Date: ___________________________

Appendix J: Verbal Script for Invitation to Join Study

I would like to invite all members of the team to participate in a research project that I am conducting, which examines clinician experiences providing services during the coronavirus pandemic to LGBTQ2IA+ communities.

I will collect data in three ways.

The first round of data collection for this study will be through online focus groups with members of the Pride Therapy Network of Montreal. Following the focus groups there will be an option to add any additional information missed during the focus group via an open form online questionnaire. There will be a $50 compensation for your participation in a focus group.

After focus group data collection, online individual interviews will be conducted. There will be an additional $50 compensation for your participation in an interview. Participation in focus groups as well as interviews is encouraged, but optional.

The principal investigator of this study is me, Jann Tomaro. I’m a doctoral candidate in counselling psychology and the work will be supervised by Professor Ada L. Sinacore, director of the Social Justice and Diversity Research Lab at McGill University. All research activities will be approved by the McGill Research Ethics Board before the research process begins.

If you are interested in learning more about participating in this study, I will send everyone on the team an email via the secure LimeSurvey platform, where you can learn more about the study and review consent forms, as well as agree to participate or decline your interest in the study.

If you have any questions or concerns about the study, or your participation in the study, please let me know, now or by email.
Thank you,

Jann
--
Jann Tomaro, M.A.
Ph.D. Candidate
Counselling Psychology
Social Justice and Diversity Research Lab
McGill University

Appendix K: Data Collection Procedure

1. Potential participants were told about study verbally in an online meeting.
2. An email invitation was sent to potential participants.
3. Participants reviewed consent forms via LimeSurvey and indicated consent by clicking on “I agree” on the online consent form.
4. After consenting to participate on Lime Survey, participants indicated their availability to participate in focus groups and interviews.
5. After scheduling, participants were asked to fill out a demographic survey on LimeSurvey.
6. Reminder emails were sent out one and two weeks after the initial email.
7. Confirmation of focus group and interview times were emailed to consenting participants with unique links and passwords to the Zoom platform.
8. Online focus groups and interviews began by reviewing consent, time limits, breaks.
9. At the end of the focus group, participants were reminded about the online questionnaire and were provided a link through LimeSurvey to access the questionnaire.
10. A reminder email for the online questionnaire was sent one and two weeks after focus groups were conducted.
11. Interview participants were contacted for member-checking following transcription of interview data.

Appendix L: Timelines of COVID-19 Pandemic Restriction

Table 3

Timeline of COVID-19 Pandemic Distancing Measures in Quebec: January 2020-April 2021

Description	Date
Recommendation for the adoption of work-from-home policies issued	10-Mar-20
Gatherings of more than 250 people prohibited	13-Mar-20
Recommendation for the adoption of work-from-home policies issued	16-Mar-20
Gatherings of any size prohibited	20-Mar-20
Outdoor gatherings of 10 people or fewer permitted	22-May-20
Indoor gatherings of 10 or fewer permitted (except Montréal, Joliette and L'Épiphanie)	15-Jun-20
Indoor gatherings of 50 or fewer permitted (except Montréal, Joliette and L'Épiphanie)	22-Jun-20
Indoor gatherings of 10 or fewer permitted in Montréal, Joliette and L'Épiphanie	22-Jun-20
Indoor gatherings of 50 in public places (e.g., worship, theatres and community halls) permitted	25-Jun-20
Measures announced to restrict bars' accommodation capacity to 50%, ban dancing and require patrons to be seated to consume alcohol	10-Jul-20
Outdoor gatherings in public places of 250 permitted	03-Aug-20
Requirement for places of worship to maintain physical distancing of 1.5 metres announced	26-Aug-20
Indoor, outdoor and private gatherings limited to a maximum of 10 (Bas-Saint-Laurent, Chaudière-Appalaches, Montréal and Montérégie)	15-Sep-20
Private gatherings and gatherings at 1 table in restaurants, bars and casinos limited to a maximum of 6 people or 2 families	20-Sep-20
Gatherings of more than 6 people prohibited (Etchemin, Montmagny and L'Islet sub-regions)	30-Sep-20
Private gatherings in red alert zones prohibited (with exceptions)	01-Oct-20
Gatherings outside of household prohibited (Montréal, MRC de la Rivière-du-Nord and Chaudière-Appalaches, part of Capitale-Nationale region)	01-Oct-20
Gatherings outside of household prohibited (Maria, Carleton-sur-Mer, Nouvelle)	05-Oct-20
Gatherings outside of household prohibited (Portneuf, Drummond, Bécancour, Nicolet-Yamaska, Trois-Rivières)	10-Oct-20
Gatherings outside of household prohibited (city of Gatineau, Collines-de-l'Outaouais)	11-Oct-20
Gatherings outside of household prohibited (Montérégie, Charlevoix, Charlevoix-Est, Arthabaska, Érable)	16-Oct-20
Gatherings of more than 6 people prohibited (Saguenay–Lac-Saint-Jean)	16-Oct-20
Gatherings outside of household prohibited (Joliette, Autray)	22-Oct-20
Gatherings outside of household prohibited (Centre-du-Québec, Mauricie)	24-Oct-20

Description	Date
Gatherings outside of household prohibited (l'Assomption)	26-Oct-20
Gatherings outside of household prohibited (Lanaudière)	31-Oct-20
Gatherings outside of household prohibited (Saguenay–Lac-Saint-Jean, Chaudière-Appalaches, Montmagny, L'Islet, Etchemins)	02-Nov-20
Gatherings of more than 10 people prohibited (Îles-de-la-Madeleine)	06-Nov-20
Gatherings of more than 6 people prohibited (Carleton-sur-Mer, Maria, Nouvelle)	10-Nov-20
Gatherings of more than 6 people prohibited (Nord-du-Québec)	10-Nov-20
Gatherings outside of household prohibited (Estrie)	12-Nov-20
Indoor/outdoor gatherings prohibited and places of worship limited to 25 people (Chapais, Chibougamau)	23-Nov-20
Indoor/outdoor gatherings prohibited and places of worship limited to 25 people (3 Quebec regions—red level)	07-Dec-20
All indoor and outdoor gathering prohibited with worship services limited to 25 people (Laurentides, Pays-d'en-Haut regions)	14-Dec-20
Work from home for all companies encouraged	17-Dec-20
Indoor/outdoor gatherings prohibited and places of worship limited to 25 people (Vallée-de-la-Gatineau, Papineau)	17-Dec-20
Indoor gathering prohibited, outdoor gatherings limited to 8 people and worship services to 25 people	17-Dec-20
Work from home for private and public business mandated (with exceptions)	17-Dec-20
Curfew between 8 p.m. and 5 a.m. announced (with medical exceptions)(except for Nunavik, Terres-Cries-de-la-Baie-James)	09-Jan-21
Indoor and outdoor gatherings prohibited (with exceptions) (except Nunavik, Terres-Cries-de-la-Baie-James)	09-Jan-21
Members of the House of Commons may participate in House proceedings either in person or by video conference	25-Jan-21
2-week extension of 8 p.m.–5 a.m. curfew for 10 red zone regions	08-Feb-21
Funerals permitted with a maximum of 25 people (15 regions)	08-Feb-21
Places of worship allowed to accommodate up to 25 people (6 regions)	08-Feb-21
Gatherings of up to 8 people allowed for outdoor sports and recreation (9 regions)	26-Feb-21
Persons residing alone or with their dependent children permitted to join a family bubble from another residence in a private gathering	26-Feb-21
Places of worship allowed to accommodate up to 100 people (6 regions)	08-Mar-21
Announced that for regions in red zones, the start of curfew will be moved to 9:30 p.m.	17-Mar-21
Curfew in effect between 8 p.m. and 5 a.m. (3 regions)	01-Apr-21
Curfew in effect between 8 p.m. and 5 a.m. (5 regions)	05-Apr-21
Curfew in place from 8 p.m. to 5 a.m. (Montreal and Laval)	11-Apr-21

Note: Data for this table was retrieved from the Canadian Institute of Health Information (*Canadian COVID-19 Intervention Timeline*, 2022)

Table 4

Timeline of COVID-19 Pandemic Closures in Quebec: January 2020-April 2021

Description	Date
Recreational facilities and entertainment/arts venues closed	15-Mar-20
Bars and buffet-style restaurants closed	15-Mar-20
Schools closed	16-Mar-20
First post-secondary school closure in province	16-Mar-20
Non-essential chiropractic services suspended	16-Mar-20
Non-essential optometry services suspended	16-Mar-20
Non-essential occupational therapy services suspended	20-Mar-20
National parks closed	21-Mar-20
Restaurants (except takeout/delivery) closed	23-Mar-20
Non-essential businesses closed	25-Mar-20
Non-emergency health services minimized	23-Apr-20
Select non-essential businesses reopened (except in Montréal)	04-May-20
Elementary schools reopened (except in Montréal)	11-May-20
Daycares reopened (except in Montréal)	11-May-20
Outdoor recreational activities permitted	20-May-20
Manufacturing companies reopened without restrictions	25-May-20
Select non-essential businesses reopened in Montréal	25-May-20
Museums, libraries and theatres reopened	29-May-20
Outdoor recreational public spaces reopened	30-May-20
Regulated health services resumed	01-Jun-20
Shopping centres reopened (except in Montréal)	01-Jun-20
Camping and outfitting businesses reopened	01-Jun-20
Tourist residences reopened (except in Montréal and Joliette)	01-Jun-20
Personal service businesses reopened (except in Montréal and Joliette)	01-Jun-20
Day camp educator-child ratios increased in preparation for opening	02-Jun-20
Outdoor recreational businesses reopened, with exceptions	06-Jun-20
Daycares reopened at reduced capacity in Montréal, Joliette and L'Épiphanie	15-Jun-20
Personal services businesses reopened in Montréal, Joliette and L'Épiphanie	15-Jun-20
Race tracks and the Institut national du sport du Québec reopened	15-Jun-20
Zoos, public gardens, aquariums and other tourism activities reopened	19-Jun-20
Places of worship reopened	20-Jun-20
Day camps opened	22-Jun-20
All activity sectors that cannot be carried out remotely reopened (e.g., casinos, spas, gaming houses)	25-Jun-20
Daycare centres permitted to operate at 75% capacity	29-Jun-20

Description	Date
Operational plan for fall school openings released requiring mask use for staff and grade 5 to 12 students when moving within the school	10-Aug-20
Daycares located in schools permitted to operate at full capacity	24-Aug-20
Announced that post-secondary students may remove masks when distancing of 1.5m is maintained	26-Aug-20
$112 million in funding announced to support a safe return to elementary and secondary school on reserves	26-Aug-20
$2 billion in funding announced for provinces and territories through the Safe Return To Class Fund	26-Aug-20
Karaoke activities held in public places closed	11-Sep-20
Arts and recreational facilities and places of worship limited to 250 people and 50/room in public indoor spaces (4 regions–yellow level)	15-Sep-20
Restaurants/bars to limit capacity to 50%, end liquor sales at 12 a.m., close by 1 a.m. and keep a patron registry (4 regions–yellow level)	15-Sep-20
Recreational sport facilities limited to 250 people and 50/room indoors (Bas-Saint-Laurent, Chaudière-Appalaches, Montréal, Montérégie)	15-Sep-20
Arts and recreational facilities and places of worship limited to 250 and organized gatherings limited to 25/room (3 regions–orange level)	20-Sep-20
Restaurants/bars to permit 6 people/table, end liquor sales at 11 p.m., close by 12 a.m. and keep a patron registry (3 regions–orange level)	20-Sep-20
Arts/recreational facilities and places of worship limited to a maximum of 250 people and indoor events limited to 25 (3 regions–orange level)	30-Sep-20
Restaurants/bars to permit 6 people/table, end liquor sales at 11 p.m., close by 12 a.m. and keep a patron registry (3 regions–orange level)	30-Sep-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (4 regions–red level)	01-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (4 regions–red level)	01-Oct-20
Arts and recreational facilities closed; organized sports and leisure activities suspended (Maria, Carleton-sur-Mer, Nouvelle)	05-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (Maria, Carleton-sur-Mer, Nouvelle)	05-Oct-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (5 regions–red level)	10-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (5 regions–red level)	10-Oct-20
Arts/recreational facilities closed; organized sports and leisure activities suspended (city of Gatineau, Collines-de-l'Outaouais)	11-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (city of Gatineau, Collines-de-l'Outaouais)	11-Oct-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 10–11)(5 regions–red level)	14-Oct-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 10–11)(2 regions–red level)	15-Oct-20

Description	Date
Arts and recreational facilities closed and organized sports and leisure activities suspended (5 regions–red level)	16-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (5 regions–red level)	16-Oct-20
Arts and recreational facilities and places of worship limited to a maximum of 250 and indoor events limited to 25 (Saguenay–Lac-Saint-Jean)	16-Oct-20
Restaurants/bars to permit 6 people/table, end liquor sales at 11 p.m., close by 12 a.m. and keep a patron registry (Saguenay–Lac-Saint-Jean)	16-Oct-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 10–11)(5 regions–red level)	19-Oct-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (Joliette, Autray)	22-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (Joliette, Autray)	22-Oct-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 10–11)(Joliette, Autray)	23-Oct-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (Centre-du-Québec, Mauricie)	24-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (Centre-du-Québec, Mauricie)	24-Oct-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 10–11) (2 regions–red level)	26-Oct-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (l'Assomption)	26-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (l'Assomption)	26-Oct-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 10–11)(l'Assomption)	28-Oct-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (Lanaudière)	31-Oct-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (Lanaudière)	31-Oct-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 9 to 11)(Lanaudière)	02-Nov-20
Distance learning expanded for Grade 9 students (all regions in red level)	02-Nov-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (5 regions–red level)	02-Nov-20
Restaurants/bars (except takeout/delivery), saunas and spas (with exceptions) closed (5 regions–red level)	02-Nov-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 9 to 11) (2 regions–red level)	04-Nov-20
Arts and recreational facilities and places of worship limited to a maximum of 250 people, 50/room (Îles-de-la-Madeleine)	06-Nov-20
Restaurants/bars to limit capacity to 50%, end liquor sales at 12 a.m., close by 1 a.m. and keep a patron registry (Îles-de-la-Madeleine)	06-Nov-20

Description	Date
Arts and recreational facilities and places of worship limited to 250 people, 25 people/room (Carleton-sur-Mer, Maria, Nouvelle)	10-Nov-20
Restaurants/bars to permit 6 people/table, end liquor sales at 11 p.m., close by 12 a.m. and keep a patron registry (3 municipalities–orange)	10-Nov-20
Arts facilities and places of worship limited to a maximum of 250 people and private indoor events limited to 25 (Nord-du-Québec)	10-Nov-20
Restaurants/bars to permit 6 people/table, end liquor sales at 11 p.m., close by 12 a.m. and keep a patron registry (Nord-du-Québec)	10-Nov-20
Arts and recreational facilities closed and organized sports and leisure activities suspended (Estrie)	12-Nov-20
Bars, brasseries, taverns, casinos, restaurants (except takeout/delivery), saunas and spas (with exceptions) closed (Estrie)	12-Nov-20
Distancing enhanced, extracurriculars banned, masks mandated (high school) and remote learning expanded (grades 9 to 11)(Estrie)	13-Nov-20
Closure of all non-essential businesses in red alert zones extended	19-Nov-20
Private professional and health services limited (Chapais, Chibougamau)	23-Nov-20
Restaurants/bars (except takeout/delivery) and saunas and spas closed (with exceptions) (Chapais, Chibougamau)	23-Nov-20
Arts/entertainment facilities, museums and libraries closed; sports and recreational activities prohibited (Chapais, Chibougamau)	23-Nov-20
Class hours reduced by 50% (grades 9 to 11), group activities prohibited and masks for all students/staff mandated (Chapais, Chibougamau)	25-Nov-20
Commercial establishments required to reduce and display capacity limits and implement traffic management measures (e.g., queue management)	04-Dec-20
Private professional and health services limited (Rimouski-Neigette, de La Mitis, La Matanie and La Matapédia)	07-Dec-20
Restaurants/bars (except takeout/delivery) and saunas and spas closed (with exceptions) (4 regions—red level)	07-Dec-20
Arts/entertainment facilities, museums and libraries closed; sports and recreational activities prohibited (Chapais, Chibougamau)	07-Dec-20
Class hours reduced by 50% (grades 9 to 11), group activities prohibited and masks mandated (3 Quebec regions—red level)	09-Dec-20
Private professional and health services limited (Laurentides, Pays-d'en-Haut)	14-Dec-20
Restaurants/bars (except takeout/delivery) and saunas and spas closed (with exceptions) (Laurentides, Pays-d'en-Haut)	14-Dec-20
Arts/entertainment facilities, museums and libraries closed; sports and recreational activities prohibited (Laurentides, Pays-d'en-Haut)	14-Dec-20
Elementary schools closed and distance learning mandated	17-Dec-20
Secondary schools closed and distance learning mandated	17-Dec-20
Class hours reduced by 50% (grades 9 to 11), group activities prohibited and masks mandated (Laurentides, Pays-d'en-Haut)	17-Dec-20
Private professional and health services limited (Vallée-de-la-Gatineau, Papineau)	17-Dec-20

Description	Date
Restaurants/bars (except takeout/delivery) and saunas and spas closed (with exceptions) (Vallée-de-la-Gatineau, Papineau)	17-Dec-20
Arts/entertainment facilities, museums and libraries closed; sports and recreational activities prohibited (Vallée-de-la-Gatineau, Papineau)	17-Dec-20
Elementary and secondary schools closed with daycare occupancy limited to children of essential workers	17-Dec-20
Restaurants/bars (except takeout/delivery), saunas, spas, personal service and non-essential business closed; big box store items limited	25-Dec-20
Closures continued and curfew for open businesses implemented (7:30 p.m.) (with exceptions) (except Nunavik, Terres-Cries-de-la-Baie-James)	09-Jan-21
Arts/entertainment facilities, museums and libraries closed; sports and recreational activities prohibited	09-Jan-21
Elementary schools opened with masks mandated (except Nunavik and Terres-Cries-de-la-Baie-James)	11-Jan-21
Secondary schools reopened with reinforced measures (e.g., mandated masks) (except Nunavik and Terres-Cries-de-la-Baie-James)	18-Jan-21
Non-essential businesses and personal care services reopened (16 regions); see scan for details	08-Feb-21
Libraries, museums, allowed outdoor social, recreational and sport activities opened for 8 people (10 regions); see scan	08-Feb-21
Libraries, museums, allowed outdoor social, recreational and sport activities opened for 8 people (6 regions); see scan	08-Feb-21
Restaurants reopened with seating restrictions and requirement for the collection of contact information (6 regions); see scan	08-Feb-21
Performance halls, cinemas, theatres opened with distancing and mask guidelines maintained (6 regions); see scan	26-Feb-21
Cinemas opened with a max of 250 people per hall; pools and skating arenas opened for individual workout or in pairs (9 regions); see scan	26-Feb-21
Libraries, museums, allowed outdoor social, recreational and sport activities opened for 8 people (4 regions); see scan	08-Mar-21
Restaurants and gyms reopened with restrictions (5 regions); see scan	08-Mar-21
Performance halls, cinemas, theatres opened with distancing and mask guidelines maintained (6 regions); see scan	08-Mar-21
Announced that for regions in orange zones, extracurricular activities as well as school outings will be permitted in stable class groups	15-Mar-21
Announced that for regions in orange zones, permitted reopening of spa establishments; indoor pools of hotels may also reopen	15-Mar-21
Announced that for regions in orange zones, students in secondary 3, 4 and 5 may return to classes full time	22-Mar-21
Places of worship in red, orange and yellow zones permitted to increase capacity to 250 people per building	26-Mar-21
Primary and secondary schools closed (3 regions)	01-Apr-21
Cinemas, theatres and museums closed; outdoor sports and leisure limited to 8 people from the same residence (3 regions)	01-Apr-21

Description	Date
Restaurants and non-essential businesses closed; businesses limited to selling essential goods; places of worship limited to 25 (3 regions)	01-Apr-21
Primary and secondary schools closed (5 regions)	05-Apr-21
Cinemas, theatres and museums closed; outdoor sports and leisure limited to 8 people from the same residence (5 regions)	05-Apr-21
Restaurants and non-essential businesses closed; businesses limited to selling essential goods; places of worship limited to 25 (5 regions)	05-Apr-21
Gyms and indoor public places for leisure and sports closed; maximum of 8 permitted for outdoor activities with distancing (red zones)	08-Apr-21
Indoor spas closed, with exceptions; maximum of 25 in places of worship (red zones)	08-Apr-21
Students in secondary 3, 4 and 5 will attend school in person every other day in combination with online learning (red zones)	12-Apr-21
Students required to wear intervention masks in class (orange zone)	12-Apr-21
Outdoor group activities limited to 12; indoor activities limited to individuals or occupants of a same residence (orange zones)	12-Apr-21
Places of worship limited to 100 people (orange zones)	12-Apr-21

Note: Data for this table was retrieved from the Canadian Institute of Health Information (*Canadian COVID-19 Intervention Timeline*, 2022)