TRANS, GENDERQUEER, NON-BINARY AND GENDER NON-CONFORMING PEOPLE’S EXPERIENCES WITH MENTAL HEALTH CARE IN ONTARIO

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Abstract

In this project, I use narrative interviewing and digital storytelling methodologies to understand the experiences of transgender and gender diverse people with the mental health care system in Ontario, as well as their experiences in regard to related health and social policies. My objective is to understand whether the stated goal of the mental health policy in force at the time data was collected—to promote well-being for all Ontarians, including members of groups facing social exclusion—was achieved for members of these communities. I interpret interview and digital story data through the lenses of critical disability studies, disability justice, mad studies, social determinants of health research, feminist new materialism and intersectionality to create a critical analysis of the neoliberal trajectory of mental health-related policy in Ontario.

While participants reported some positive and helpful experiences with the mental health care system, many found it to be inaccessible, culturally unsafe, or even harmful. While participants came into contact with mental health care for a wide range of reasons, many discussed difficulties and harms resulting from the requirement to navigate around gatekeepers in the mental health professions to access gender confirming medical treatment. Participants also reported problems regarding other dimensions of the social determinants of mental health, including income, employment, housing and social inclusion and exclusion. I conclude the project with a discussion of participants' perspectives on the changes needed to support the well-being of the trans and gender diverse communities, arguing for the promotion of cultural safety and improved access to health care, as well as for meaningful changes in regard to the social determinants of mental health.

Dedication

For people who have been harmed by systems that should have helped, for people who have done what they can to make things better.

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Chapter One: Introduction

Background

This project uses narrative interviewing and digital storytelling to highlight the experiences of gender diverse people and assess whether their interactions with mental health care in Ontario achieved the aim of promoting their well-being.[1] Interview and digital story data have been interpreted using theoretical perspectives from critical disability studies, mad studies, social determinants of health research, feminist new materialism and intersectionality, to create a critical analysis of the neoliberal trajectory of mental health policy and related health and social policies in Ontario.

Participants in this project identified with a range of identity labels, including trans (as well as transgender, transfeminine, transmasculine or transsexual), non-binary/enby,[2] genderqueer, genderfluid, gender non-conforming and agender, and some rejected, exceeded or transcended gender labels. Throughout this work, I use the terms "gender diverse," "transgender," "trans," and "the trans umbrella" as relevant to refer to "the extended family of identities that share in common a subversion of dominant gender norms" (Fogarty & Zheng, 2018, p. 7).[3] My decision to include a breadth of trans and non-binary identities in this work is rooted in Enke's (2011a, 2011b) theoretical work on the "anti-identitarian" potential of trans to challenge taken-for-granted categorical boundaries of identity, institutions, and structures (2011a). This choice also responds to Serano's (2007) discussion of the excessive research focus that has been placed on trans people who have medically transitioned (and especially trans women who have medically transitioned), whose experiences have often been co-opted by mental health researchers in constructing a narrative of trans as both pathological and as primarily—or even exclusively—represented by medical transition.

In recent decades, Ontario mental health policy has focused on facilitating and/or mandating medical treatment for the kinds of difficulties and differences that come to be labelled as "mental illness" (Gray et al., 2000; Hartford, 2003). At the time that interviews and digital storytelling workshops for this project were conducted, the province's then-current mental health policy statement was, *Open Minds, Healthy Minds* (Ontario Ministry of Health and Long-Term Care, 2011), and while it retained a biomedical understanding of mental illness and a plan to increase access to medicalized mental health care, it also placed a new emphasis on promoting "mental health and well-being for all Ontarians" and "creat[ing] healthy, resilient and inclusive communities" (p. 4).

The *Open Minds, Healthy Minds* statement noted that certain marginalized communities and populations were identified as being at greater risk of "mental health and addictions problems," and it promoted interventions targeting members of these groups to promote their capacity to "become much more resilient and to better cope with adversity" (p. 10). Gender diverse people were not specifically mentioned in the statement, but the applicability of such a mandate to members of this community is clear. In Ontario, gender diverse people frequently face multiple dimensions of exclusion (Scott-Dixon, 2009). For instance, trans people often encounter employment discrimination, which results in an extremely high rate of poverty (Bauer et al., 2010). This problem is compounded by a lack of available income support and the scarcity of affordable housing (Bryant, 2004; Abramovich et al., 2020) as well as the fact that social services have often been inaccessible to members of this community (Namaste, 2000, 2005).

Further, many gender diverse people are unable to rely on private support or assistance from family members (Budge et al., 2013b; Grant et al., 2011; James, 2014).

Marginalization and lack of support are often understood as major contributors to the high rates of mental health difficulties among gender diverse people documented in the literature (Abramovich et al., 2020; Bockting, 2014; Boza & Perry, 2014; Budge et al., 2013a; Carmel et al., 2014; Coleman et al., 2011; Hong Lam & Abramovich, 2019; McNeil et al., 2012, pp. 49–69). Data from the Trans PULSE project in Ontario (Rotondi et al., 2011b) showed that more than 61% of trans women/transfeminine participants and more than 66% of trans men/transmasculine participants met the criteria for depression. Other data from the project revealed that rates of suicidal thoughts and attempted and completed suicide were also high among trans people (Bauer, et al., 2013).[4] Those who face impacts of structural oppression (Young, 2011) such as unemployment, lack of social support, and instances of transphobic violence are particularly vulnerable to experiencing these forms of distress (Bauer et al., 2013; Rotondi et al., 2011a; 2011b). The high rates of mental health difficulties experienced by gender diverse people mean that they often come into contact with the mental health care system (Abramovich et al., 2020; Carmel et al., 2014). A lack of access to transition-related care is noted by Proctor et al. (2016) as contributing to the very high prevalence rate of depression of 81% among trans people in their study. They point out that improving access to necessary transition treatments may help improve mental health and reduce rates of depression in this population (p. 255).

Gender diverse people may also encounter the mental health care system for reasons relating directly to gender nonconformity or gender identity: From the mid-20th century onward, psychiatrists engaged in research and clinical practice aimed at promoting gender conformity (Ault & Brzuzy, 2009; Burke, 1996; Burroway, 2011a, 2011b; Lev, 2005; Schilt, 2010; Sedgwick, 1991), and in 1980 the diagnostic categories of Gender Identity Disorder of Childhood and Transsexualism were included in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) (American Psychiatric Association, 1980). The construction of gender diverse identities as potentially psychiatrically "disordered" has persisted through subsequent *DSM* revisions, with the most recent fifth edition amending the diagnosis of Gender Identity Disorder to Gender Dysphoria (American Psychiatric Association, 2013).

Although the majority of gender diverse people have not been subjected to psychiatric treatment for childhood gender nonconformity (Meyer, 2012), until recently psychiatrists have remained in the role of encouraging gender conformity among children (Hopwood & dickey, 2014). In Ontario and several other provinces, some gender diverse and gender non-conforming children were required to undergo treatment at Toronto's Centre for Addiction and Mental Health (CAMH) Gender Identity Disorder Service (also called the Child Youth and Family Services Gender Identity Clinic) (Centre for Addiction and Mental Health, 2008; Conway, 2009; Grant, 2009; Hill et al., 2006; James, n.d.), which was widely criticized as retaining a "reparative" or conversion approach, wherein the objective was to promote conformity with the assigned sex rather than to alleviate gender dysphoria (Centre for Addiction and Mental Health, 2008; Conway, 2009; Grant, 2009; Hill et al., 2006). The damaging effects of "reparative" or conversion treatment are well documented by survivors of these types of "therapies" (Burke, 1996; Burroway, 2011a; 2011b; Scholinski, 1997; Winters, 2008). By the mid-2000s, standards for the provision of mental health care for gender diverse and gender non-conforming children began to promote an approach that supported children in expressing their felt gender (Brill & Pepper, 2008; Pyne, 2014), and as a result of the gender diverse and 2SLGBTQQIA+ community's activism, conversion treatment for sexual orientation and gender identity was banned for minors and generally barred from Ontario Health Insurance Plan (OHIP) funding in June of 2015 (Ferguson, 2015). Following this, CAMH undertook a review of the Gender Identity Disorder Service in response to allegations of problematic practices including the imposition of conversion treatment on patients. Although the review indicated that the service was not engaging in conversion practices, it described the clinic as failing to keep up with evidence-based approaches to the care of gender diverse children and as a result, operations were "wound down" (Caton, 2015; James, n.d.) with no new patients accepted into the clinic from the time the review was announced in February 2015.

Not all gender diverse people seek access to gender confirming medical procedures (Chyten-Brennan, 2014; Serano, 2007), but gatekeeping practices are another reason why some gender diverse people have come into contact with mental health care. In Ontario, access to gender confirming treatment has been subjected to numerous restrictions. In 1998, the Conservative government under Mike Harris ended all provincial insurance coverage of gender confirming surgeries, a total moratorium that remained in place until 2008, when some surgeries were reinstated as fundable (Ferguson, 2008). Until March 2016, anyone who sought access to the gender confirming surgical procedures approved for funding by OHIP was required to be assessed by psychiatrists at the Gender Identity Clinic at CAMH (Ontario Ministry of Health, 2016), which until that time acted as the sole gatekeeper for access to these procedures for anyone who could not afford the huge expense of private treatment. A range of procedures are under the umbrella of gender confirming surgery, but all cost many thousands of dollars

(Chyten-Brennan, 2014). Trans PULSE (Bauer et al., 2010) study data revealed that half of study participants had an annual income of $15,000 or less, making taking on the cost of expensive medical procedures an impossibility for most.

Published accounts from people who underwent CAMH Gender Identity Clinic's assessment process have indicated that the criteria used to determine eligibility were problematic. Until the 2016 reforms occurred, the clinic persisted in applying outdated and more arduous criteria for eligibility for access to hormone therapy and surgery than recommended by the World Professional Association for Transgender Health's (WPATH) widely accepted international standards (Carter, 2005; Conway, 2009; Withers, 2014). Additionally, some unemployed people reported that they were classified as ineligible for surgery (Withers, 2014), despite the fact as a result of pervasive discrimination, the employment rate of trans and gender non-conforming people was substantially lower than that of the general population (Bauer et al., 2011). Further, the criteria applied by the clinic prevented some people labelled as having mental health difficulties from accessing gender confirmation procedures (Centre for Addictions and Mental Health, 2012; Withers, 2014), which represented a significant barrier to care for many gender diverse people, given the high rates of mental health difficulties experienced by members of this group (Rotondi, 2011a; 2011b).

In November 2015, the provincial government announced that they were planning to grant the ability to assess and approve requests for gender confirming medical procedures to a broader range of health care providers, to address the long waiting list that had developed at CAMH and improve access to care (Fraser, 2016; Leslie, 2015). From March 2016 onward, gender diverse people have been able to access approval for gender confirming procedures from qualified primary providers across Ontario (Sherbourne Health, 2016), but the problem of long waiting lists has persisted (Donato, 2020; Gibson, 2017) and there remains no guarantee that gender diverse people in the province can access health care services from knowledgeable and respectful providers (Blodgett et al., 2017; Pullen Sansfaçon et al., 2019; Weeks, 2016).

In Ontario, as in the rest of Canada, people seeking medical treatment for mental health concerns most often receive care from family doctors, rather than specialized mental health care providers (Davis, 2006). Most Ontario family doctors have limited knowledge about Two Spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex, asexual and other sexual and gender minorities (2SLGBTQQIA+) issues, especially pertaining to concerns around mental health (Mitra & Globerman, 2014). Even specialized mental health care service providers, programs and institutions have shown limited awareness of 2SLGBTQQIA+ issues (Lev, 2004; The Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-spirit(ed), Intersexed, Queer and Questioning Equity, 2004). For instance, a 2007 report on 2SLGBTQQIA+ inclusion within CAMH showed that most health care provider staff across the institution had limited knowledge of sexual and gender diversity, and revealed a lack of training and education programs (Conway, 2009). In recent years organizations such as Rainbow Health Ontario along with community activists have undertaken education and awareness efforts with health care providers across the province to promote cultural competency and improve access to health care for members of 2SLGBTQQIA+ communities, and while these efforts have had significant impacts (Abramovich & Cleverley, 2018; MacDonnell & Fern, 2014), it has remained the case that members of these communities still face greater difficulty accessing supportive mental health care than do other Ontarians (Bauer et al., 2009; Rapid Response Service, 2017).

Questions about the cultural competency of health care providers represent a main strand of the growing body of literature concerning mental health care for gender diverse people (Daley & MacDonnell, 2011; Kattari, et al., 2016, pp. 636–639, 645; McNeil et al, 2012, pp. 56–59). Another significant area of concentration in the current literature concerns the etiology and treatment of transsexuality/transgender(ism)/gender nonconformity/gender dysphoria in themselves (Benson, 2013; Serano, 2007). Following Serano's (2007) comments on the function of gender identity and gender dysphoria research in promoting the nonacceptance of trans people and the naturalization of cisgender[5] people, I would like to note that the objective of this project is not to validate the constructs of Gender Identity Disorder/Gender Dysphoria, or to bring into question the identities of gender diverse people, but rather to query the role of mental health care in promoting the well-being of gender diverse people.

Despite the recognition of the central role of structural oppression in the high prevalence of mental health difficulties experienced by gender diverse people (Budge et al., 2013a), the question of whether interactions with the mental health care system have promoted the well-being of gender diverse people has not been researched from the perspectives of diversely situated members of this community. The question of the utility of promoting "coping" and "resilience" in the interest of supporting mental health in a context of deep and worsening inequality has also not been analyzed in relation to this marginalized community. In this project, I seek to respond to these topics.

Researcher Positionality

Figure 1: Still from Knitting *by Elisabeth Harrison*

While this project is not about my own experiences, I share some of my personal story here as a means of locating myself in relation to this research. Some of the personal history that brings me to this research is captured in the first digital story I made with what was then Project Re•Vision, in 2012. The story is entitled *Knitting* (Figure 1) and can be viewed at the following link: https://youtu.be/XrI9Xh-Cx6U. The story I told in 2012 is a partial one, and the following narrative is intended to provide additional context for this work.

My interest in the politics of mental health care began when I was a teenager in the early 2000s, after I was brought into contact with the mental health care system and quickly learned that my embodied reality, my subjectivity, and the context of my life were all seemingly irrelevant to the medical professionals who suddenly had the authority to make enormous decisions for me about what I could do, and what would happen to me. I learned that it did not matter that I was facing a difficult home environment and bullying and sexual harassment at school. As though either of those things were rare or even unusual, my stories about these experiences were dismissed as evidence that I was delusional. It did not matter that I had not been eating much of anything for months. It did not matter that during the months leading up to my hospitalization my family doctor had prescribed me a brand new antidepressant medication, Effexor XR, which caused my thoughts to race, my feelings of sadness morphing into agitation as the dose I was prescribed was increased over and over. Instead of acknowledging or addressing any of these issues, the psychiatrist at the inpatient clinic I was admitted to diagnosed me with schizophrenia after interviewing my parents, screening me for drug use (negative apart from Effexor) and scanning my brain for possible tumours (fortunately also negative). The psychiatrist withdrew me from Effexor with no taper and immediately put me on the "atypical antipsychotic" medication risperidone.[6] When I went back to my regular life, the difficult circumstances I was facing continued, but now thanks to the medication's effects of fatigue, severe brain fog and an increase in the hormone prolactin, I also had to deal with needing to sleep about 18 hours a day, no longer being able to read, and the awkward fact that my shirts were often stained with breast milk.

My relationship to gender diversity began to develop around the same time. I was assigned female at birth and grew up as a girl, then at adolescence I was diagnosed with the hormone condition polycystic ovary syndrome (PCOS), and told that my body was producing "too much" testosterone. I was given surgery to remove a large cyst that had developed on one of my ovaries but was not offered any other treatment or support for the condition, so I had to try to manage what I saw as my "masculine" facial and body hair growth and body fat distribution on my own. This helped me become familiar with hair removal techniques, but as I mentioned, it also led me to develop significant problems with eating, which may have contributed to the difficult emotions I was experiencing at that time. Since my Catholic school education had not familiarized me with the notion that sex and gender were constructs, or about anything related to sex and gender diversity, I believed myself to be some kind of “unnatural” or “wrong” girl and felt deeply ashamed. Although I was aware of the LGBT community and recognized I was queer as a teenager, it wasn’t until I became an adult that I learned about genderqueer and non-binary identities and realized that even though I had a feminine gender expression, I did not have to be a woman and could instead identify outside of the binary that I had found so painful and restrictive.

Ultimately, I was allowed to stop taking neuroleptic medication after a little more than a year. My psychiatrist told me it may have saved my mind from psychosis, and I might not develop schizophrenia after all, but I would have to wait and see. I thanked her for helping me. I had to take an extra year of high school to earn the credits I had missed due to the effects of the medication. When I went away to university, I made sure to go to the student health service to asked to be referred to a psychiatrist so I could be monitored for signs of psychosis. When I shared my history with the new psychiatrist, he explained that a new warning had been issued recently, telling doctors not to prescribe Effexor and similar drugs to anyone under the age of 18 as they had been linked with symptoms of mania and aggression in children (Healy et al., 2020; Ho, 2012; Mitchell et al., 2014). He thought the diagnosis of schizophrenia was wrong and I had really been suffering from the harmful effects of the medication I had been prescribed.

My initial inspiration for undertaking this project was Dylan Scholinski’s (1997) book, *The Last Time I Wore A Dress*, which I found in my hometown’s public library about a year and a half after I had been discharged from the hospital. Scholinski’s experiences with mental health care were very different from my own, but his political analysis of the material and ideological impetus for the profoundly abusive and violent treatment to which he was subjected was my introduction to the idea that mental health care as well as “mental health” and “mental illness” themselves are not inherently benevolent and bias-free entities. As I was introduced to antipsychiatry, consumer/survivor/ex-patient and critical psychology literature throughout my university studies, I started to understand what had happened to me. The psychiatrist who diagnosed me with schizophrenia dismissed my disclosures of abuse and harassment and ignored the fact that the intensification of my problems coincided exactly with my being prescribed increasing amounts of a novel medication. My family doctor had known that our family was lower income and that we did not have private insurance to cover the cost of medication, but Wyeth-Ayerst had provided him with many free samples of their new drug, so he passed some along to me. I do not know anything else about my doctor’s relationship with that company or its sales representatives, but given what is now known about the efficacy of pharmaceutical industry sales tactics (Sismondo, 2018), it seems unlikely that the company’s promotional work had no influence on his decision to prescribe their profitable in-patent drug to me (Light & Lexchin, 2012). The drug that harmed me was unsafe for children, which was information the company may have suppressed (Healy et al., 2020) or at least failed to adequately research (Ho, 2012; Mitchell et al., 2014).

My discomfort with my “unnatural” body had fuelled my self-hatred. That did not seem to correspond with the ideas about problem eating I had been exposed to when I was younger. In the literature I borrowed from the public library where I worked as a teenager, I learned that eating disorders were supposedly about the rejection of adult femininity (Bordo, 1993, pp. 178–179; Bruch, 1978). This did not resonate with my experience, so it was only later that I recognized that my problem eating could be understood as an attempt to ameliorate or disguise my non-feminine morphology (Rice, 2014). Learning from fat studies and gender studies was what ultimately helped me achieve a sense of comfort with my body. Coming to identify as a non-binary femme and as a fat person helped alleviate my discomfort my sense that my body was “wrong” due to its differences from sexist, cissexist, queerphobic and fatphobic norms.

I write from my necessarily partial and limited perspective. I am white, and I come from a lower income white settler family from rural Eastern Ontario. The community I grew up in and where my family still lives is on the Kanien’kehá:ka territory of the Haudenosaunee people, which was included in the Crawford’s Purchases treaty signed with the Mississaugas. I am now middle class and I live in Toronto, on the territory of the Mississaugas of the Credit, the Anishinaabe, the Chippewa, the Haundenosaunee Confederacy and the Wendat, covered by Treaty 13 signed with the Mississaugas of the Credit, as well as the Williams Treaties, signed with Mississaugas and Chippewas bands.

I am a non-binary femme but unless I disclose my gender identity, other people usually perceive me as a cisgender woman. I recognize that many non-binary people experience this as erasure, and while for me it can be frustrating, it often feels more like unearned privilege and safety. I identify as fat, and as a psychiatric survivor and a trauma survivor. I am extremely fortunate and privileged to have an incredibly loving and supportive partner, true friendships and amazing mentors, as well as resources that have enabled me to access non-pathologizing, trauma-informed psychotherapy, which has improved my life in many ways, including by enabling me to address past difficult experiences and develop much better relationships with my family members. My experiences have brought me to my goal of seeking gender and health justice for everyone whose bodyminds[7] do not conform to medicalized and psychiatrized standards, or the societal norm of the sex and gender binary.

Problem Statement

In Ontario, despite important recent gains in legal rights and recognition,[8] gender diverse people are generally marginalized, facing discrimination and social exclusion. Many community members experience violence and abuse (Singh & McKleroy, 2011; Woulfe & Goodman, 2019). Gender diverse people face a high rate of poverty due to rampant employment discrimination (Bauer et al., 2011) and the inaccessibility and inadequacy of social assistance (Namaste, 2000; Namaste 2005; Smith-Carrier et al., 2020). Members of this group also experience difficulties in accessing housing (Bauer et al., 2010) both as a direct result of discrimination and as an effect of the prevalence of low income in concert with extremely high market-rate housing costs and a lack of affordable housing (Ontario Non-Profit Housing Association, 2016). Gender diverse people also experience food insecurity at substantial rates (Giblon, 2016). These difficulties are compounded by the fact that many members of this community are not able to access the kinds of family support and resources that might otherwise be able to help bridge these types of gaps (Budge et al., 2013b; Grant et al., 2011; James, 2014). Gender diverse people have been identified as experiencing high rates of mental health difficulties, being diagnosed with substance use disorders, anxiety disorders, depression, post-traumatic stress disorder and psychotic disorders at high rates (Proctor et al., 2016, pp. 251, 255). The multiple dimensions of marginalization that gender diverse people face are also recognized as playing a large role in the mental health difficulties that face this group as a whole.

While some research has suggested that gender diverse people may avoid seeking health care due to a lack of appropriate and culturally safe services (Safer et al., 2016), others have noted that gender diverse people often come into contact with the mental health care system due to the high prevalence of mental health difficulties in this group (Carmel et al., 2014). Supporting this, a recent Ontario-based study by Abramovich et al. (2020) found that gender diverse people were more likely than average to access health services, attributed in part to higher rates of mental health difficulties and self-harm. In addition, as noted above, in Ontario many trans and gender diverse people have been required to engage with the mental health care system due to the longstanding requirement that the gender identity clinics at CAMH approve them for transition-related medical care.

The general problem is that Ontario mental health policies have largely focused on individual solutions for mental health difficulties. The policy statement in place at the time this research was undertaken, *Open Minds, Healthy Minds* (Ontario Ministry of Health and Long-Term Care, 2011), identified individuals within marginalized populations as especially vulnerable to developing difficulties with mental health and substance use. Instead of offering solutions intended to address the root causes of these difficulties, the plan promoted “education and awareness programs” (p. 10) intended to help such individuals to “become much more resilient and to better cope with adversity” (p. 10).

The specific problem is that the promotion of individual “coping” and “resilience” does nothing to address the structural oppression that causes members of the gender diverse community to experience mental health difficulties at such high rates. While improving access to individual mental health services can be helpful in some regards, it does not provide solutions to the underlying problems of discrimination, violence, poverty and lack of support that this community faces. It also does not respond to the fact that the publicly funded individual services offered may not be accessible to gender diverse people due to unhelpful content, a lack of cultural safety, or even a lack of availability, particularly in underserved areas of the province.

Research Aim

Through this project, I seek to contribute to our understanding of the social, political and economic forces shaping the lives of gender diverse people and the ways these impact the mental health and well-being of members of these communities. As I will discuss, while the mental health policy in place at the time that this research was undertaken did not specifically mention gender diverse people, people in a range of other similarly marginalized groups were identified as being in particular need of support (Ontario Ministry of Health and Long-Term Care, 2011, p. 10). The policy paid lip service to the social determinants of mental health and made unfulfilled promises to do more in support of them by funding affordable housing and reducing poverty, while simultaneously characterizing mental health as something for which individuals, irrespective of social location, bore primary responsibility. Ontario's subsequent and current mental health policy statement, *Roadmap to Wellness* (Ontario Ministry of Health, 2020), represents a further step toward the responsibilization of individuals for their mental health, with even less recognition of the role of the social determinants of health. It also featured a new emphasis on providing cognitive behavioural therapy (CBT) as a one-size-fits-most solution to mental health difficulties, a move very much in line with other neoliberal governments (Linton, 2020).

Key Research Questions

- How does mental health care in Ontario aim to promote the well-being of gender diverse people? Does it achieve its aims?

- What are the recent mental health care experiences of gender diverse people in Ontario? What do members of this community think could be changed within mental health care and beyond to improve their well-being?

- Can intersectional analysis of narrative and digital storytelling-based accounts of gender diverse people's mental health care experiences illuminate the dynamics of power, oppression and privilege that shape people's lives?

Contribution to Research

The issue of trans and gender diverse mental health has often been addressed from mainstream, medical model-based perspectives, which pathologize gender variance and reify the biological understanding of distress and difference as mental illness (Bauer et al., 2009; Benson, 2013; Serano, 2007). This has served to obscure the role of power relations in causing what come to be interpreted as individual, mental health difficulties, rooted primarily in biological dysfunction rather than problematic life contexts.

Critical studies on similar topics to that addressed by this project have generally been either much broader in scope (such as the ground-breaking work undertaken by Namaste [1995, 2000], which addressed the exclusion of trans people from a range of social and health services in Canada; the Trans Health Project led by Gapka and Raj [2003; 2004], which reviewed access and equity issues impacting the health of trans people in Ontario across a wide range of categories, including physical health, mental health, transition-related care, sexual health, and spiritual health [2003, pp. 3–4]; and the subsequent work of Bauer et al. [2009], which drew from Trans PULSE project data to analyze the general health care experiences of trans people in Ontario), or have been more narrowly focused (such as Rotondi's [2011 a; 2011b] research on depression rates among trans Ontarians; or Rowe's study of the experiences of a group of white trans men who had sought access to gender confirmation surgery in Ontario, and had experiences of "auditioning for care" [2014, p. 209] at the CAMH Gender Identity Clinic). These studies also diverge from my project in regard to their methodological approaches, as well as their theoretical foundations (for instance, Bauer et al. [2009, 2013] and Rotondi et al. [2011a; 2011b] used quantitative approaches and applied medicalized understandings of mental health). While each of these studies have important implications for the areas of mental health care and related social policy, for some, these topics are not their primary focus, while others address them in less detail.

This project utilizes a unique range of theoretical perspectives from critical disability studies and mad studies, social determinants of health research, intersectionality theory and feminist new materialism to understand the material circumstances of participants' lives in relation to shifting relations of power at multiple levels and across multiple dimensions of identity/embodiment and experience.

Methodology

My project draws from narrative interviews and digital stories created by members of the gender diverse community who have had contact with the mental health care system in Ontario.

Information gathered from community members will shape and illustrate my analysis of the neoliberal trajectory of Ontario's mental health policy. Policy analysis also draws from mental health and related health and social policy statements, as well as relevant legislation.

The voices and perspectives of people who have had contact with the mental health care system (Reaume, 2006) and gender diverse people (Serano, 2007) have often been co-opted by researchers. The methods I selected for this project were intended to enable participants to tell their own stories in ways of their own choosing (Benmayor, 2008). Some traditional social research methodologies have been criticized as positioning researchers as knowers with a unique capacity to interpret the stories told by research participants, who are relegated to the role of passive providers of raw data whose own knowledge and meaning making are ignored. In contrast to this, narrative methods highlight the role of participants as holders and creators of knowledge (Riessman, 2008). The digital storytelling methodology also challenges this hierarchy by empowering storytellers to exert a high degree of control over how they present their own story, positioning them as knowers, makers of meaning, and as creators of art (Alrutz, 2013; Hull & Katz, 2006; Vivienne & Burgess, 2013). Social research methods that involve the creation of works of art are recognized as making several unique contributions, highlighting the interpretive nature of research, enabling the creation of artistic works that can promote deeper understandings, and promoting reflexivity among those who engage with the works created (Goldstein, 2008). Digital storytelling's capacity to counter stereotypes is recognized as particularly strong (Beltrán & Begun, 2014). Vivienne's (2011) work with transgender digital storytellers in an Australian city highlights the method's potential to support members of marginalized communities as "everyday activists" by amplifying their stories and voices (p. 53).

Recruitment of 13 narrative interview participants was undertaken using a purposive and snowball sampling method, with an emphasis on seeking diversely situated participants so as to better account for the impacts of intersecting dimensions of oppression and privilege among members of this group (Cuadraz, 1999). The objective of qualitative research is to create knowledge that is "significant in its own right," not to generate "generalizable" data that can be applied across a population (Myers, 2000). That noted, Riessman (2008) argues that qualitative research findings based on small, purposively sampled groups can be understood as illustrating social processes. The small sample size has facilitated deep analysis of participants' narratives, and the relations of power that shape their experiences (Squire, 2013).

Open-ended questions facilitated participant storytelling and meaning-making around experiences (Riessman, 2008). Questions focused on life experiences and circumstances that led participants to come into contact with the mental health care system; What participants' experiences were in the mental health care system (including interactions with medical staff, experiences with pharmacological and other interventions, interactions with other service users); What participants' understandings were of what could promote their well-being (in the mental health care system, and in regard to the social determinants of health).

As Phoenix (2013) cautions, narratives are often "canonical" in nature, relying on dominant cultural discourses to make sense of experience. Pairing narrative interviews with the digital storytelling workshop methodology developed by the Re•Vision Centre has enabled participants to consider and challenge dominant cultural ideologies around gender identity/expression and mental health. Interview data guided the creation of a presentation uniting participants’ perspectives with critical literature-based information on gender, mental healthcare and well-being. This presentation was delivered at the beginning of the three-day digital storytelling workshop, which utilized Dr. Carla Rice’s REDLAB mobile digital media lab to enable five participants from the narrative interview stage of the project to create their own digital stories, which are two- to three-minute-long short films pairing voiced narration with still and moving images (Rice et al., 2015; Rice & Mündel, 2018; Vivienne, 2011; Vivienne & Burgess, 2013). Having participated in digital storytelling workshop facilitation training through a Re•Vision Centre project, I facilitated the workshop alongside three paid co-facilitators and a technical assistant.

Information shared by participants in their narrative interviews was coded using a thematic analysis approach (Braun & Clarke, 2006) to locate points of connection and intersections between and among stories. As I undertook this process, I avoided the social science researcher tendency to decontextualize participants’ stories by “taking bits and pieces, snippets of a response” from each in order to create a generalizable conclusion (Riessman, 1993, p. 3). Digital stories have been interpreted using a narrative visual analysis methodology, facilitating the interpretation of imagery as narratives in themselves, and therefore as open to textual analysis (Riessman, 2008). The methodology involves “the interpretation of images closely and in light of details inside and outside the frame (the image itself, the context in which it was produced, and the context in which it is read)” (Bell, 2013, p. 145).

Dissertation Structure

The literature review begins with an exploration of the development of medical and psychiatric approaches to gender nonconformity. This starts with a description of the history of ways that those who have not conformed to the gender binary have been subjected to medicalization and ultimately psychiatrization[9] as a means of promoting normativity. I then review the literature on well-being, wellness, and resilience to illustrate the distinctions between the concepts and the significance of their appearance in recent Ontario mental health policy statements. Following this, I provide a historical overview of the reification of "mental health" as a biomedical entity, and a discussion of the history of mental health policy in Ontario. Here, I focus on the recent use of mental health care policy and practice to provide ideological and material support for the neoliberal austerity agenda in the province.

This project brings together a broad scope of critical theory, each serving to illuminate aspects of the experiences of participants. I begin with an overview of relevant critical theories of disability and madness, including the social and cultural models of disability, disability justice and mad studies perspectives. Next, I review the social determinants of mental health. Finally, I discuss intersectionality and feminist new materialism, perspectives that facilitate the political analysis of complex realities. The methodology chapter provides a consideration of the story-based approach to research that informs this project, explaining the undertaking and analysis of narrative interviews, as well as the Re•Vision Centre's innovative approach to digital storytelling (Douglas et al., 2020; Friedman et al., 2020; Lind et al., 2018; Rice et al., 2020a; Rice et al., 2020b; Rice et al., 2020c; Rice & Mundel, 2018; Rice & Mundel, 2019; Viscardis et al., 2019). I also consider the analysis of digital stories as visual and auditory media.

My results and discussion chapters begin with a summary of each participant's personal narrative describing their identities and experiences. Next, I consider the experiences of participants in relation to the social determinants of mental health, considering how social inclusion and exclusion impacts well-being. I then discuss participants' experiences with mental health care, focusing on participants' stories that highlight the ways that the mental health care system is supportive and/or unsupportive of gender diverse people's well-being. I conclude with a discussion of participants' resilience within the context of neoliberal disinvestment, and their perspectives on what kinds of social and policy changes could better promote their well-being.

Chapter Two: Psychiatric Politics and Gender Nonconformity

Introduction

From its initial development in the private madhouses and public asylums of Europe and North America in the 18th and 19th centuries (Porter, 1987, pp. 16–17) until the present, the discipline of psychiatry has been concerned with the control and elimination of deviancy (Moncrieff, 1997, p. 63; Porter, 1987, p. 9). This has been reflected throughout history not only in the many abusive and rights-denying practices to which people identified as mad or mentally ill have been subjected under the guise of "helpful" psychiatric treatment, but also by the use of psychiatry as a tool for the oppression of subordinated groups in society, including queer[10] and gender non-conforming and gender diverse people. This is demonstrated in the history of the psychiatrization of homosexuality as well as the connected and ongoing pathologization of gender transgression. In this chapter, I explore the history of psychiatry's function as an agent of social control, oppression and exclusion, focusing on the cases of queerness and gender nonconformity. I begin with an overview of the history the implication of psychiatry in exclusion, oppression and human rights abuses. Next, I turn to an examination of the history of queerness and its treatment within psychiatry, as well as the development, use, and eventual removal of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) diagnosis of Homosexuality. I then discuss the history of transgender and gender nonconformity and the responses of psychiatry to it, including the creation of the diagnosis of Gender Identity Disorder (GID). Following this, I review the debate concerning whether GID should have been removed from the fifth edition of the DSM, discussing the ways in which some trans people have been able to strategically utilize GID, alongside GID's other oppressive implications and effects. Next, I consider the implications of the diagnosis' retention under the label of Gender Dysphoria (GD). I conclude with a discussion of recent shifts toward affirming and informed consent-based access to transition-related care.

Exclusion and Oppression in the History of Psychiatry

Even prior to their designation as "mentally ill," people exhibiting behaviours and beliefs regarded as strange in relation to the norms of their particular socio-cultural context (Porter, 1987, p. 9) have been subjected by others to what is now recognized as abusive, rights-depriving treatment. In Europe and European colonial/settler societies during the 18th and 19th centuries, those identified as "mad" were generally "cared for" in family homes and in the general community, wherein many common practices of home care involved confinement, segregation and abuse (Peterson, 1982, p. 108). People whose families did not provide care often fared little better, sometimes being given pittances of public assistance, used as free labour, or confined in jail cells, if they were not excluded from the community altogether through the practice of "dumping," wherein a mad person was taken by force to another town and prohibited from returning (Peterson, 1982, pp. 108–110). The large-scale confinement of mad people in institutions, notorious for their ill-treatment of inmates began in European and colonial settler societies in the 18th and 19th century, when "catchall institutions for the needy" were opened as part of the emergence of liberal governance at the time (Foucault, 1997, p. 74; Peterson, 1982, p. 111).

An understanding of madness as a medical problem arose only after separate asylums for mad people were founded and doctors began to develop therapeutic models for the treatment and rehabilitation of madness (Peterson, 1982, pp. 111–112; Porter, 1987, p. 17).[11] As Porter (2002) writes, “The asylum was not instituted for the practice of psychiatry; psychiatry rather was the practice developed to manage its inmates” (p. 100).

Once madness came to be conceptualized as a disease, the containment facilities that had been developed to hold mad people began to be transformed into treatment facilities for those designated as mentally ill. These institutions claimed to specialize in rehabilitation and promised to cure or at least ameliorate those who received their care (Porter, 1987, p. 17). Initially, the treatments meted out differed little from the often violent techniques of control that were common in the old catchall institutions, comprising techniques such as isolation as well as forcible confinement and restraint using such devices as cribs, shackles and restrictive clothing (LaJeunesse, 2002, pp. 44–45, 59–68; Peterson, 1982, pp. 115–116, 238–239; Reaume, 2000, p. 14).

The Biomedical Model of Mental Health

As advances in somatic treatments took place within the field of medicine as a whole during the 19th and 20th centuries, some of these interventions began to be applied to people identified as mentally ill. Lobotomy, electroconvulsive therapy (ECT), insulin shock therapy and psychosurgery were some of the non-pharmacological treatments that were used, often on an experimental basis, and without informed consent. These frequently caused severe physical harm and emotional trauma (Burstow & Weitz, 1988, pp. 27–28; Coppock & Hopton, 2000, pp. 126–128, 158; Peterson, 1982, pp. 240–242; Shimrat, 2000, p. 41; Simmons, 1990, pp. 209–216). Early on, medications tended to be substances with tranquillizing effects, such as bromide, opium, chloral hydrate, and even alcohol (Reaume, 2000, pp. 14–15), and by the 1930s, amphetamines were also widely used (Porter, 2002, p. 205). None of these treatments were particularly effective, and like the non-pharmacological interventions, they often damaged the health of patients. This did not dissuade scientists and physicians from persisting in the search for pharmacological treatments for mental illness, and more drugs were developed. These included various types of “antidepressants,” “anxiolytics” and “antipsychotics” (Healy, 1997, pp. 258–261) many of which have severe side-effects (Coppock & Hopton, 2000, pp. 128–130; Hornstein, 2009, p. 196; Molnar, 1997, p. 107; Shimrat, 2000, pp. 5–7; Szasz, 1995, pp. 151–152).

By the 1970s, a primarily biological model of mental illness had achieved a position of dominance (Hanly, 1970, p. 36), a state of affairs which persists today (Diamond, 2014, p. 295; Hornstein, 2009, pp. xx, 202). Generally, in recent decades the biomedical model has formed the basis of mental health policy and service provision in Canada (Arnett, 2006, p. 171; Davis, 2006, pp. 3–12; Gaspar et al., 2021) and around the world (Deacon, 2013; Fennig & Denov, 2019, Jenkins et al., 2002, pp. 3–5).

The notion that “mental illness” may be culturally constructed or caused by social factors, and therefore may not be a good candidate for the forms of treatment informed by this reductionist model was regarded as unintelligible by proponents of the bacteriological understanding of mental illness, defined by Healy (1997) as the notion that all diseases have a monocausal, biological explanation. It is called the “bacteriological model” because it arose as antibiotics were developed and were found to target bacterial infection with great precision and efficacy. This influenced the way that doctors and pharmaceutical researchers thought about what medications for all types of diseases could do. If a medication did not work, it only served to prove that what was needed was a better medication (Healy, 1997, pp. 28, 257–258; Porter, 2002, p. 205). As Rogers and Pilgrim (2003) explain, some advocates of the medical model of mental illness adopted a hard biologically deterministic position, arguing that mental health outcomes are determined almost solely by “pre-natal determinants” including “genetic inheritance and *in utero* events” (p. 109).

Medicalization and Oppression

Advocates of the biomedical model of mental health have lauded medications as improving people’s well-being and as having facilitated the shift from confinement to life in the community for people identified as mentally ill (Davis et al., 2012). In contrast, critics of psychiatry and medicalization have argued that psychiatric medication is a technology of control. For instance, Burstow and Weitz (1988) write,

> … On one level, [drugs] make you dopey and confused as hell. On another … they anaesthetize and immobilize bodies and minds so you can hardly move, think or feel. On these drugs you are forever in pain. You find yourself shaking, trembling and twitching involuntarily. You start to drool. You can’t remember much. You cannot learn too well. Once in this state, naturally, you’re not going to be too much trouble for the psychiatrist (pp. 26–27).

Psychopharmacological treatment can serve as a tool of oppression in other ways. Sometimes it is the only form of treatment offered to people seeking support for their emotional difficulties, which denies them choice. People are sometimes coerced into taking medication (Coppock & Hopton, 2000, pp. 131–133). Further, from the 1990s onward, in many Canadian, American and European jurisdictions, involuntary outpatient commitment laws have been used to legally compel people considered mentally ill to take medication, under threat of incarceration in a psychiatric hospital (Fabris, 2006; Laurance, 2003, pp. xx, 56–57). People subjected to coercive treatment are deprived of the rights to freedom of conscience and bodily integrity.

The Politics of Psychiatrization

The problem with the total dominance of the biomedical model of mental health is evident from the range of critical perspectives I employ in this project. As the feminist new materialist perspective implies, it is unlikely that the conditions identified as mental illness definitely have no connection whatsoever with biology (Trivelli, 2014; Wilson, 2008),[12] but they demonstrably have a basis in social and political relations. Rates of diagnosis with psychiatric disorders are often correlated with determinants of social location such as race, gender and level of income (Goldner et al., 2011, pp. 46–49; Goodwin, 1997, pp. 73–76). At the same time, what comes to be defined as constitutive of a "mental illness" is itself both socially and politically determined, as historical examples of once-valid diagnoses of psychiatric "disorders" targeting racialized enslaved people ("drapetomania") (Fernando, 2010, p. 68), women ("hysteria"), and queer people ("homosexuality") (Kutchins & Kirk, 1997, p. 29) demonstrate. Beyond overtly targeted diagnoses, the practice of psychiatry from its initial development until the present has been more broadly implicated in enacting and upholding oppressive political and social relations of colonialism, racism, sexism and ableism (Gambino, 2008; LaJeunesse, 2002, pp. 97–105; McClintock, 2001; Ussher, 1991, pp. 166–170; Vaughan, M., 1997, p. 1; Yellow Bird, 2009).

Further, contemporary mental health diagnoses as enshrined in all editions of the American Psychiatric Association's official diagnostic manual, the *Diagnostic and Statistical Manual of*

Mental Disorders (*DSM*) are the result of a political process, rather than reflecting "objective" or "scientific" reality (Kirk & Kutchins, 1992). Focusing on the discovery of treatments or "cures" for individual problems with genes or brain chemistry may prevent the recognition of the social and political factors that have been shown to play a significant role in both mental and physical health outcomes and may therefore preclude efforts to change these factors.

The Psychiatrization of Queernesss

Although same-sex/same-gender sexuality has always existed (Herman, 1995), it has not always had the same social significance (Aldrich, 2006, p. 1; Katz, 2001, p. 11; Rupp, 1999, pp. 15–36). In the West, homosexuality did not exist as a social identity until the late 19th century. From the 13th century same-sex sexual activity was made illegal in many jurisdictions (Hergemöller, 2006, pp. 57, 63–67),[13] but participating in such activity was considered aberrant, rather than as revealing something about participants' identities (Bayer, 1987, pp. 17–18; Faderman, 1981, pp. 259–253; Foucault, 1990, pp. 42–44; Katz, 1995, p. 45). While what might now be described as queer sexuality was long under the purview of the legal system, it only became a target of the medical field in the mid-to-late 1800s as part of a broader trend of labelling non-normative behaviours—and the people who engaged in them—as pathological (Faderman, 1981, p. 241; Fone, 2000, p. 275; Mondimore, 1996, pp. 36–39; Terry, 1999, pp. 36, 45–50). At this time and through the turn of the 20th century scientific researchers sought biological explanations for queer sexuality and identity. Some of these researchers understood queer sexuality as undesirable and worthy of punishment, or (often harmful but ostensibly more humane) "treatment" aimed at its elimination. Others—such as Hirschfeld of the Scientific-Humanitarian Committee, the world's first homosexual rights organization—thought that giving a medical account of the causes of homosexuality would provide support for ending the criminalization of homosexuality (Bayer, 1987, p. 21; Terry, 1999, pp. 53–55). At this time, there was substantial overlap between understandings of homosexuality and gender identity. For instance, Ulrichs believed that homosexuality was the result of "psychical hermaphrodit[ism]," which was characterized by the presence of a "female" psyche in a "male" body, or vice versa (Terry, 1999, p. 44). As Rice (2018) points out, this represents an instance of medicine's fixation with bodyminds perceived as mismatched in comparison with dominant standards (p. 537).

The Rise of Conversion Therapy

Biology-based theories concerning the causes of homosexuality were largely supplanted by the new psychological theories that were articulated beginning in the 1890s by Freud, who regarded homosexuality as the result of a failure to successfully navigate the difficult process of psychosexual development, although he seemed not to regard this outcome as especially problematic (Flanders et al., 2016). Despite this, many of Freud's successors in the early- to mid-20th century used his theories as a means of supporting arguments that homosexuality was pathological and should be eliminated through treatment (Bayer, 1987, pp. 30–38; Black, 2001, p. 110; Mondimore, 1996, p. 72). During this time, some gay and lesbian community members—and early "homophile" rights organizations such as the Daughters of Bilitis and the Mattachine Society—regarded pathologization as preferable to criminalization and accepted these perspectives (Adam, 1995, pp. 60–64; Bayer, 1987, pp. 68, 71–81; Black, 2001, p. 111; Miller, 2006, p. 306; Terry, 1999, pp. 268–286, 354). While homophile activists believed that supporting "neutral" scientific research would eventually lead to the social acceptance of non-normative sexuality, many of the practical uses of the results of psychological and medical research concerning homosexuality had terrible consequences for those who were unfortunate enough to come into contact with the mental health care system and began to be subjected to the wide range of psychological and physical interventions intended to eliminate queerness. Such interventions would now be referred to as “conversion therapy.”

During the 20th century, “treatment” techniques intended to change gay men’s sexual orientation included castration, the transplantation of testicular tissue from heterosexual men into homosexual men (Cruz, 1999, p. 1305), and libido-suppressing hormone treatment (Davidson, 2009, pp. 407–408; Kaplan, 2004, p. 1415; Smith et al., 2004). Brain surgeries performed with the aim of eliminating homosexuality included lobotomy and hypothalamotomy (Cruz, 1999, pp. 1304–1305).[14] Electroconvulsive therapy (ECT) was also used (Burstow, 1990). Aversion therapy using emetics and electric shock was widely employed throughout the 1950s and 60s, and even later in some cases (Chandran, 2006; Cruz, 1999, pp. 1305–1306; Jones, 2008, p. 408; Kaplan, 2004, p. 1415; King et al., 2004; Smith et al, 2004). In South Africa during the Apartheid era in the mid 20th century, some gay men were forced to have gender reassignment surgery (Kaplan, 2004, p. 1416), again reflecting the conflation of queer sexuality and gender identity. Lesbians were also targeted by harmful treatments aimed at changing their sexual orientation, including ECT, clitoridectomy, oophorectomy and hysterectomy (Blackbridge & Gilhooly, 1985; Cruz, 1999, p. 1305; Murphy, 2008, pp. 17–18).

Homosexuality in the DSM

Prior to the 1950s, the classification of psychiatric disorders was not standardized, with diagnoses varying widely depending on the philosophical orientation of individual doctors, but as I note above, same-gender/same sex sexuality had been generally regarded as evidence of a mental disorder since the 1890s, so in 1952 when the American Psychiatric Association (APA) published the first edition of the *Diagnostic and Statistical Manual* (*DSM*), its standard classificatory system for mental disorders, homosexuality was included in the disorder of "sexual deviation" (American Psychiatric Association, 1952, pp. 38–39; Kutchins & Kirk, 1997, p. 29). By the time of the first revision of the *DSM* in 1968, queer activists had begun to fight for legal rights and social recognition (Mondimore, 1996, p. 238; Bayer, 1987, pp. 89–90; Terry, 1999, p. 367), and a movement aimed at securing the removal of Homosexuality from the *DSM* arose, with activist organizations staging protests at APA conferences and advocates doing educational work with the organization's members (Bayer, 1987, pp. 91–92, 99; Drescher & Merlino, 2007, pp. 2–3; Gittings, 2007, p. xvii; Marcus 2002, pp. 146–147). In 1973 the general membership of the APA voted in favour of removing Homosexuality from the *DSM* (Drescher & Merlino, 2007, p. 3; Mondimore, 1996, p. 239).

At the same time, the psychiatrization of queerness persisted as subsequent printings of *DSM-II* were amended to include "Sexual Orientation Disturbance [Homosexuality]," a diagnosis intended to apply only to queer people "disturbed by, in conflict with, or wish[ing] to change their sexual orientation" (American Psychiatric Association, 1968, p. 44).[15] A similar diagnosis, "Ego-Dystonic Homosexuality" (American Psychiatric Association, 1980), was also included in *DSM-III* in 1980. With queer activists pointing out that the desire to change one's sexual orientation is a result of homophobia and heterosexism rather than individual pathology, the diagnosis was finally removed from the *DSM-III* in 1986 (Bayer, 1987, pp. 209–213).

The Persistence of Conversion Therapy

Despite this change, a 1991 APA survey revealed that many psychiatrists maintained the belief that homosexuality was pathological, even 18 years after the diagnosis of Homosexuality was eliminated from the *DSM* (Herman, 1995, pp. 129–130). From the 1990s onward, queer people receiving psychiatric treatment have continued to report that some mainstream mental health workers have regarded their queerness as problematic, and as either a symptom or cause of their mental health difficulties and have otherwise displayed homophobic and heterosexist attitudes (Ayhan et al., 2020; Lerner et al., 2021; Platzer, 2006, pp. 98–120). Although it has now been banned in many jurisdictions including Ontario, some psychiatrists and other mental health care providers have continued to promote "reparative" or conversion therapy, targeting queer people and trans and gender diverse people (Centre for Gender and Sexual Health Equity, 2020).

The Contingency of Gender and Sex

Like same-gender/same-sex-oriented sexuality, gender nonconformity has always been part of human life. Further, gender systems themselves vary widely across cultures. There are many contemporary and historical examples of cultures in which more than two genders are recognized (Brown & Mar, 2018; Califia, 2003, p. 151; Brill & Pepper, 2008, pp. 8–9; Furth, 1993; Mohr, 2010, p. 25; Vasey & Bartlett, 2007; Whitehead, 1993).

Perspectives about gender roles and ideologies, gender and sex have varied widely across time and between cultures. Feminist analyses of gender roles rooted in the binary gender system that locates at opposite poles men/maleness/masculinity and women/femaleness/femininity have revealed the many ways in which historically contingent (Lerner, 1986) and even arbitrary social norms have determined whether a social role, behaviour, attribute or value is regarded as the purview of men or women, or as masculine or feminine. They have also highlighted the limiting and harmful impacts of these designations on everyone, but especially those placed in the subordinate position in the binary as well as those positioned outside of it all together.

The notion that humanity naturally divides into two distinct, biologically (and socially) complementary sexes has long been the dominant perspective in mainstream Western cultures, but this view is neither natural nor inevitable. Sex has not always been understood as a tidily divided binary system. Prior to the rise of the currently dominant model, the one-sex model, which conceptualized men as the norm and women as deformed, incomplete and necessarily inferior versions of men held sway (Laqueur, 1992). Advances in anatomical research, as well as the discovery of hormones and chromosomes showed up the deficiencies of the one-sex model and led to the development of the two-sex model. But the binary model of sex is no more an “objective” view of human bodies than the one-sex model. In fact, humans are much more varied than the model states. Significant numbers of people have genitals and other physical features designated as “sex characteristics” that do not conform to a binary ideal and could be considered intersex (Davis, 2015). Most people have not been karyotyped, so the extent to which any given individual fits in to the XX/XY chromosome model is more likely to be an assumption rather than a substantiated fact. Numerous variations of sex chromosomes and anatomy are found among humans, appearing fairly regularly, and variations in sex hormones are common. For example, polycystic ovary syndrome is thought to affect up to 20% of people assigned female at birth, and one of its diagnostic features is androgen levels that exceed what is considered “normal” for women (Yildiz et al., 2012). This often leads to a range of physical effects considered evidence of “virilization.”

Where medical resources are available, intersex conditions apparent at birth have often been treated as a problem to be solved through medical means, despite the fact that most physical characteristics of intersex conditions do not pose immediate health risks. Many people born with intersex conditions are subjected to involuntary surgical procedures soon after birth or during childhood, permanently changing their bodies to conform to the gender binary, regardless of the substantial risk of physiological damage inherent in such procedures, as well as the frequent emotional and social difficulties that people who have been subjected to involuntary surgery report (Davis, 2015).

As I will discuss, feminist new materialist perspectives reveal that because the social and the material are intertwined and inseparable, sex and gender are socially constructed as well as biological. This validates the need for trans and gender diverse people to access gender affirming physical procedures as well as hormone replacement, challenging the idea that the meaning of bodies can be resignified purely in the realms of the cultural and social, making physical, embodied changes “unnecessary.” This could be understood as a corollary of the social constructionist view, where matter may be understood as having no meaning outside that which is brought to it through language[16] (Burr, 2003, pp. 46–48, 50–56, 62). In contrast, new materialist perspectives recognize that matter has its own agency and its own effects (Barad, 2003), which we can and should engage with, instead of ceding the territory of the body or seeking to depoliticize the material (Tremain, 2002).

Gender Nonconformity and Psychiatry

Although gender non-conforming people have been subjected to various forms of “treatment” throughout the history of psychiatry (Terry, 1999, pp. 83–84), no specific diagnosis relating to this "problem" existed until the introduction of Gender Identity Disorder of Childhood (GIDC) and Transsexualism in *DSM-III* in 1980, the first edition of the *DSM* in which Homosexuality did not appear (Valentine, 2007, p. 55). The diagnoses of GIDC and Transsexualism were introduced as a result of two factors: First, from the late 1940s onward in Europe and the United States, physicians and psychologists had been conducting research on increasing numbers of trans adults, many of whom were interested in changing their social gender or having gender confirming physical treatments (Califia, 2003, pp. 52–66; Meyerowitz, 2002, pp. 43–50, 106–111, 141–154; Reicherzer, 2009, p. 31), rather than attempting to alleviate their dissatisfaction with their assigned sex by means of treatments such as psychotherapy, "carbon dioxide therapy," aversion therapy, ECT, lobotomy, and institutionalization (Bryant, 2007, p. 67; Dittman, 2003, p. 51; Fallowell & Ashley, 1982, pp. 29–32; Meyerowitz, 2002, p. 135). During the 1960s and 70s, some trans people became engaged in political struggles for social and legal recognition.[17] Some of the more radical members of the movement rejected the psychiatrization of gender variation, arguing that a psychiatric diagnosis would be unnecessary if surgery and hormonal treatment were made available on demand to trans people who wished to access them, but this idea was rejected by medical professionals. As a result of this, many of the more liberal activists were interested in having "Transsexualism" recognized by the APA as a diagnostic category to improve access to gender-confirming medical treatments (Meyerowitz, 2002, pp. 228, 255), as well as to bolster their claims to legal rights (Meyerowitz, 2002, pp. 253–254).

Second, gender non-conforming children came to be regarded as problematic between the 1950s and the 1970s, particularly in the United States. Bryant (2007) argues that the reason for the sudden problematizing of this issue is the confluence of several factors, including "white masculinity crises, the rising hegemony of psychological understandings of personal troubles and public issues, the gender upheavals of the Great Depression and World War II, and the rising visibility of homosexual communities" in addition to questions concerning whether treating gender non-conforming children could prevent the development of homosexual or transgender adults (pp. 55–56, 63–65). In fact, preventing homosexuality would become one of the major objectives of most treatment for GIDC, even after the removal of the diagnosis of Homosexuality from the *DSM* (Ault & Brzuzy, 2009, pp. 187–188; Lev, 2005, pp. 49–50; Sedgwick, 1991, p. 22).

GIDC and the Prevention of Homosexuality

The prevention of homosexuality was one of the stated objectives of the original research on which the GIDC diagnosis would be based (Bryant, 2007, pp. 79-82; Burke, 1996, pp. 49, 144–145; Califia, 2003, p. 67). Similarly, the fact that gender nonconformity in childhood is the "most robust predictor of homosexuality" would later be noted by the committee of the APA that worked on revising the Gender Identity Disorder criteria for *DSM-IV* (Cotton, 1993, p. 14). Grant (2001) points out that the "sissy boy" was regarded as threatening to the hypermasculine identity of the United States in the context of the Cold War (p. 118). It is perhaps no coincidence then that substantial government funding became available to researchers to study this issue (Bryant, 2007, pp. 56, 69–70; Burke, 1996, pp. 46–47). They interviewed and observed thousands of "effeminate" boys, but could not agree whether the boys' effeminacy had a biological basis or whether it was psychogenic, although all agreed that treatment was necessary (Bryant, 2007, pp. 94–113).[18]

The entry for GIDC in *DSM-III* stated that it differed from commonplace "tomboyishness" or "sissyness," instead representing "… a profound disturbance of the normal sense of maleness or femaleness" (American Psychiatric Association, 1980, p. 264), however, the bulk of the text describing the diagnosis was a list of typical "tomboyish" and "sissy" behaviour:

> Girls with this disorder regularly have male peer groups, an avid interest in sports and rough-and-tumble play, and a lack of interest in playing with dolls or playing "house" (unless playing the father or another male role).
>
> Boys with this disorder invariably are preoccupied with female stereotypical activities. They may have a preference for dressing in girls' or women's clothes, or may improvise such items from available material when genuine articles are unavailable. (The cross-dressing never causes sexual excitement.) They often have a compelling desire to participate in the games and pastimes of girls. Dolls are often the favorite toy, and girls are regularly the preferred playmates. When playing "house," the role of a female is typically adopted. Rough-and-tumble play or sports are regularly avoided. Gestures and actions are often judged against a standard of cultural stereotype to be feminine (American Psychiatric Association, 1980, p. 264).

Conversion Therapy for Gender Non-Conforming Children

Treatments for children diagnosed with GIDC (and later Gender Identity Disorder [GID], following the 1994 release of *DSM-IV*, which collapsed GIDC and Transsexualism into this single category) (American Psychiatric Association, 2000) were intended to force children to conform to stereotypically masculine or feminine standards of behaviour. This form of conversion therapy often involved abusive treatment practices. This included long-term inpatient psychiatric treatment, often featuring behaviourism-based interventions requiring conformity to gender stereotypes of appearance and behaviour. Survivors of conversion therapy for GIDC and GID also reported being subjected to abusive counselling, forced medication, isolation and restraints. These treatments were degrading and traumatic, resulting in significant, long-term emotional distress (Scholinski, 1997; Volin, 2005; Winters, 2008). While behaviourism, psychotherapy and medication dominated the "care" of GIDC patients during the 1980s and 1990s, other damaging treatments such as ECT and hormone injections were also used (Burke, 1996, pp. 76–84; Pela, 1997, p. 55; Winters, 2008).

Gatekeeping Gender Confirmation for Adults

Even prior to the creation of the DSM diagnosis of Transsexualism, adults wishing to undergo gender confirming procedures faced medical gatekeeping that denied them the right to make choices about their bodies. In the United States from the 1960s until the 1980s, access to transition was controlled by a limited number of gender clinics, which were often affiliated with universities (Schilt, 2010, p. 21). In Canada, a gender clinic opened at the Clarke Institute[19]—now CAMH—in Toronto in 1968 (Daubs, 2016; James, n.d.), and a children's gender clinic was established at the same institution in 1975 (Singal, 2016). Given the centrality within the Canadian health care system of the CAMH gender clinics, it is arguable that the gender clinic model persisted as until the mid-2010s in Canada. From their inception, gender clinics upheld a medicalized, pathologizing view of trans people. At the same time, cultural beliefs about gender were taken for granted by clinicians and imposed on clients (Schilt, 2010, pp. 22–23). For instance, access to treatment was often contingent on clinic psychiatrists' perceptions of patients' physical appearance and their ability to “pass” as cisgender following their transition (Barrett, 2007, pp. 10, 15, 73, 104; Denny, 2004, p. 29; Rivers, 2007, p. 344; Schilt, 2010, pp. 24–25; Seil, 2004, pp. 102–103). Gender clinic clients were often expected to completely hide their gender history from as many people as possible. This often meant ending relationships and friendships, leaving an existing job, and moving (Schilt, 2010, p. 22). In the gender clinic model, it was often the case that only those who avowed that they would be heterosexual following their transition would be permitted to undergo transition (Denny, 2004, pp. 29–30; Rubin, 2006, p. 494; Seil, 2004, pp. 104–105). Due to these profoundly biased restrictions, many prospective patients were rejected by gender clinics: As Schilt (2010) points out, less than 10% of the people who sought care at Stanford University’s gender clinic between 1969 and 1973 were granted access to surgery (p. 25).

Schilt (2010) notes that from the 1990s onward in response to trans activism, a broader range of options for accessing transition have become available in the United States, with more doctors from outside the clinic system beginning to provide transition-related care to clients. At the same time, activists continued their challenges to pathologizing and stereotype-driven DSM criteria, as well as the rigidity of the “standards of care” first published by the Harry Benjamin International Gender Dysphoria Association, now called the World Professional Association for Transgender Health (WPATH) (Schilt, 2010, pp. 29–34). As I note above, in Canada the gender clinic system remained relatively more important until fairly recently, as it was positioned as the sole gatekeeper of access to publicly funded gender confirming surgical treatment until 2016 (Ontario Ministry of Health, 2016). At the same time, access to care gradually became less centralized in response to similar pressure from activists as well as advocates and supporters within health care systems in Canada (Fraser, 2016). Despite this loosening of restrictions, people seeking access to medications, hormone treatments or surgery as part of gender confirming treatment are still required to be assessed and recommended for treatment by either one or two qualified health care providers (Ontario Ministry of Health, 2021).

Until recently, the process of gaining approval for gender confirming treatment was often complicated and difficult, requiring consultations with general practitioners, psychologists, psychiatrists, endocrinologists and surgeons (Barrett, 2007, pp. 9, 62–63, 72; Califia, 2003, p. xxii; Shelley, 2008, pp. 68–70). Securing a diagnosis and the specific types of treatment offered were often contingent upon the personal beliefs of the clinicians that the person seeking treatment happened to consult, rather than any defined standard or the desires of the patient (à Campo et al., 2003; Shelley, 2008, p. 161). People who lived in smaller cities or rural areas often had limited or no access to practitioners who were willing to provide a diagnosis and treatment (Shelley, 2008, p. 67), a problem that has persisted in Canada (Blodgett et al., 2017).

From GID to Gender Dysphoria

While it is clear that conversion therapy and the medical gatekeeping of people seeking access to transition-related care have been significant problems for the trans and gender diverse communities, in contrast to the fight to have Homosexuality removed from the *DSM*, supporters of trans rights have been divided about the removal of diagnoses pertaining to being transgender. Those who have called for the removal of these diagnostic categories have argued that they pathologize something that should not be considered as such, even in accordance with the *DSM*'s own definition of pathology (Bartlett et al., 2000; Langer & Martin, 2004, p. 11). Some have argued that societal values concerning gender are what is truly problematic (Denny, 2004, p. 31). Discussing the many horrific acts of violence to which trans people have been subjected, transexual[20] activist Wilchins (1997) writes, “the regime of gender is an intentional, systemic oppression” (p. 25). Wilchins argues that because gender is contingent and not “natural,” it is nonsensical to consider only those people whose gender performance diverges from the socially determined norm as pathological.[21]

Advocates for the removal of transgender-focused DSM diagnoses have also pointed out the stigmatizing effects of the listing of transgender as a “mental disorder” (Burns, 2003, p. 193; Girshick, 2008, p. 165; Kamens, 2011, pp. 38–39; Vance et al., 2010, pp. 6–7), in a context in which people considered “mentally ill” are often perceived as flawed and dangerous. The status of transgender as “mental illness” has been used to justify discrimination against trans people in areas including child custody agreements, employment, and access to health services (Meyer-Bahlberg, 2010, pp. 468–469). That noted, the act of transgressing gender norms in itself often functions as a basis for discrimination and violence against trans people and others who are gender non-conforming (Devor, 2004, p. 60; Kailey, 2005, pp. 78–79; McCloskey, 1999; Shelley, 2008, pp. 46–48, 65, 71; Wilchins, 1997, pp. 19–25).

Supporters of the retention of diagnoses pertaining to being transgender in the *DSM* generally agreed that the diagnosis of GID was flawed and in need of revision. Most proposals for its revision argued that the inclusion of the category in the *DSM* was necessary, but its focus on gender nonconformity rather than gender-based dysphoria was counterproductive (Bockting & Ehrbar, 2005; Ehrbar, 2010, pp. 71–72; Ehrbar et al., 2008, pp. 400–402; Haraldsen et al., 2010; Lawrence, 2010). Supporters also argued that if a transgender-related diagnosis remained in the *DSM*, it could be used to justify the expenditure of public funds for hormonal and surgical treatment, which many trans people want and are unlikely to be able to afford on their own, given both the high costs of the procedures and the fact of trans people’s high rates of unemployment and underemployment (Bockting & Ehrbar, 2005, p. 132; Califia, 2003, pp. 265–266; Valentine, 2007, p. 275; Narrow & Cohen-Kettenis, 2010, p. 127; Pascal, 2008; Seil, 2004, p. 104).[22] For example, in most Canadian provinces, some types of genital surgery are covered by public health insurance, as is bilateral mastectomy (Ontario Ministry of Health and Long Term Care, 2008). That noted, many other gender confirming procedures are not covered by insurance. The retention of a diagnosis related to being transgender could also serve as a basis for rights claims under disability laws, especially in the United States, where disabled people are protected by the Americans with Disabilities Act, but discrimination against transgender people is often not prohibited (Levi & Klein, 2006; Wahlert & Gill, 2017).

Ultimately, some arguments concerning the problematic nature of GID were taken up by the authors of *DSM-5*'s Sexual and Gender Identity Disorders Work Group[23] who recommended the replacement of the diagnosis of GID with the diagnosis of Gender Dysphoria (GD). As the Work Group members explained, the GD criteria retained many of the characteristics of the GID diagnosis, but drew from perspectives of trans activists and allies as well as other experts in the field of trans care (including the members of WPATH) to identify emotional distress around gender identity as the primary problem rather than labelling non-normative gendered behaviour or identifications as in themselves "disordered" (Drescher, 2014, p. 10–12). Some critics of the move from GID to GD have pointed out that not all trans people experience dysphoria, which could limit access to care for trans people who do not fit the DSM criteria (Ashley, 2019a). Others have commented that the change did not go far enough in recognizing gender diversity as the part of human diversity it has always comprised (Rosario, 2011, pp. 1–3), As Lev (2013) writes,

> The story of Gender Identity Disorder, and the new diagnosis of Gender Dysphoria, is a narrative of an oppressed people and their liberation struggle, amid the psychobabble of gender conformity, mental illness, and medicalization of human diversity (p. 290).

Lev's argument is that the removal of transgender-focused diagnoses from the *DSM* would serve as a crucial step in moving away from pathologization and toward a rights- and identity-based understanding of transgender (pp. 293–295). In contrast, Withers (2013) argues that advocates who support the deletion of "the trans sections of the *DSM*" while remaining silent about the problematic nature of the manual's other contents may be motivated primarily by ableism (p. 46).

From Conversion to Affirmation and Informed Consent

Reflecting the unsettled status of this situation, parents of children labelled with GD have received conflicting advice about how to proceed. Some clinicians have advocated a "wait and see" approach, under the assumption that the majority of gender non-conforming children will eventually "desist," so access to medical interventions should be prohibited until a consistent trans identity is evident in later adolescence (Ehrensaft, 2018; pp. 38–39; Keo-Meier & Ehrensaft, 2018, pp. 12–13). Other clinicians have retained a "reparative" or conversion approach, recommending that parents encourage gender conformity by carefully monitoring and controlling their child's gender expression. The objective of the approach is to help children to feel "comfortable" with their gender as assigned at birth (Hill & Menvielle, 2009).

These approaches have been widely challenged by trans and queer activists, as well as allies in the field of children's mental health who have argued that any directives that deny children the right to express themselves is inherently damaging, so children's gender nonconformity should be completely accepted (Brill & Pepper, 2008; Hill & Menvielle, 2009, p. 256). This perspective has given rise to a shift toward the gender affirming model, wherein children are socially supported in exploring their gender expression and identity, and conformity to cisgender norms is not required or even regarded as a more desirable outcome (Anderson, 2018; Keo-Meier & Ehrensaft, 2018). The affirming model also enables children to access medical interventions such as puberty blockers, if desired. This approach has expanded access to care for trans and gender diverse children, but it is still by no means universally available (Pullen Sansfaçon et al., 2019).

For adults who seek access to transition-related medical care, movement toward an informed consent-based model has also taken place in recent years. The informed consent model eliminates some barriers caused by medical gatekeeping and aims to centre the epistemic authority of the person seeking access to transition-related medical care (Ashley, 2019a; Schulz, 2018). Similarly to the affirming model, informed consent-based care is not always available. Further, in Ontario, a formal diagnosis of GD is still required for access to OHIP-funded gender confirming care (Ontario Ministry of Health, 2021; Rainbow Health Ontario, 2020). Such a diagnosis can now be made by a much wider range of health care providers (including nurse practitioners and family doctors), and the same providers are also permitted to prescribe hormone replacement therapy without making a referral to a specialist. While this has allowed more people to access care, many practitioners have limited understanding of gender diversity and remain reluctant to provide transition-related care (Blodgett et al., 2017).

New Obstacles to Accessing Care

A conservative backlash against the greater visibility and acceptance of trans and gender diverse people has arisen in recent years. Among English-speaking countries in the Global North,[24] the so-called “gender critical” movement is centred in the United Kingdom and the United States, with logistical and financial support from conservative organizations in the latter country. The movement has worked to demonize trans people—especially trans women—as somehow threatening to the rights and safety of cisgender women as well as children (Dugyala, 2021; Lewis, 2019; Pearce et al., 2020). This has led to substantial rises in hate crimes against community members (Bradley, 2020). Proponents of this perspective have also mounted opposition to the legal recognition and social inclusion of trans people, and have worked to support legal cases and legislation aiming to limit access to gender confirming care. In the United Kingdom, the Bell decision meant that without parental support, trans and gender diverse children under 16 would not be able to access publicly funded care related to gender identity (Parsons, 2020). In the United States, a wave of state laws prohibiting children from accessing treatment for gender dysphoria have been proposed and passed (alongside similarly transmisogynist legislation that block trans women from accessing public washrooms, and laws prohibiting trans girls from participating in school-based sports) (American Civil Liberties Union, 2021; Serano, 2021). Although some of these laws may not withstand legal challenges, they represent a significant additional barrier to accessing care in the affected jurisdictions, and caution is warranted in regions such as Canada that have not yet been as widely impacted by these efforts aimed at perpetuating hatred and exclusion.[25]

Conclusion

Despite the recent rise of the informed consent model, the retention of the requirement to be diagnosed with GD to access publicly funded transition-related care in Ontario means that many trans people remain subject to psychiatrization. A proposed alternative to the *DSM* label of GD is to include “an alternative non-pathologizing category” for transgender in the International Classification of Diseases (which lists all types of diseases, rather than only “mental disorders,” unlike the *DSM*) (Wareham, 2009), which would enable trans people to access medical care while maintaining a separation between transgender and “mental illness” (Lev, 2013, p. 294). I would argue that this proposal is flawed in that it reifies the other *DSM* categories, doing nothing to challenge the fundamental problem of psychiatry’s role as an agent of social control. This has been illustrated historically with the removal of the psychiatric diagnosis of Homosexuality from the *DSM* in 1973, which allowed queer people to make a claim to normalcy, instead of provoking questions about the basis of the process by which specific behaviours, affective states, beliefs, and identity markers come to be considered indicative of pathology and therefore as requiring treatment aimed at their elimination or control.

Chapter Three: Well-Being, Wellness and Resilience

Introduction

"Well-being," "wellness" and "resilience," are words that arise frequently within mental health discourses, including in the policy statement *Open Minds, Healthy Minds*, which outlined the government's approach to mental health care at the time this research was undertaken. Despite the frequency of their appearance and their apparent importance to the strategy, these terms remained undefined within the document, reflecting how the use of these concepts is often characterized by vagueness and overlap (Kimhi, 2014 p. 2). In this chapter I provide an overview of the theoretical foundations of each concept, to better illustrate what might be intended through their use by policy makers and practitioners. While each of these terms could be dismissed as empty buzzwords[26] sharing positive connotations of person-centredness and holism, their uses in fact reflect their particular conceptual roots. I argue that the intended meanings of these terms should be clarified so as to facilitate their contestation, noting that some of these meanings hold more liberatory potential than others.

Well-Being

Defining Well-Being

There is no singular, broadly-accepted definition of well-being. The concept has been the matter of inquiry from a broad range of perspectives within and beyond disciplines including philosophy, psychology, health promotion, development, and economics (Schensul, 2019, p. 99). As I will discuss, Indigenous perspectives on well-being describe it as living in balance with the self, others, and the environment (Blue Bird Jernigan & Haring (2019). As health researchers

Page-Reeves and McKinney (2019) point out, that no consensus exists as to what "well-being actually is or means" (p.3), but they argue despite this lack of clarity, it is generally recognized that the concept exceeds the bounds typically associated with individual wellness. They note that psychological and economic instruments designed to measure well-being across populations include themes related to a wide range of personal and social dimensions, including "mental, social, physical and spiritual well-being, plus personal activity level, physical and mental functioning, and economic circumstances" (p. 3). That stated, the idea that the concept of well-being necessarily accounts for factors extending beyond the individual is not universally accepted, with some well-being researchers retaining a focus on individual lifecourses and health outcomes rather than attending to community-based dynamics (Shiell & Hawe, 1996; Trickett & Rauk, 2019, p. 75).

Western Philosophies of Well-Being

Despite the lack of a clear definition, the concept of well-being has been the subject of contemplation and study for thousands of years. Eger and Maridal (2015) explain that in European thought from the ascendency of Ancient Greece and Rome until the Enlightenment of the 1700s, the notion of "happiness" typically referred to "a life worth living," which is something more akin to current holistic conceptions of well-being rather than the positive feeling of happiness itself. They write that a "truly happy person [was one who] pursued virtue over the course of a lifespan" (p. 45). The notion of well-being as characterized by living a worthy, virtuous life has often been referred to using the Aristotelian concept of "eudaimonia" or flourishing. Whether someone achieves eudaimonia is determined by how close they come to achieving the highest levels of human potential (Forgeard et al., 2011, pp. 89-90). Aristotle considered eudaimonia and true happiness to be one, writing, “living well and doing well are the same as being happy” (Laurent 2018, p. 4). Laurent (2018) notes that Aristotle drew a distinction between what he considered to be false happiness based solely in pleasure, and true happiness, which he defined as engagement in what he understood as the most edifying activities in which a person could engage: “higher learning and public life” (p. 77). This, of course, reflected Aristotle’s position in society. The majority of people were barred from access to such public institutions at the time and would therefore have been incapable of achieving eudaimonia (Heath, 2008).

Eger and Maridal (2015) argue that Bentham’s development of the hedonic theory of utilitarianism in 1789 played a key role in shifting the definition of happiness away from referring to eudaimonia/flourishing and toward its more common current definition, as a descriptor of a hedonic/pleasurable feeling (p. 46). Since that time, many philosophers have considered whether hedonism might be the most robust theory of well-being, or whether other approaches might best capture its essence. For instance, in addition to hedonism, Bradley (2015) lists desire fulfilment, the capabilities approach (in part rooted in Aristotelian eudaimonia theory)/pluralism/“the objective list theory,” utilitarianism, and deontology as alternatives, but concludes that hedonism—which, as he notes, is the perspective grounding most social science based research into the topic (p. 111)—is perhaps the best way to understand well-being, although he concedes that this is not the most popularly-held position among philosophers of well-being (p. 111). Bradley explains that beyond pleasure in itself, other dimensions of life often identified as components of well-being, such as “friendship, desire fulfillment, developing one’s capacities, knowledge, meaningfulness, [and] freedom” (p. 108) are things that make people happy, and argues that to get pleasure, it is generally more effective to pursue other things than to pursue pleasure directly (p. 109).

There have been many further contemporary philosophical explorations of the concept of well-being: For instance, Todres and Galvin's (2010) phenomenological work on the notion of well-being derives from an interpretation of Heidegger's concept of homecoming (pp. 2–3; Galvin & Todres, 2011, p. 2), which they use to construct a theory of well-being as both "a way of being-in-the-world and a felt sense of what this is like as an experience" (Todres & Galvin, 2010, p. 1). They describe this as "dwelling-mobility," outlining the many kinds of stillness and movement in relation to others and the environment that combine to create a full life (Galvin & Todres, 2011).

Objectivity and Subjectivity

Researchers and theorists often divide the components of well-being into "objective" and "subjective" domains. Objective aspects of well-being are theorized as being "determinants of quality of life" and can be measured through economic and social indicators (Eger & Maridal, 2015, p. 47) such as poverty rates, per capita income, community characteristics, social support, education completion, life expectancy, and health measures (Forgeard et al., 2011, p. 90). A particularly prominent objective list of well-being dimensions is found in Nussbaum and Sen's "capabilities approach," which states that a good life is one that is worth living and characterized by human dignity (Bradley, 2015, p. 56)

Nussbaum claims that the capabilities approach is universal, rooted in characteristics shared by all people (Nussbaum, 2000, pp. 70–86; Taylor, 2015, p. 75), but whether it—or any given list of objective measures of well-being—is necessarily comprehensive and relevant across contexts and to particular individuals can be questioned (Forgeard et al., 2011, p. 91). Other researchers have engaged in work to assist people to determine and cultivate their own notions of well-being. For instance, in a study undertaken with Mexican-born women living in Alabama, public health promotion researchers worked with participants to help them define and achieve what they personally understood as “la buena vida,” rather than imposing a pre-determined list of indicators of well-being upon them. Participants mentioned a broad range of items, from basic material goods to access to education, health care, leisure time, spiritual community, and relationships with others (Andrews, 2019).

Subjective dimensions of well-being include hedonic measures such a happiness/positive affect or emotion, as well as eudaimonic measures such as life satisfaction, accomplishment, meaning and relationships with others (Adler & Seligman, 2016 pp. 6–7; Forgeard et al., 2011, pp. 79–88).

Some psychology research has suggested that subjective well-being is more strongly determined by individual temperament and personality (or even genetics [Walker, 2011, p. 129]) than external factors. According to this theory, each person has an affective “setpoint,” and while external changes in circumstances may provoke a temporary affective shift, individuals will soon return to their personal emotional baseline (Angner, 2011, p. 36). Thus, for proponents of setpoint theory, objectively measurable circumstances have only a limited impact on most people’s subjective well-being. Other researchers have found substantial evidence to counter this claim, pointing out that the kinds of emotional lows sometimes described as depression are often either caused or exacerbated by difficult circumstances. They have argued that improving the well-being of people in these circumstances would necessitate going beyond providing individually-focused health care or wellness interventions, instead addressing determinants of health such as poor infrastructure, a lack of childcare, a lack of employment opportunities, and low income (Stoppard, 2000; LaFrance & Stoppard, 2006; Schoenberg & Snell-Rood, 2019).

Well-Being Across Populations

Prior to the rise of research directly targeting well-being measures themselves, gross domestic product was often used as a proxy measurement, with the idea being that a country's level of economic development would largely reflect the well-being of the population by reflecting the overall standard of living (Forgeard et al., 2011, pp. 79–80). It is clear that this is not the case, as GDP does not measure economic inequality within a country (Laurent, 2018, p. 36), non-monetized activities, or the many facets of social life that impact people's quality of life (Adler & Seligman, 2016, p. 17; Forgeard et al., 2011, p. 80). Population-level well-being research is intended to more accurately measure "how society is doing" (Forgeard et al., 2011, p. 80).

Economic and public health approaches to understanding well-being often deploy large-scale measurement tools intended to show the impact of multiple factors on the health and well-being of populations. Tools such as Gallup's Healthways Wellbeing Index (Adler & Seligman, 2016, p. 5) the OECD's Your Better Life Index, the United Nations' World Happiness Report, the Social Progress Index, and the Happy Planet Index (Adler & Seligman, 2016, pp. 6, 10–12) measure a range of subjective and objective factors such as life satisfaction, physical and mental health, income, basic needs, work, education and environment. Bhutan's famous "Gross National Happiness" survey was adopted in 1974 (Tantam, 2014, p. 89), and includes nine domains including psychological well-being, health, ecological diversity and resilience, and living standards (Centre for Bhutan Studies & GNH Research, 2016; Oxford Poverty and Human Development Initiative, n.d.). In Canada, the Canadian Index of Wellbeing (2016), which is a project based at the University of Waterloo, measures indicators from the following domains: "community vitality, democratic engagement, education, environment, healthy populations, leisure and culture, living standards, and time use" (p. 15). The project's most recent report found that improvements in well-being were not keeping pace with GDP growth, identifying particular problems in regard to the growing precarity of work, reductions in leisure time, increased rates of health difficulties, concerns about housing affordability, and poor environmental outcomes (pp. 1–7).

The measurement of well-being or happiness at the level of populations is certainly never value-neutral, and indeed it is often politically charged. For example, the government of Bhutan explicitly seeks to promote Buddhist values through their GNH research, whether or not those values are shared by the people (Tantam, 2014, p. 89). The Bhutanese government has also been criticized for paying scant attention to the happiness of the Nepali minority population (Laurent, 2018, p. 86). In the UK, a happiness survey undertaken by the Conservative government beginning in 2011 might be understood as a means of distracting from the austerity-driven program of cuts to services and support upon which the government had embarked, as well as an attempt to responsibilize people for negative outcomes stemming from those harmful policy choices (Cederström & Spicer, 2015, pp. 61–62).

The Eugenic Roots of Well-Being Research in Psychology

Angner (2011) notes that although the recent work of positive psychologists is sometimes perceived as the first serious engagement with the notion of well-being within psychology, the earliest research on the topic within the field actually dates as far back as the early 20th century. He cites Harvard University neuropathology professor and Taunton State Hospital director

Myerson's 1917 work promoting "eupathics," or "the wellbeing of the normal" (Angner, 2011, p. 5) as perhaps the first work to engage directly with the notion of well-being.

The full title of Myerson's article is "Eupathics – A Program for Mental Hygiene" (1917, p. 343). In it, Myerson clarified the relationship of his theory to that of eugenics:

> Now I have no quarrel with Eugenics, and indeed am greatly interested that its work of introducing genuine good breeding into society shall go on, but I quarrel with the Eugenists who make it the whole of a program of Mental Hygiene. My objections arise on two grounds: The one, logical; the second and more important, practical. Logically because the part is not equal to the whole. Practically, because the field of Mental Hygiene which I desire to emphasize has for its aim the *well-being of the normal*, while Eugenics largely simmers down to a program for the elimination of the unfit. *Eugenics* points out in charts and figure the cost of maintaining Insane Hospitals, Feeble-Minded Schools and Jails. *Eupathics,* its more gracious sister, speaks of means by which the mood of Mankind may be elevated. Essentially, it is a democratic program seeking to irradiate throughout Society the tone and mood that now graces the lives of the very few (p. 344).

Myerson recommended the promotion of physical health (pp. 345–346) and "social health"—through improved access to housing, financial stability, labour-saving technologies, and even changes to the tone of popular news and entertainment media as means through which people's moods can be improved (pp. 346–347). He recognized the deleterious impacts of precarity upon mood, writing, "To preach 'Don't worry' to the clear-sighted person continually foreseeing really imminent economic and social ruin is as futile as it is unsympathetic" (p. 346). Myerson's sympathy was reserved for those labelled as "normal," whose well-being had been negatively impacted by adversity. The well-being of those labelled as "unfit"—particularly those confined to the carceral institutions he listed in the above quotation—did not appear to be a concern of Myerson, and questions as to whether harmful social relations might have led to their incarceration were likewise left unconsidered in this article.[27]

Psychologists intensified their study of well-being in the mid 20th century, as more researchers sought to understand the psychological characteristics of people considered "ordinary," or at least not labelled as mentally ill (Dodge et al., 2012, p. 223). Thus, in well-being research, the distinction between "the normal" and those perceived as deficient persisted. An influential study at the time was undertaken by Jahoda (1958), who developed a set of multidimensional criteria for "positive mental health" (pp. 96–99), and questioned how and whether they might be applicable to those identified as mentally ill (pp. 103–104). Another important study was by Bradburn (1969), who invoked the concept of eudaimonia in positing that having an affect of happiness/well-being was the key factor determining how well people were able to cope with difficulties in their lives (Dodge et al., 2012, p. 223). This positioned well-being as in large part determined by individual characteristics, a line of thought that has also persisted in this area of study.

Positive Psychology and Well-Being

More recently, psychology research into well-being has become strongly identified with the "positive psychology" movement. As Kristjansson (2010) explains, this movement seeks to "replace a *disease-remedy* model of human functioning with a *wellness-enhancement* model," suggesting that the positive characteristics of humanity are as relevant and interesting as subjects of research as difficulties and dysfunction (p. 297). The movement was founded and led by US-based psychologist Seligman in the early 2000s (Becker & Marecek, 2008, p. 1767; Dodge et al, 2012, p. 225; Kristjansson, 2010, pp. 296, 298). While Seligman's earlier research focused on happiness as measured by life satisfaction (Seligman 2011, p. 12), he later moved toward a more comprehensive understanding of well-being aimed at promoting flourishing (2011, p. 26). Seligman's construct of well-being is summarized via the acronym PERMA: "Positive emotion; Engagement or flow; positive Relationships; Meaning or purpose; and Achievement" (Adler & Seligman, 2016, p. 5; Seligman, 2011, pp. 16–18). These items are intended to represent "domains of life that people pursue for their own sake" (Adler & Seligman, 2016, p. 5). Other positive psychology researchers have also put forth definitions and accounts of well-being and its function. For instance, Dodge et al. (2012) define well-being as "the balance point between an individual's [psychological, social and/or physical] resource pool and the [psychological, social, and/or physical] challenges faced" (p. 230).

The positive psychology approach is generally individualistic, seeking to measure and improve personal well-being (Adler & Seligman, 2016, pp. 6–10). It positions well-being as a set of skills and values that each person can learn. Adler and Seligman (2016) argue in favour of "positive education," which teaches "the tools for wellbeing" across formal and non-formal settings (Adler & Seligman, 2016, pp. 16–17). This is consistent with the approach put forth in the *Open Minds, Healthy Minds* policy document (Ontario Ministry of Health and Long-Term Care, 2011), which promotes similar educational efforts as a key means of facilitating good mental health. The objective of positive education is to enable each individual to control their thoughts and behaviours through engaging in practices and techniques intended to reduce negative feelings and improve mood, thereby facilitating better functioning in life (Seligman et al., 2009).

Political Critiques of Positive Psychology's View of Well-Being

As I noted above, the Aristotelian notion of eudaimonia or flourishing was inaccessible to most due to the political realities of the time and place, which positioned a small minority of Greek men as aristocrats while all others were excluded from power and civic participation, and many were enslaved (Frank, 2004, pp. 94, 101–102). Aristotle argued that because the cultivation of virtue through engagement with politics and philosophy was fundamentally a leisure activity, if everyone had to do their own labour no one would have adequate time to achieve eudaimonia. As such, he believed that for those in power to live virtuous lives of well-being, the majority would have labour on their behalf (Frank, 2004, pp. 91–92). He saw no problem with this arrangement due to his beliefs in the existence of "natural slaves" as well as the inherent inferiority of women (Heath, 2008). In the contemporary situation of increasing financial and social inequality under neoliberalism, I wonder whether in some ways positive psychology's vision of flourishing might in some regards be similarly inaccessible today? Its proponents would never suggest that enslavement is acceptable, and most would very likely reject claims as to the inherent inferiority of women. But the fact that the most prominent perspective on well-being within positive psychology is based upon a concept of well-being that was only ever intended to reflect the positionality and interests of a powerful few seems to resonate with the current situation.

Positive psychology theories of well-being have been critiqued as lacking applicability to those who are not beneficiaries of privilege (Coyne, 2013). As Becker and Marecek (2008) explain, positive psychology understands well-being as simply “a matter of private satisfaction,” and is unconcerned that it is not something that everyone can access or achieve (p. 1774). They write,

> The good life is not readily or equally available to all. Disparities in status and power resulting from social class, gender, skin color, race, nationality, and caste, markedly influence well-being. These structural differences dramatically affect one’s access to healthcare, educational and economic opportunity, fair treatment in the criminal justice system, safe and secure living conditions, a promising future for one’s children, and even mortality… What kind of fulfillment is possible in the absence of these basic conditions? To suggest that self-help exercises can suffice in the absence of social transformation is not only short sighted but morally repugnant (p. 1771).

The idea that learning techniques intended to promote well-being is an adequate substitute for fair and adequate social provisioning is clearly problematic, but the positive psychology framework does not account for the existence of structural oppression or inequality (Becker & Marecek, 2008, p. 1772). In fact, Seligman (2011) has explicitly stated that material political analysis is not relevant to his theory of well-being:

> There is a politics behind positive psychology. It is not a politics of left versus right, however. Left and right are the politics of means—empowering the state versus empowering the individual—but, stripped to essentials, they both advocate similar ends: More material prosperity, more wealth. Positive psychology is a politics that advocates

> no particular means but rather another end. That end is not wealth or conquest but well-being. Material prosperity matters to positive psychology, but only insofar as it increases well-being (p. 221).

Seligman does not consider how the well-being of the vast majority of individuals who are not in fact "empowered" by right wing political choices might be impacted by the adverse—immiserating rather than prosperous—material conditions they create.[28] The person most likely to achieve high levels of well-being being in accordance with the positive psychology framework is quite likely to be one of the few for whom the existing political reality works well. That person might look very much like the "passive nihilist" described by anarchist philosopher Critchley (2007): "Rather than acting in the world and trying to transform it, the passive nihilist simply focuses on himself and his particular pleasures and projects for perfecting himself" (p. 4).

As Becker and Marecek (2008) explain, positive psychology is rooted in the "middle class culture of the United States" in similar ways to previous popular individualistic positive thinking and self-improvement movements, going perhaps a step further than predecessors by "promot[ing] self-enhancement and personal fulfillment as *the* goals of living" (p. 1768). Despite its clear boundedness within mainstream/privileged US culture, positive psychology constructs are often claimed to be universal in ways that are not supported by evidence. For instance, Seligman claims that the "moral virtues" and "character strengths" that comprise his "Values In Action" project are applicable across every society (Kristjansson, 2010, p. 305–306), but evidence suggests that this is not the case (Coyne & Tennen, 2010; Shryack et al., 2010). Further, positive psychology perspectives presuppose and valorize the notion of the individual as autonomous, and while this is often a taken-for-granted assumption, it is not inarguably valid, and may be even less relevant in cultural contexts in which an “interdependent self-concept” prevails (Kristjansson, 2010, p. 299).

Famously, positive psychology claims that its techniques to promote well-being have benefits beyond the psychological and emotional, going so far as to suggest that the positive emotions, “fighting spirit” (Coyne & Tennen, 2010, p. 17; Coyne et al., 2010, p. 39) and optimism that they promote play a role in improving clinical outcomes and longevity among those experiencing a range of serious illnesses, including AIDS, heart disease, and cancer. The findings showing that people’s personal attitudes and/or their engagement with positive psychology’s well-being enhancing techniques are generally not supported by solid evidence (Coyne, 2013; Coyne & Tennen, 2010, p. 17; Coyne et al., 2010). The utility of positive psychology techniques even for emotional difficulties such as diagnosed depression is similarly unproven (Tantam, 2014, p. 49).

Beyond the disavowal of its cultural specificity and the demonstrated lack of validity of some of its key constructs and claims, positive psychology as a field has also been criticized for its questionable funding and commercialization streams, including those embracing pseudoscience (Coyne, 2015) as well as prominent researchers’ engagement with ethically questionable and empirically unproven resilience training for military members, as well as allegations of morally indefensible involvement with the development of the CIA’s “enhanced interrogation” torture techniques (Coyne, 2015).

Well-Being and Ableism

Although ableist ideologies have suffused positive psychology concepts of well-being from their inception, similarly problematic assumptions are found in notions of well-being arising from other schools of thought. For instance, as Marcum (2019) explains, within a society in which “a life worth living” is often explicitly characterized as a non-disabled life free from impairment or even encumbrance, the concept of well-being is often wielded as a weapon to justify the devaluation and exclusion of disabled people (p. 149). Those who are understood as inherently unable to achieve well-being can be ignored, their needs and interests disregarded. Marcum argues that society’s response to disability is what results in limitations to well-being for disabled people:

> Common conceptions of disability and well-being … reveal how well-being is shaped by culturally specific and historically contingent notions of what constitutes a “good” or “happy,” “healthy,” and “prosperous” life and suggest that well-being is relational and highly dependent on one’s position in society and on one’s ability to obtain or fulfill basic needs such as housing, transportation, access to the community, rewarding activities and relationships, and support in completing the ordinary tasks of daily life, such as toileting, bathing, and eating (p. 149).

In Ontario, as in most North American jurisdictions, publicly funded social, housing, personal service and financial support programs for disabled people have long been recognized as deeply inadequate, both in regard to how many people who require them are excluded from access due to unfair restrictions and limits placed upon resources, and in the level of support that they provide to those who are able to access them (Chouinard & Crooks, 2005; Lightman et al., 2009; Smith-Carrier, 2020). Policy choices that deprioritize disabled lives diminish the well-being of disabled people.

Indigenous Perspectives on Well-Being

Many scholars have considered the connection between concepts of well-being and Indigenous ways of knowing. For example, Trickett and Rauk (2019) describe the medicine wheel as illustrating “a balance of the physical, cultural, emotional and spiritual” (p. 84) that reflects multiple facets of well-being. Blue Bird Jernigan and Haring (2019) have developed a framework for understanding well-being from Indigenous perspectives. They write that although each Indigenous community has its own understanding of well-being, developed across time in relation to place and culture, there are important points of connection between these viewpoints, particularly around the concepts of “interconnectedness”—within and between people, across generations, as well as between the physical, mental, emotional, spiritual, and the environmental (p. 181); “balance”—“the state of being when one’s spiritual, mental, physical and emotional world operate in harmony” (p. 183); “the Good Mind”—a Haudenosaunee concept focused on peace, strength, power and love, experienced when a “meaningful balance” is achieved “between self, others, and environment” (p. 184); “One Dish, One Spoon”—an understanding of shared resources in the best interest of all (p. 185); and “sustainability”—exemplified by “seven generations thinking” which centres future generations in considering sustainability (p. 185).

Smith et al. (2018) explain that for some transgender Indigenous people, cultural knowledges embracing the existence of Two Spirit people can lead to greater acceptance and inclusion, thus contributing to improved well-being. An Apsáalooke (Crow) participant in their study explained that in their nation prior to colonization,

> … When a child was born they weren't assigned male or female. When a child was born they have a child. The reason why Two Spirit people are at a higher level is… a majority of the Two Spirit people in our history had medicine. Had powers and stuff like that. And [the members of the Crow tribe] see them as wiser… because there is that status of medicine in the background" (p. 127).

This is just one specific example of how Indigenous ways of knowing and being have promoted well-being, whereas colonizer ideologies have been harmful. The suppression and replacement of Indigenous knowledges is a key means through which the process of colonization has operated from its inception. Many scholars have pointed out that historical and ongoing colonial relations have done much to damage the well-being and health of Indigenous people (Blue Bird Jernigan & Haring, 2019; Reading & Halseth, 2013; Sasakamoose et al., 2017, p. 4). As Sasakamoose et al. (2017) point out in their work describing the development of the Indigenous Cultural Responsiveness Theory to improve Indigenous well-being, when signing Treaty 6, the First Nations signatories shared their land in exchange for certain resources and medical services, but they "did not surrender their traditional healing practices or medicines. Instead, they stood to protect their health system and supplement this section with Western medical care and medicines." They write that if the government had honoured the treaty, Indigenous people could have been "among the healthiest in Canada" due to their access to both health systems. Instead, the program of genocide to which the government and non-Indigenous people have subjected the

First Nations has been the cause of high rates of health difficulties among Indigenous people across Canada (pp. 3–4).

For Indigenous people, decolonization is the means to restore well-being. This happens through the restoration of Indigenous sovereignty and self-determination (Blue Bird Jernigan & Haring, 2019, p. 186), reparation and healing in relation to the trauma of colonization, and the embrace within each community of culturally-based healing practices that seek to restore "balance in the four realms of spiritual, emotional, mental and physical health" (Sasakamoose et al., 2017, pp. 3–4, 6).

The Well-Being of Trans and Gender Diverse People

Studies of the well-being of trans and gender diverse people have found that there are often disparities between members of this group and the general population. A New Zealand-based survey of high school students found that gender diverse students were less likely to believe that at least one of their parents cared about them, and were more likely to experience symptoms consistent with a diagnosis of depression, to have engaged in self-harm, to have attempted to die by suicide, and to have experienced bullying or violence, particularly in the school environment (Clark et al., 2014, pp. 95–96).

A study of the well-being of LGBT+ adults from across the United States (Warren et al., 2016) found that transgender women had a higher incidence of depression symptoms, anxiety and stress in comparison with cisgender LGB participants. They were also more likely to be in recovery from substance use, and to report lower levels of social support (pp. 118, 119). Despite this, transgender women were less likely to report needing mental health care or to have had a history of mental health concerns, which the researchers suggest could be a result of the prevalence of discriminatory attitudes and practices in health care that make it difficult for transgender women to access services (pp. 119–120). Transgender men also experienced increased levels of depression symptoms, anxiety and stress, as well as lower levels of social support and self-esteem when compared with cisgender participants (p. 118). Non-binary/genderqueer participants' responses were generally more similar to those of cisgender participants than to the responses of other transgender participants, but they were more likely to have experienced mental health difficulties in the past, and were also more likely to have recently considered themselves as in need of mental health care than cisgender participants (p. 121).

Research with transgender adults living in rural Montana (Smith et al., 2018) found that many people felt unsafe due to living in unaccepting, socially and politically conservative communities (p. 123). Many reported experiencing employment discrimination, and often noted that a lack of legal protection against this form of discrimination made them more likely to experience job loss and more vulnerable to abuse and harassment at work (p. 124). Participants also reported significant difficulty accessing care for physical and mental health concerns, as well as for transition-related services. Because having the ability to transition in ways of their choosing is vital the well-being and mental health of transgender and gender diverse individuals, lacking access to needed services is especially problematic (p. 124). Participants identified support from family, friends and romantic partners as particularly important to their well-being (pp. 124–127).

Wellness

Defining Wellness

The distinction between well-being and wellness is not always clear. The two terms are frequently used in ways that seem interchangeable, often appearing when addressing the promotion of mental and physical health rather than the treatment of illness (Schensul, 2019, p. 99). I have provided an extensive discussion of the uses of well-being above, noting the range of underlying perspectives that shape its various meanings. I would argue that the main distinction that seems to be found between it and wellness, is that while using the terminology of well-being sometimes connotes a recognition the social and structural upon multiple dimensions of health and happiness, the latter term is more typically used to refer specifically to the pursuit of individual health (Page-Reeves & McKinney, 2019, p. 2), many times in ways that position health as something available for purchase by those who can afford it. Schensul (2019) explains further:

> … in current parlance, wellness tends to refer to individual responsibility to achieve personal health through personal strategies such as relaxation, stress reduction, healthy eating, and adequate exercise. In recent years, wellness has become a preventative health goal, especially with the emergence of multiple chronic conditions that threaten both quality and duration of life in the West. At the same time, wellness is also a commodity, available for purchase from spas, gyms, and holistic physicians and other naturalistic practitioners (p. 99).

If wellness is a commodity, only those who have access to the money, private health insurance, and leisure time required to access the kinds of wellness products and services identified by Schensul in the above quotation will be able to purchase it. Describing the results of their research with food insecure rural seniors, Edwards and Page-Reeves (2019) write,

> If, because of your life circumstances, you are stuck trying to get your basic needs met, it is highly likely you are not spending a lot of your time contemplating your own wellness. Even if you are, it is probably you do not have the physical, mental, and emotional energy to respond in any significant way. Fundamentally that means even if your circumstances are killing you, you may not have the means to change them (p. 234).

But as the above quotation implies and as I will explain in my discussion of the social determinants of health in Chapter Six, the direct effects of these kinds of wellness interventions are likely not as impactful upon health as social factors such as income, social status, race and indigeneity, gender, and so forth. The ability to engage with commodified wellness practices might be more of a proxy for privilege than something particularly helpful for health in its own right.

Wellness, Neoliberalism and Healthism

It certainly seems positive and helpful to take a holistic, prevention-oriented approach to health, but the fact that wellness has become such a buzzword in recent years likely has less to do with a genuine interest in promoting each person's well-being, and more to do with the neoliberal goal of responsibilizing individuals for their health. Due to the ascendency of neoliberalism, with its emphasis on personal responsibility in the face of government divestment from social welfare, wellness and happiness now are regarded as individual responsibilities, and illness and discontentment are regarded as a moral failures (Cederström & Spicer, 2015). As Kirkland (2014) writes,

> Wellness promotes a conservative, individualistic health ideology, thereby undercutting communal, structural, redistributive, and sympathetic approaches to health. The more health is framed as within personal control, the more it will seem that everyone deserves [their] place in the health hierarchy (p. 976).

An ideology that underpins the promotion of wellness as a means of inculcating neoliberal values within individuals is "healthism" (Turrini, 2015). The term was originally coined by sociologist Zola (1977), whose formulation of healthism was closely intertwined with his critique of medicalization, the means through which medicine came to control more and more dimensions of daily life, including by framing social issues as biomedical ones to be addressed by medical professionals within the body of the individual (pp. 62–65). In contrast to Zola's perspective, Crawford (1980) posited that rather than rendering health professionals as agents of social control, healthism reified the body as medicalized and positioned individuals as personally responsible for the management of their own physical and mental health regardless of structural conditions (pp. 376–377). LeBesco (2011) argues that in the contemporary context of neoliberalism, this formulation of healthist ideology hails people to be "active citizens who can effectively manage their own risk" (p. 155). The objective of the inculcation of healthism in the populace is to reduce claims upon the state while maximizing people's capacity to promote economic growth through contributions to productivity and sanctioned forms of consumption (Harrison, 2012).

Skrabanek (1994) argued that healthism has underpinned racist and eugenic campaigns that separate the “healthy” (which equates to moral and pure) from the “unhealthy” (the foreign or impure). Thus, if people do not succeed in achieving the healthy ideal, they are responsible not only for their own deficiencies, but also for damaging “the health of the nation” (Skrabanek, 1994, p. 16). Similarly to Zola’s (1977) concerns about the increasing overreach of the medical profession, Skrabanek (1994) worried that the state’s embrace of “lifestylism” would effectively give it unlimited coercive/prescriptive power around issues of health. Rose (1999), following Foucault (1991) instead emphasized the hegemonic character of healthism, pointing out that the state does not need to force people to be healthy if citizens have already internalized the desire to be healthy as a condition of living in a society that marginalizes and punishes those who “opt out” of health (LeBesco 2011, p. 160). Cederström and Spicer (2015) describe the internalization of wellness ideologies as “the wellness command” (p. 10).

The Wellness Industry

Beyond the state’s interest in promoting wellness as a means of creating better neoliberal citizens, in the private sphere commodified wellness is a several trillion-dollar industry (Lewis, 2017, p. 2; Shapiro, 2018, p. 895). An incredibly array of services and products fall into the category of wellness: Counselling and coaching; exercise and movement classes and equipment; vitamins and nutritional supplements; diet foods and regimens; as well as a vast array of other products and services claiming esoteric and unprovable spiritual and energetic benefits such as “purifying,” “cleansing,” “balancing,” and “rejuvenation.” All of these are supposedly in the service of promoting individual health. In reality, many facets of the wellness industry are not subject to regulation, so these interventions often have little or no proven benefit, and some may be actively harmful, especially when pursued in lieu of medical treatment in response to a serious health problem such as cancer (McCartney, 2018).

Currently, one of the most common ways that the wellness industry comes into people's lives is through workplaces, with increasing numbers of employers offering programs that they claim are intended to improve the physical and mental health of their employees (Mello & Rosenthal, 2008). In reality, these programs have not been shown to provide measurable benefits (Lewis, 2017; Jones et al., 2019), and are often coercive—particularly in situations in which employees' primary health insurance is employer-based, which is often the case in the United States—as well as discriminatory against employees who do not instantiate neoliberal physical, mental and behavioural ideals (Kirkland, 2014; Lewis, 2017).

Workplace wellness programs harness employee self-monitoring and self-discipline in the service of improving productivity, decreasing absenteeism and presenteeism and curtailing health insurance costs (Kirkland, 2014, p. 975; Lewis, 2017, p. 1750). Such programs are often oriented toward producing workers who meet corporate expectations about how a "good employee" behaves both at and outside of work, and even what that ideal employee looks like: With the "fit" employee perceived as the "productive" employee, those who do not conform to this image are "automatically seen as inactive and unproductive." Mentally and psychologically, the wellness-enhanced employee should able to achieve "peak performance" at all times (Cederström & Spicer, 2015, pp. 32–33). In Western contexts, workplace wellness programs often engage in the cultural appropriation and exoticization of Buddhist concepts and practices including mindfulness, decontextualizing Buddhist teachings about the impermanence of life to normalize precarious work and excessive productivity demands. Such programs teach employees that their negative assessments of their working conditions can be resolved not through collective action but through individual improvements to focus or even proper breathing techniques (Cederström and Spicer, 2015, p. 23).

The rise of workplace wellness raises several questions, including what might become of employees with differences or disabilities that make these ideals unsustainable or unattainable? In addition to disability, how do these wellness demands differentially impact workers along the lines of race, gender, class and other dimensions of social location? For example, Bergman (2009) explains that body size-based appearance standards are often applied more stringently to women and people perceived as feminine. Kirkland (2014) points out that wellness programs are often developed and run by white people, with research suggesting that many of them are "likely to associate deviance from the wellness program… with minority status," thereby subjecting racialized participants to additional scrutiny (p. 981). And why should an employer have the right to compel or even pressure their employees to comply with "wellness-promotion" directives that have a significant impact on how they spend their time outside of work, not to mention the intimate and personal nature of such commands in respect to food and eating, as well as movement and exercise? It is clear that commodified wellness programs normalize ableist expectations in the service of capitalism.

Resilience

The Origins of Resilience

Norris et al. (2011) explain that the concept of resilience has emerged from several disciplines in the sciences and social sciences, including ecology, physics, engineering, sociology and psychology, and note that across disciplines, resilience research investigates how "adaptive capacities" are connected to "a positive trajectory of functioning and adaptation after a disturbance" (p. 162). Bourbeau (2018) concurs that the origin of the concept is multidisciplinary and that the often-repeated claim that the concept of resilience was created by ecologist Holling in 1973 (specifically in his article "Resilience and the Stability of Ecological Systems") is not accurate, pointing to the existence of a large body of literature in the fields of psychology and social work that pre-date Holling's work (pp. 4–7). Joseph (2018) explains that despite this, many social science approaches to resilience draw from Holling's ecological approach, which explains how a complex ecosystem responds to an "external shock" by changing state, reorganizing and finding a new balance. This is described as "the capacity to persist" (p. 13). Whereas ecological approaches to resilience emphasize environmental shocks, societally-focused studies of resilience address social shocks such as financial crises, terrorism and pandemics (p. 14). Joseph notes that societal resilience combines the capacity to reorganize in response to changes and problems as well as "the social capacity to learn and adapt" (p. 15).

Research on psychological resilience began in the 1950s, focusing on childhood development as well as adaptation to trauma and risk (Joseph, 2018, pp. 11–12). In the 1960s, the search for the cause of social problems such as "delinquency" as well as for the possible roots of mental health diagnoses such as schizophrenia in childhood experiences. In working to identify "risk factors" or "threats" for these conditions, researchers found that despite experiencing significant adversity some "high risk" children were doing better than might have been expected, sparking additional research into the factors that enable good functioning among those facing difficult circumstances as well as whether interventions promoting these factors lead to better outcomes (Masten et al, 2011, p. 103). Masten et al. (2011) note that contemporary research into resilience in children has found that those who have experienced a greater cumulative exposure to risk or adversity experience more problems and worse mental health (p. 105).

Mental Health Research Perspectives on Individual Resilience

Mainstream mental health researchers have put forward a range of definitions of resilience, including demonstrating good functioning after experiencing trauma; adapting to adversity in positive ways; and even having improved regulation of fear and stress related biological markers (Southwick et al., 2011). Good adaptation is sometimes described specifically as "the absence of mental health disorders or impairment" in the presence of a challenge or threat that could "disrupt or destroy normative function or development" (Masten et al., 2011, p. 105). Others have described resilience as having the capacity to perform necessary tasks of daily living even if experiencing disruptions following exposure to a potentially traumatic event (Bonanno & Mancini, 2011, p. 124), and as "bounciness" or "the ability to recover from some adversity and bounce back from the shock to one's former state" (Tantam, 2014, p. 53). Resilience research has investigated which personality traits, psychological characteristics and cognitive factors might impact resilient outcomes (Benight & Cieslak, 2011; Miller & Harrington, 2011; Troy & Mauss, 2011), as well as what biological processes may play a role in resilience (Feder et al., 2011). The impacts of social support and integration as well as religion and spirituality have also been researched (Janicki-Deverts & Cohen, 2011; Foy et al., 2011).

The American Psychological Association (2020) defines resilience as follows: "The process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress—such as family and relationship problems, serious health problems, or workplace and financial stressors." In the same document, they set out a series of actions that individuals can take to improve their resilience, including building connections ("prioritize relationships," "join a group"); fostering wellness ("take care of your body," "practice mindfulness," and avoid substance use); find purpose ("help others," "be proactive," "move toward your goals," and "look for opportunities for self-discovery"); and embracing healthy thoughts ("keep things in perspective," "accept change," "maintain a hopeful outlook," and "learn from your past").

While some of the listed items involve interpersonal relationships, the overall focus is on individual actions and attitudes: What can each person do to "come back" after facing hardship? Community is mentioned, but although directives to "join a group," and "help others" encourage the development of bonds with others as well as opportunities to experience "a sense of purpose or joy," these activities are positioned as apolitical. Walsh (2011) writes, "Most resilience theory, research and intervention approaches since the early 1980s have been individually focused, reflecting the dominant medical and mental health paradigm and the cultural ethos of the 'rugged individual'" (p. 149).

Beyond Individual Resilience

Individually-focused conceptualizations of resilience have been criticized as paying inadequate attention to the social, political and environmental contexts of people's lives. Kimhi (2014) argues that responses and planning that account for the multiple levels upon which resilience can be operationalized (individual, community and national) are more likely to lead to successful outcomes. Southwick et al. (2011) explain that stressors themselves sometimes reduce access to the resources needed to respond with resilience, explaining:

> Resilient processes are not strictly intrapsychic and biological; rather they reflect the transaction or interaction between the person and his or her environment. … The individual who adapts to stress does so not in isolation but rather in the context of available resources, other human beings, families, specific cultures and religions, organizations and communities and societies, all of which adapt to challenges as well (p. xii).

In keeping with this perspective, Laurent (2018) offers a more expansive, context-sensitive definition of resilience:

> Resilience… tries to determine if well-being can resist and survive shocks. More precisely, it measures the ability of a community, a locality, a nation, or the whole planet to cope with economic, social or environmental shocks and their capacity to return afterward to their pre-shock level of well-being without seeing it degraded or destroyed (p. 3).

Bourbeau (2018) agrees that resilience takes place across multiple levels, and further points out that it is a process (p. 51), rather than a reified “set of qualities” (p. 7). In contrast to the positive normative stance taken up by many (or most) resilience researchers, as well as the negativity of critiques of resilience that position it as solely a technology of neoliberal governance (pp. 47–49), he argues that resilience is not inherently positive or negative, but is rather a dynamic which can only be assessed with respect to its effects within particular situations. He explains:

> Resilience is [not] always about positive adjustments. Shocks need not be inherently negative, and that the adjustments to them may not be necessarily positive. In some cases, being resilient might, in fact, mean being an obstacle to positive change… There might be good reasons for wanting to transform a social structure, a given situation, a regime, a norm, etc., and that being resilient to these changes could be considered negative (p. 15).

Resilience has also been analysed from the perspective of feminist new materialism, which I will discuss in greater detail in Chapter Seven. Citing the work of feminist new materialist theorist Barad, Joseph (2018) argues that the new materialist understanding of entanglement as “the inseparability of humans and things” (p. 183) as an indicator of the complexity and uncertainty of the material/social/political world can be invoked to justify resilience as a form of governmentality. He posits that because a complexity perspective holds that the impacts of any given policy can never be fully controlled or even anticipated, policy failure is assumed, and the responsibilization of the individual to mitigate the impacts of potential threats is intensified (pp. 183–184). I think that this is not necessarily the case. For example, as my later discussion of the impacts of the mental health and social policies on the lives of the participants in this project will show, policies and their implementation do have significant impacts on people’s lives, even if they do not completely determine outcomes in every instance, and even if the instability of “outcomes” is recognized. Further, I do not believe that the recognition of complexity—whether through the lens of new materialism of through an intersectional analysis, for instance—implies the futility of a policy response. On the contrary, it reveals the importance of accounting for complexity and enabling adaptations and responses to unforeseen consequences within policy development and implementation.

The Resilience of Trans and Gender Diverse People

Due to the prevalence of transmisia[29] and transphobia, which result in discrimination and stigmatization (Puckett et al., 2019), trans and gender diverse people are recognized as facing substantial adversity (Singh, 2013). For this reason, researchers have sought to identify the social and individual factors influencing community members' resilient responses. Several studies have found that social factors such as higher degrees of family support, friendships, community belonging and engagement and activism are strongly linked to better mental health and well-being (Bockting et al., 2020; Matsuno & Israel, 2018; Puckett et al., 2019; Singh, 2013). In their transgender resilience intervention model (TRIM), Matsuno and Israel (2018) identify optimism, hope, self-worth, self-acceptance and pride, self-definition and transition as individual-level dimensions of resilience for trans people (Matsuno & Israel, 2018, p. 632), but point out that these "individual" factors are influenced by social conditions. For instance, it may be difficult to feel optimistic while facing employment discrimination, poverty and social exclusion. Similarly, not all people who wish to access transition-related care and services are able to access them, putting this resilience-promoting factor out of reach for many. Matsuno and Israel continue that interventions seeking to promote resilience among trans and gender diverse community members must also promote structural-level changes to the "societal norms, social environments, and laws and practices that perpetuate anti-transgender stigma" (2018, p. 641).

Conclusion

Well-being, wellness and resilience are interconnected concepts with distinct histories and meanings. While well-being research rooted in the positive psychology movement tends to be individualistic and depoliticizing, more critical approaches to well-being account for the social and political dimensions that shape people’s lives (Trickett & Rauk, 2019, p. 75). In contrast, wellness is typically individually focused and commodified. Although it is often positioned as a universally positive personal characteristic, resilience can be beneficial or harmful. Some research understands it as an individual trait, but it can also be regarded as a contextual and social process. As I describe in the following chapter, the appearances of these terms in Ontario’s recent mental health policy statements can be interpreted as indicators of the policies’ political trajectories.

Chapter Four: Ontario Mental Health Policy and Neoliberalism

Introduction

An examination of past and recent mental health policy in Ontario, in conjunction with an analysis of the legal and funding regimes that have shaped the formation of policy statements and their implementation (or lack thereof) reveals that the way that the Ontario government addresses mental health issues is the result of the influence of two intertwined ideologies: the biomedical model of mental health, and neoliberalism.

As I explained in Chapter Two, the biomedical model of mental health is based in the idea that the emotional, perceptual or cognitive differences or difficulties that come to be characterized as “mental illness” are caused by individual brain chemistry dysfunction. This ideology masks the role of social and political factors in determining people’s mental health outcomes, as well as the ways in which social and political factors shape ideas about what constitutes “mental health” and “mental illness.” As I will explain, the mental health policy statement in place at the time this research was conducted, *Open Minds, Healthy Minds*, characterized mental *illness* as a medical problem, but also suggested that good mental *health* was largely a matter of individual flexibility and adaptability, with the policy seeking to improve Ontarians’ ability to cope with any adverse situation that may arise. The neoliberal basis of the policy is revealed through its emphasis on the promotion of individual coping skills, along with other aspects of the policy that advocate for family responsibility and correct embodiment. The document’s co-optation of the language of the social determinants of health, in the absence of concrete measures taken with the aim of reducing socioeconomic inequality, also exposes its neoliberal foundations. I follow this with a discussion of the current mental health policy statement, *Roadmap to Wellness*, which intensifies the neoliberal trajectory of the previous policy.

Defining Neoliberalism

Upholding the idea that mental health difficulties are the result of individual biomedical problems, rather than problems with a basis in social and political relations is politically useful in the current political context in Ontario, which is shaped by the entrenchment of the political and economic ideology of neoliberalism. Neoliberalism is a specific form of free-market capitalism that became dominant in the 1980s, shaping political relations around the world, from the micro level through to the transnational (Dobrowolsky, 2009, pp. 1, 6–7; Mercer & Barnes, 2004, p. 3; Steger & Roy, 2021). It broadly applies a "market" rationality, through deregulation, liberalization and privatization (Steger & Roy, 2021, p. 14) emphasizing the necessity of the "free" movement of capital. It forces the retrenchment of the state's former roles of redistribution and regulation, eroding both liberal or civil and social citizenship rights (Revi, 2014), the latter of which includes the rights to social inclusion and "economic welfare and security" (Marshall 1992, p. 71–72), which can also be described as the social safety net. Through its valorization of ideologies of "freedom" (Page-Reeves & Cardiel, 2016), individualism and libertarianism, and its claims that its rationality is derived from natural or scientific principles, neoliberalism discourages social-level analysis or action (Dobrowolsky, 2009, pp. 1–7).

Neoliberalism demonizes social safety net provisions as the true causes of the social problems they seek to address, claiming that they "foster dependency" (Kivisto & Faist, 2007, p. 63). The communitarian ideals of social citizenship and equity are anathema to neoliberal ideology, so good neoliberal citizens are called upon to take "personal responsibility" for themselves, working hard and adapting to circumstances in ways that minimize their claims upon the state to the greatest extent possible. This takes place across all aspects of life, from the realm of employment (Thomas et al., 2020) to sexuality, reproduction, and family life (Davies & Robinson, 2013; Hindman, 2019); and health (Harrison, 2012, pp. 329–331). As neoliberalism has ascended and the social safety net has become increasingly frayed, socioeconomic inequality has risen substantially (Kivisto & Faist, 2007, pp. 66, 73). The impacts of neoliberalism are especially difficult for marginalized people, including disabled people (Fritsch, 2015), racialized people, and trans and gender diverse people (Quinan, 2017).

The History of Mental Health Policy in Ontario

The Creation of Large Institutions

From the colonial period until the 1960s, the development of mental health law and policy in all Canadian provinces (with the exception of Quebec) was heavily influenced by British legal responses to mental illness (Gray et al., 2000, p. 34; Joseph & Moon, 2002, p. 2194). The first responses of what would become the government of Ontario to mental health difficulties took place in 1833 when Upper Canada's legislature passed a law providing for the "relief" of "destitute lunatics," and by 1841, the first asylum was opened (Frankenburg, 1982, p. 172; Goodwin, 1997, p. 6). In 1867, The British North America Act made the establishment and maintenance of "Hospitals, Asylums, Charities and Eleemosynary Institutions" a provincial responsibility (Pollock, 1974, p. 23). By the 1930s, there were 12 large psychiatric hospitals in Ontario (Simmons, 1990, p. 3), all of which were under the control of the Minister of Health, who was personally responsible (along with the Department of Health's mental health bureaucrats and the hospitals' superintendents) for setting mental health policy (Simmons, 1990, pp. 9, 14–15). Ontario's psychiatric hospitals were overcrowded, underfunded in comparison with other hospitals (Pollock, 1974, pp. 114–115, 194–195), and were beginning to serve as sources of test subjects for experimental treatments involving radical techniques such as insulin coma, drug-induced convulsion, electroshock and lobotomy, none of which were effective in alleviating the symptoms of mental illness, but all of which were extremely physically and psychologically damaging to patients (Simmons, 1990, pp. 15–23).

As overcrowding in Ontario's psychiatric institutions worsened throughout the 1940s, the provincial government moved to ameliorate the problem by expanding existing institutions and building additional large psychiatric hospitals (Simmons, 1990, pp. 39–44). Six psychiatric hospital-based mental health clinics had been opened in the 1930s in an effort to provide preventative care to community members and thereby decrease hospital admission rates, but the program proved counterproductive, as the clinics regularly referred a significant number of their patients for inpatient admission. A boarding home program had also been established in the 1930s, but it was largely unsuccessful, with only 467 patients participating by 1947 (Simmons, 1990, p. 49).

Throughout the period of the ascendancy of large hospitals, patients, former patients and their allies worked to publicize the often extremely poor conditions within the institutions and the abuse to which patients were subjected with the aim of promoting the institutions' closure and the release of patients (Reaume, 2002, pp. 408–409; Reiss, 2008, pp. 169–190). For the most part, these kinds of complaints went unheeded in Canada, as mental health care practitioners were regarded as having "professional expertise," and were regarded by policy makers as the only source of "legitimate knowledge" in this area until as recently as the 1980s (Goodwin, 1997, p. 67). The idea that people identified as mentally ill should be segregated from the community in institutions remained dominant until the late 1950s.

Psychopharmacology, Deinstitutionalization and Transinstitutionalization

The downfall of large institutions was not precipitated by patient advocacy (Goodwin, 1997, pp. 36–44), but was more likely largely the result of the mid-20th century turn to pharmacology in the treatment of mental illness (Goodwin, 1997, pp. 29–36; Joseph & Moon, 2002, p. 2196). While earlier treatments had been extremely ineffective, some of the newly-developed neuroleptic medications affected patients' behaviour, cognition and emotional state in ways that appeared to enable many patients to "recover" sufficiently to function outside of a custodial institution (Simmons, 1990, p. 59). As a result of this, in tandem with the fact that it is typically much less expensive to prescribe medication than it is to provide people with shelter, food and psychotherapy (Goodwin, 1997, p. 60; Wilson, 2006, p. 96), the number of patients living in psychiatric institutions dropped sharply between the 1950s and the 1980s. In Ontario, there were 15,257 beds in the provincial psychiatric hospitals in 1962, but by 1980, only 4948 of those beds remained (Hartford et al., 2003, p. 67).

The pursuit of deinstitutionalization policies has often led to negative outcomes for people identified as mentally ill (Goodwin, 1997, pp. 116–130; Hartford et al., 2003, p. 67), and may have been motivated by cost containment rather than an interest in improving people's lives (Arnett, 2006, p. 167; Davis, 2006, p. 109). As Goodwin notes, when hospital services were cut, the provision of shelter and food for people labelled as mentally ill was eliminated (Goodwin, 1997, p. 97). Capponi (2003) points out that in Ontario, the practice of deinstitutionalization did not lead to the integration of people identified as mentally ill into the community, but to their segregation in private “boarding homes” rather than hospitals. Most boarding homes offered low-quality, unsafe housing, little or no therapy or programming, and forcible treatment with medication. Thus, with the closure of the psychiatric hospitals, the quality of life of many formerly institutionalized people was diminished even further, and integration and acceptance within the community was not achieved. For this reason, Capponi argues that deinstitutionalization might more accurately be described as transinstitutionalization (pp. 112–114, 161–162). Capponi’s contention is supported by the fact that as rates of long-term psychiatric hospitalization declined in Canada, rates of the incarceration in jails and prisons of people considered mentally ill increased, as did the rate of homelessness (Davis, 2006, p. 103; Goldner et al., 2011, p. 12).

With the closure of the large psychiatric institutions came the creation of general hospital-based psychiatric wards, which began to open in the late 1940s and early 1950s (Pollock, 1974, p. 226; Simmons, 1990, p. 69). By 1970, more psychiatric patients were being admitted to general hospital wards than to the psychiatric hospitals (Simmons, 1990, p. 65). Simmons (1990) points out that the establishment of psychiatric community care as a hospital-based service eliminated the possibility of involving public health perspectives (which emphasized social and environmental conditions) in psychiatric treatment in any significant way. He argues that this policy was informed by medical model ideology, and that it served to further entrench the dominance of the medical model in mental health care in Ontario (pp. 55–60). As Hartford et al. (2003) note, this move was not driven by any kind of “systematic policy response,” as the provincial governments of the 1960s and 1970s refused to create overarching plans for the restructuring of mental health care and service provision (p. 67).

From Hospital-Centred Care to Community-Based Care

In the late 1980s, following significant changes to the legal regime surrounding mental health care (which I will discuss in the next section of this chapter), the provincial Liberal government commissioned a report on mental health services in Ontario. Released in 1988, following the election of the majority Liberal government of David Peterson, the "Graham Report," *Building Community Support for People: A Plan for Mental Health in Ontario*, by the Provincial Community Mental Health Committee and Robert Graham, revealed a stark funding disparity between mental health and other health spending areas (Provincial Community Mental Health Committee & Graham, 1988, p. 2), as well as an overall lack of a comprehensive and systematic strategy for mental health service planning and provision across the province (Hartford et al., 2003, p. 69).[30] The report recommended that longer-term planning should be accompanied by fundamental systemic transformation from a system focusing on hospital-centred care to one that was community-based (Provincial Community Mental Health Committee & Graham, 1988, p. 7; Hartford et al., 2003, p. 69).

The report also introduced some important new terminology to the discourse of mental health in Ontario. First, it demarcated the category of people considered "seriously mentally ill" as being defined by "the 3 Ds" of diagnosis, disability and duration (Hartford et al., 2003, p. 69) and designated people with "serious mental illness" and their families as the government's "first priority" (Provincial Community Mental Health Committee & Graham, 1988, p. 4). Responding to the upsurge of activism by psychiatrized people in Ontario and beyond, the report also adopted the term "consumer" to describe people who use mental health care services, and "partnership" to describe the relationship between mental health consumers and service providers (Hartford et al., 2003, p. 69). As I will explain, this terminological shift arose in the midst of increasingly stringent requirements that the psychiatric system respect the rights of patients, although it appears that the shift would become largely a matter of rhetoric rather than a representation of a fundamentally changed view of people labelled as mentally ill.

The emphasis on recognizing the importance of moving away from institutional treatment, and for maximizing opportunities for consumers' "control" and "choice" in treatment and service was retained in the province's next mental health reform strategy as outlined in the 1993 policy document *Putting People First: The Reform of Mental Health Services in Ontario* (Ontario Ministry of Health, 1993) which was published by the Ontario Ministry of Health during the Bob Rae NDP government's tenure. The document promised that putting consumers at the centre of services would serve as a means of addressing the many gaps in service provision (Hartford et al., 2003, p. 69; Ontario Ministry of Health, 1993, p. 5). The consumer focus of the policy continued with its recognition that by 1993, the province was funding 36 consumer/survivor initiatives (demonstrating the efficacy of consumer/survivor/ex-patient activism) (Ontario Ministry of Health, 1993, p. 6), and was also providing funding for several treatment programs located in the community (Ontario Ministry of Health, 1993, pp. 10–11).

Like the Graham Report, *Putting People First* also cited providing services to meet the needs of people identified as having "severe" mental illness as "the first priority" (Ontario Ministry of Health, 1993, p. 15). In addition, it noted the importance the social context around people identified as mentally ill. The document stated:

> Some 75,000 people in Ontario … are severely mentally ill. Because of the nature of their problems. they are particularly vulnerable. Most are poor, and they have difficulty getting

> the basics in life, such as shelter and jobs, as well as treatment and community support services (p. 15).

The document mentioned that while it is important to fund formal mental health care, so too must funding be allocated to “housing, employment, and social supports” (p. 3), as more people would be at risk of developing mental health problems if those resources were not available (p. 3). Noting that in 1992/1993, 80% of the mental health budget was spent on institutional care, the document explained that systemic reform would enable the reallocation of funds for community-based services (p. 28). Unfortunately, the recognition of the importance of providing adequate funding for these kinds of social programs was not translated into action, as the Rae government was facing a severe budget deficit as a result of the recession of the early 1990s (Blythe, 1993) and was under increasing pressure from business interests to reduce social spending (Caplan, 2010). In 1998, the Progressive Conservative government published a report in which the shift toward community-based care that was outlined in *Putting People First* was endorsed, but the report noted that neither the previous government nor the sitting government had allocated funds for the reforms (Newman, 1998). As Hartford et al. (2003) explain, the policy of moving toward community services dovetailed with the Conservative government’s ongoing efforts to restructure hospital services in order to reduce health care expenditures (p. 70).

In 1999, the Progressive Conservative government introduced *Making it Happen* (published as two volumes: *Making it Happen: Implementation Plan for Mental Health Reform* [Ontario Ministry of Health, 1999a], and *Making it Happen: Operational Framework for the Delivery of*

Mental Health Services and Supports [Ontario Ministry of Health, 1999b]), a mental health policy statement they claimed would serve as “the next step” in the reform process initiated by *Putting People First* (Ontario Ministry of Health, 1999a, p. 3). The policy stated that efforts to integrate and coordinate mental health services were continuing (Ontario Ministry of Health, 1999a, p. 8), explained that a number of provincial psychiatric hospitals were slated for closure (Ontario Ministry of Health, 1999a, p. 9), and wrote that mental health policy should be based in “best practices,” emphasizing community-based services (Ontario Ministry of Health, 1999a, p. 7).

Like *Putting People First*, *Making it Happen* noted the importance of the social, explaining that mental health consumers sometimes require a variety of supports, including “housing, self-help and alternative supports, income support and sources, vocational and employment programs, consumer-run businesses, family supports, and social/recreational programs” (Ontario Ministry of Health, 1999a, p. 14). The statement included a long discussion of the importance of access to housing (Ontario Ministry of Health, 1999a, pp. 28–32), and stated that the government seeks to “increase, over a period of time” the availability of housing appropriate for the needs of mental health consumers (Ontario Ministry of Health, 1999a p. 31). In reality, this “increase” never came to pass, as the Conservative government made almost no investment in the creation of new social housing,[31] and passed laws that made private rental housing significantly less accessible, permitting landlords to discriminate on the basis of income and eliminating many forms of rent control (Bryant, 2004, p. 642). The government also reduced the already very low public income assistance rates by 21% (Fennell, 1995), and froze disability income assistance rates (Wilton, 2004, p. 28), which meant that many recipients of income assistance could not afford to access any market-rate housing at all.

The policy endorsed the idea that consumers should always be provided with choice, as well as the “least restrictive” treatment option relative to the consumer’s safety needs (Ontario Ministry of Health, 1999b, p. 7). It is interesting that the “consumer’s” rights to choice and the greatest degree of freedom legally permitted was emphasized in the discussion of the principles underlying the policy, given that the document soon turns to an extended discussion of the many ways in which people with “serious mental illness” are prone to disruptive, aggressive and violent behaviour, and must therefore be subjected to control so as to manage “risk” (Ontario Ministry of Health, 1999b, pp. 15–16), which reflects the prevalence of the discourse of dangerousness that dominated the development of mental health law at the time, as I will explain.

Although the Progressive Conservative government was voted out of office in 2003, the new Liberal government did not substantially change the course of the province’s mental health policy, continuing to endorse the shift toward community-based mental health services (Ontario Legislative Assembly Select Committee on Mental Health and Addictions, 2010; Ontario Ministry of Health and Long-Term Care, 2006). As I discuss below, they also instituted reforms to the structure of the provincial health care system, which was intended to address some of the problems of service discontinuity identified in *Making it Happen*. In 2011, the Liberal government introduced *Open Minds, Healthy Minds* (Ontario Ministry of Health and Long-Term Care, 2011), then after the Progressive Conservatives formed government again in 2018, they released *Roadmap to Wellness* (Ontario Ministry of Health, 2018). I will analyze the two most recent policy documents following my discussion of the legal and funding regimes underpinning their development.

The Legal and Funding Regimes

The Legal Regime and Mental Health in Ontario

As deinstitutionalization took place, the legal regime underpinning mental health care in the province started to undergo some significant changes, many of which were intended to advance the human rights of people coming into contact with the mental health system. In Ontario prior to 1967, committal to a psychiatric facility could be imposed upon a patient identified as mentally ill if they were considered by medical authorities to have a “need for treatment,” but the 1967 Mental Health Act enshrined into law the right of patients to refuse treatment for mental illness except in cases where they were considered as posing a danger to themselves or others (Gray et al., 2000, pp. 39, 109; Hartford et al., 2003, pp. 67–68). The 1978 changes to the Act narrowed the criteria, making only patients thought to pose a physical danger to themselves or others subject to compulsory treatment (Gray et al., 2000, p. 39; Hartford et al., 2003, p. 68), although, as Frankenburg (1982) notes, many psychiatrists continued to apply the old criteria in cases of involuntary commitment (p. 175).

The 1967 Mental Health Act had established review boards that could override competent patients’ treatment decisions (Pollock, 1974, pp. 325–326). Patients won the right to appeal the board’s decisions to the courts in 1983, but the board’s ability to override patient decisions was eliminated in 1987 when legislation was passed in order to bring the Mental Health Act into compliance with the equality rights provisions of the Charter of Rights and Freedoms (Hartford et al., 2003, p. 68). At the same time, a law empowering substitute decision makers to make treatment decisions on behalf of incompetent patients was passed, and in 1991, a legal ruling came down that would prevent the review board from overriding substitute decision makers’ treatment decisions. As part of the trend toward the recognition of the rights of patients, the

Psychiatric Patient Advocate Office (PPAO), an independent legal advocacy body charged with promoting the rights of psychiatric patients in Ontario was founded in 1983, following the deaths of three patients at a psychiatric hospital in Toronto (Hartford et al., 2003, p. 68).

As I note above, the 1988 Graham Report emphasized patients' civil rights (Provincial Community Mental Health Committee & Graham, 1988, pp. 54–55), and for a period of time, it appeared that mental health law and policy were moving toward a substantially increased respect for the rights of people identified as mentally ill. Then in the mid-1990s, a series of high-profile violent incidents involving people identified as mentally ill took place in Ontario.[32] In 2000, the Mental Health Act was amended in response to a discourse that emerged around these incidents, which overwhelmingly emphasized the "dangerousness" of people identified as mentally ill.[33] With the changes, the criteria for the imposition of psychiatric hospitalization were again broadened, enabling forced committal in cases of "mental deterioration where the person has a history of successful treatment" and in cases of patients' posing a risk of non-physical harm to themselves (Gray et al., 2000, pp. 110, 129). Despite these changes, in Ontario, capable patients could still refuse drug treatment even if they had been subjected to committal (Gray et al., 2000, p. 201).

Another significant change taking place in 2000 came with the introduction to Ontario of Community Treatment Orders (CTOs). A CTO is a legal instrument used to require certain psychiatric outpatients to submit to psychopharmacological treatment, as well as other criteria as defined by physicians. If a patient who is on a CTO refuses to comply with their treatment plan, they can be forcibly confined in a psychiatric facility (Fabris, 2006, pp. 1–3). Patients who are subjected to CTOs are those who are regarded by physicians as "likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person" (Mental Health Act, R.S.O. 1990, c. M.7, s. 33.1).

Proponents of CTOs claim that their objective is to prevent violent incidents that put both psychiatric patients and members of the public at risk, while providing a less restrictive alternative to forcible confinement in a psychiatric facility (Geller, 2000, pp. 90–91; Gray & O'Reilly, 2005, p. 14; O'Brien & Farrell, 2005, p. 27; Ontario Ministry of Health and Long-Term Care, 2006).[34] Critics of CTOs argue that they subject many people who have not broken the law to surveillance and both carceral and chemical control by the state (Fabris, 2006, p. 26). Critics have also pointed out that the application of CTOs is unequal, subjecting oppressed people to additional burdens (Dhand, 2009; Mfoafo-M'Carthy, 2014). As Fabris (2006) notes, the Mental Health Act's endorsement of mandatory pharmacological treatment for "mental illness" (or mandatory committal for those who refuse such treatment) assumes the validity of the biological model of mental illness, rendering other ways of conceptualizing psychological differences and difficulties inconceivable (p. 113).

Mental Health, Rights Discourses and Disability Policy

Although mental health policies seemed (in their conception, although not in practice) to move toward an increased recognition of the social determinants of health, none of the recent statements adopted insights from the cultural model of disability (reflecting the fundamental perception of the biomedical model of mental illness). That noted, the adoption of rights language within mental health policy coincided with the increased emphasis on human rights in the post-Charter reality, which prompted the adoption of liberal rights-focused general disability policies and laws. The understanding that disability is produced by ableism and non-accommodating physical and social environments is evident in laws and policy statements from the federal government and the provincial government that concern disability in general. These documents emphasize the right of disabled people to participate in the life of the community by ensuring that barriers to access are removed.[35] It appears that as mental illness was legally recognized as a type of disability, the discourse of disability rights spilled over into mental health policy, although the resistance to pathologization embedded in social model understandings of (physical) disability was not translated to conceptualizations of mental health, which remained dominated by the biomedical model.

The Funding Regime and Mental Health in Ontario

As I have explained, throughout the history of Ontario, mental health difficulties have been conceptualized as a medical issue best resolved at the level of the individual, through carceral "care" and/or through biomedical intervention. The shift from a system dominated by regional institutions toward the provision of mental health care services within local general hospital wards coincided with the changes to the structure of health care funding that were taking place in the late 1960s as universal, single-payer health insurance was implemented in Ontario. The Ontario Medical Services Insurance Plan (now the Ontario Health Insurance Plan, or OHIP) was introduced in 1966. In addition to insuring Ontarians for physical health care (provided within hospitals and by independently practicing physicians), it also provided insurance coverage for mental health services provided by general practitioners and psychiatrists, as well as mental health services provided at general and psychiatric hospitals (Pollock, 1974, p. 322).

In Ontario, as in the rest of Canada, "universal" public health insurance plans have focused narrowly upon insuring hospital and physician services (Arnett, 2006, p. 151; Bryant, 2009, p. 147), with other health services and resources covered at the discretion of each province or territory.[36] One omitted service particularly relevant to mental health is counselling or psychotherapy, which is not covered by OHIP except when performed by a medical doctor such as a psychiatrist or general practitioner, most of whom do not perform this service (Bieman, 2019). Because most counsellors, psychotherapists and psychologists charge fees that are out of reach for many people, this form of treatment or support has been underutilized in the province (Scharf & Oinonen, 2020), despite evidence that it has been shown to be very effective, often more so than drug treatment (Cohen & Peachey, 2014).

Funding formula restrictions deriving from the structure of OHIP (which mandated fee-for-service billing and did not typically insure services provided by non-physician practitioners) (Institute for Clinical Evaluative Science, 2012, p. 4), along with the ongoing existence of "silos" caused by fragmented care provision systems (Hartford et al., 2003, p. 69) created barriers to the reorganization of mental health care as a community-based service provided by a team of physicians and other health care providers. Policy statements have long called for increased resources for community-based mental health services and resources (Kemp, 1993, p. 7) and some of these calls have been—to some extent—heeded. For example, during the second half of the 1980s, funding for community-based mental health services increased significantly (although it actually declined as a percentage of total health spending in the province) (Provincial Community Mental Health Committee & Graham, 1988, p. 2). In 1993, the government spent 80% of its non-OHIP mental health expenditures on institutional care, and stated that its goal was to spend 80% of its non-OHIP mental health expenditures on community care by 2003 (Ontario

Ministry of Health, 1993, p. 28). A 1998 review of the province's mental health service provision showed that the plan was not on track, as a result of a failure to "provide the necessary dollars [and] implement the reform necessary" (Newman, 1998, para. 6). Beginning in the mid-2000s , the Ontario government undertook several significant reforms to the structure of the health care system and health care funding in Ontario, including creating alternative family practice structures and continuing the process of implementing alternative funding plans (Health Force Ontario, 2013; Institute for Clinical Evaluative Science, 2012, p. 4), and increases in funding for community-focused mental health services (Ontario Ministry of Health and Long-Term Care, 2006), as well as the more fundamental change that accompanied the 2007 institution of Local Health Integration Networks (LHINs). These changes were intended to address the problems caused by lack of service integration (Fierlbeck, 2011, pp. 81–86). Following their 2018 election, the Progressive Conservative government began the process of eliminating the LHINs and replacing them with the Ontario Health "super-agency," with the stated intention of reducing bureaucracy while eliminating service fragmentation (LaFleche & Frketich, 2019).

Despite the implementation of changes designed to improve direct access to a variety of mental health supports and services, most people who receive mental health care in Ontario still obtain services through their family doctors, who sometimes refer patients to psychiatrists for more "complex" treatment. This is a longstanding trend: Davis (2006) notes that a 1998 Ontario study found that 75% of mental health service users received care only from their family physicians and did not access any specialized mental health services (p. 138). Typically, family physicians do not provide patients with counselling, but instead write prescriptions for psychiatric medications (Arnett, 2006, p. 157), with family doctors writing most psychiatric drug prescriptions in Canada (Davis, 2006, p. 138). Psychiatric drug treatment also forms the backbone of most psychiatrist-directed programs of treatment. In Ontario (as in the rest of North America), prescription rates for antidepressants, anxiolytics, stimulants, and antipsychotics (increasingly marketed as second-line treatments for depression, in addition to their typical use in patients diagnosed with psychotic disorders or bipolar disorder) have all increased substantially from the 1990s until the present (Davis, 2006, p. 205; Patten et al., 2012, pp. 717, 720; Tamblyn et al., 2019), while rates of hospitalization (and particularly long-term hospitalization) have declined (Davis. 2006, pp. 127–128).

Although prescription medications provided to hospital inpatients are covered by OHIP, and the provincial government provides some drug benefits to recipients of social assistance, Ontario lacks a universal pharmacare program (Collier, 2017; Lexchin, 2001, p. 41). As a result, most people who take prescription medications are responsible for paying for them, either using private insurance provided by an employer, supplementary insurance products purchased as an individual, or directly as an out-of-pocket expense (Fierlbeck, 2011, p. 19). This means that policies that uphold the biomedical model of mental health, with its strong emphasis on pharmaceutical treatment are more cost-effective for the government than alternatives that would require more health care or social service spending.[37]

Essentially, the fundamental premise underlying the provision of health services in Canada is that medical treatment for illness should be publicly funded. Thus, governments in Canada have generally done little by way of ameliorating the unjust economic and social conditions that often give rise to ill health (Williams et al., 2001, p. 11). As Coburn (2001) writes, “health care does not produce health” (p. 49), although he also points out that neoliberal cuts to social services have also been accompanied by cuts to health care spending, which has diminished the potential that health care could provide “buffer[ing] effects” in a context of increasing socioeconomic inequality (p. 51).

So, despite changes that have resulted in better health service integration, the ongoing compartmentalization of health services from social services makes it difficult to fund and put into practice the systemic changes that the policy documents promise. Further, the rise of neoliberalism at the federal and provincial levels of government in Canada has led to reductions in funding levels for both health care and social services. At the same time, broader economic changes driven by the same neoliberal agenda have led to persistent problems with unemployment and increasing rates of income inequality and poverty (Raphael, 2001, pp. 223–235), both of which have been associated with “increased mental health risk” (Beiser & Edwards, 1994, p. 77).[38] People diagnosed with a mental health condition experience unemployment and poverty at rates vastly exceeding average rates in Ontario (Canadian Mental Health Association, Ontario Division, 2007), leading to social exclusion (Wilton, 2004). Thus, addressing the problem of health care “silos” (Hartford et al., 2003, p. 69) may serve to streamline access to medical services, but it will do nothing to address the social basis of mental health difficulties, or to address the exclusion of people labelled as mentally ill.

Recent Mental Health Policy in Ontario

Open Minds, Healthy Minds and the Neoliberal Model of Mental Health

I now turn to an analysis of *Open Minds, Healthy Minds*, published in 2011. To do this, I analyse the content of the document in accordance with the social determinants of health and the social and cultural models of disability. Because policy statements are not legally binding, I also situate the document within the broader political and legal situation in Ontario, looking at spending decisions and other policies to understand how (and whether) the policy was put into practice. As Bakker (2009) points out, Canadian governments' claims about budgetary "constraints" often lead to "policy incoherence," situations in which government actions directly contradict their stated policy objectives (p. 227).[39]

Open Minds, Healthy Minds was explicitly positioned as being developed to "reinforce [the Liberal government's] efforts" in other social policy areas, as expressed in their documents: The *Poverty Reduction Strategy*, the *Early Learning Strategy*, and the *Long-Term Affordable Housing Strategy* (Ontario Ministry of Health and Long-Term Care, 2011, p. 4). The four "guiding goals" of *Open Minds, Healthy Minds* were listed as follows:

1. Improve mental health and well-being for all Ontarians;
2. Create healthy, resilient, inclusive communities;
3. Identify mental health and addictions problems early and intervene;
4. Provide timely, high quality, integrated, person-directed health and other human services (p. 4).

The policy's objectives were to "create systems that complement each other to provide the basic personal opportunities that support safe, stable and healthy lives" and to "prevent and reduce the personal, social and financial burdens of mental health and addictions" (Ontario Ministry of Health and Long-Term Care, 2011, p. 26). The policy document outlined some of the problems of organization and access that persisted and discussed plans to improve these issues (p. 6).

Like previous Ontario mental health policies, *Open Minds, Healthy Minds* adopted language that appeared to recognize the importance of social determinants of health. It included statements such as, "All Ontarians deserve access to the basic elements of a safe and healthy life—education, employment, income and housing—as well as opportunities to participate in meaningful ways in their community" (p. 7); "Ontario is working to eliminate the individual and social injustices that contribute to mental illness and addictions" (p. 9); and "We need to look beyond the health care system to other factors that enhance mental health and create supportive communities where Ontarians with a mental illness and/or addictions no longer have to suffer alone or in silence" (p. 5). The latter statement displayed a tension between an apparent recognition of the social factors that influence mental health, and a view of mental health issues as things that some Ontarians "have" and "suffer" from, and that isolate them from the community.

Unfortunately, the policy resolved this tension by developing a neoliberal model of mental health, which rendered individuals responsible for managing themselves correctly to stave off the threat of mental illness, with those who do become mentally ill being recast as people with biomedical problems who should be provided treatment in the health care system.

The neoliberal model of mental health has three essential characteristics: The interpellation of a neoliberal subject (marked by flexibility, adaptability, and self-reliance, and unaffected by social and political contexts); correct neoliberal embodiment; and private individual and family responsibility (appearing particularly in the policy's discussion of health and social service integration, housing, and poverty). Throughout, the policy promised that the government would take action to increase "opportunities" for people identified as mentally ill in Ontario, through improvements to social housing, "poverty reduction" measures, and through efforts to reduce stigma and discrimination (against people identified as mentally ill and against other oppressed groups). The government's plans to meet these objectives were themselves informed by neoliberal ideology, and there is limited evidence to show that these led to outcomes benefitting anyone other than those who are generally advantaged by neoliberalism, as I will discuss, and as my later discussion of the experiences of participants in this research will show.

The Biomedical Model of Mental Health in Open Minds, Healthy Minds

Following the document's introduction, *Open Minds, Healthy Minds* began with this statement:

> Ontarians do many things to maintain their physical health, like eating healthy foods, staying active and not smoking. When people do become physically ill, our health system is there to provide treatment and support. It's time to take the same approach to mental health and addictions, from prevention, to identification, to treatment (5).

In a similar vein, the policy later stated that seeking care for mental illness should not be substantially different from seeking care for hypertension (Ontario Ministry of Health and Long-Term Care, 2011, p. 16). In stating that approaches to the prevention, identification and treatment of mental illness should be the same as those applied to physical illness, the policy demonstrated that it adopted a view of physical and mental health difficulties as biomedical. By suggesting that individual actions determine physical health outcomes, it also constructed mental health as produced through individual actions, rather than as shaped by external circumstances (Bryant, 2009, p. 316). As research concerning the social determinants of health has shown, social factors play a much greater role in determining physical and mental health outcomes than do individual actions (Bryant, 2009, pp. 41–42).

The document suggested that it endorsed approaches to treating mental illness that emphasized “recovery and wellness” (Ontario Ministry of Health and Long-Term Care, 2011, p. 16). While these models are more hopeful and likely more helpful than approaches that characterize mental illness as a chronic, unremitting disease with a poor prognosis, they can still be consistent with medicalized and individualized understandings of mental health (Jacobson, 2004, pp. 82–84). Due to its adoption of the biomedical model, ideas consistent with critical understandings of mental health do not appear anywhere in the document.

The Interpellation of a Neoliberal Subject

Open Minds, Healthy Minds listed its first goal as to “improve mental health and well-being for all Ontarians” (Ontario Ministry of Health and Long-Term Care, 2011, pp. 7, 10), and outlined the strategies that would be deployed to achieve this goal. The document stated:

> Good mental health is a resource for living. It enhances physical health and helps people succeed in school, at work and in their relationships and to contribute to our communities. People who feel good about themselves and their lives are more productive and less likely to take sick days. To improve their mental health, Ontarians must know how to manage stress and enjoy work-life balance. They need constructive ways to deal with negative emotions such as anger, sadness, fear and grief. … Ontarians of all ages can benefit from a better understanding of the skills they need to improve their mental health and the factors that put them at risk – such as stress, a loss, or a lack of self-

> esteem. Each person has the potential to become much more resilient and to better cope with adversity (p. 10).

The policy said little about changing the environments in which people live to be less likely to induce stress or lead to situations that provoke negative feelings, which would be consistent with the social determinants of health approach and the social model of disability. Instead, the policy called upon people in the province to adopt a neoliberal subjectivity characterized by flexibility, self-management and self-reliance. Individuals were called to be as flexible as possible, capable of adapting themselves—with as little assistance as possible—to any situation, changing themselves rather than making any demands upon their environment. As I have discussed, because of the ascendancy of neoliberalism in Ontario, the situation to which individuals must adapt involves a high degree of uncertainty and instability. This policy suggested that people must function as well in these circumstances as in any other, learning "skills" that would enable them to "constructively" deal with any difficult emotions that arise (irrespective of their origin), and to "manage" their affective responses to remain "mentally healthy" under absolutely any level of stress. Thus, this policy was consistent with Jenson's (2009) formulation of the "social investment perspective," which invokes claims that learning will provide individuals with the "capacity to respond to new challenges throughout the life course," constructing "security" as a matter of flexibility, rather than as defined by the immediate availability of resources. Within this perspective, social spending can only be warranted if it will lead to future increases in economic productivity and decreases in government expenditures (pp. 29–31).

More explicitly, the policy specifically mandated education endeavours as a means of creating "mentally healthy" Ontarians, including the implementation of "targeted education and awareness programs" aimed at people considered "most at risk of mental health and addictions problems," such as Indigenous people, disabled people, immigrants, and unemployed people (Ontario Ministry of Health and Long-Term Care, 2011, p. 10). In the case of Indigenous people, for instance, this rendered insignificant the fact that the "risk" they face has roots in a centuries-long history and still ongoing situation of economically exploitative and white supremacist colonialism. But the policy did not discuss how a decolonizing approach to improving the mental health and well-being of Indigenous people, such as by respecting claims to nationhood, abiding by treaties and resolving land claims.

Research focusing on the experiences of refugee women who are newcomers to Canada has shown that many immigrants would be more likely to benefit from programs aimed at improving their access to education and employment than from improvements to mental health service provision or mental health "awareness programs" (Hayward et al., 2008), but instead of working to improve the conditions of people's lives, or responding to oppression and deprivation, the policy claimed that problems could be solved by reassuring oppressed people that they have hidden reserves of resilience that "awareness programs" would enable them to access and mobilize.

Similarly, the policy did not mandate the kinds of changes to workplaces that would enable people to find "work-life balance"—this implies that making these kinds of changes is something that individuals could and would do if they only had the correct knowledge. As some research has demonstrated, the image of the high-status "workaholic" executive as most vulnerable to stress-related psychological and physical problems is not accurate. Often, the people who are most affected by workplace stress are those who are least likely to be able to ask for reduced hours: the people who endure the most work-related stress and resulting health impacts are those in low-status, and often low-waged jobs (Marmot et al., 1991; Subedi & Rosenberg, 2017; Waenerlund et al., 2011). Low-status workers would be unlikely to succeed in negotiating increased time away from work, and low-waged workers would almost certainly be unable to afford the reduction in pay that would accompany a reduction in work hours. In Canada, approximately half of all working age people who are poor are employed full-time, year-round (Jackson, 2018).

Open Minds, Healthy Minds emphasized “early identification” and “early intervention” generally, and especially for children and youth, reflecting how the strategy sought to shape people in Ontario into flexible, self-managing and self-reliant subjects: The policy stated that it intended to “reach out to people with problems wherever they are” (Ontario Ministry of Health and Long-Term Care 2011, p. 10), and promised to train employers and educators to screen for mental health issues and provide information about mental illness in workplaces and schools. The stated objective of this increase in surveillance and pedagogization[40] (Bernstein, 2001) was to decrease the direct economic costs of mental illness (which are said to drain the economy of $51 billion/year in lost productivity, insurance costs, and health and social service expenditures) (Dewa et al., 2011), and to promote a better economic future by increasing the likelihood that young people would be more successful in school and ultimately become economically productive, “mentally healthy” adults who had successfully internalized the ideologies of the neoliberal model of mental health and governed themselves accordingly (p. 20).

Correct Neoliberal Embodiment

Through its adoption of the biomedical model of mental health, *Open Minds, Healthy Minds*, located mental health problems within individual bodies, understanding bodies (and generally not society) as the appropriate target of interventions. One of the ways in which the policy worked to create a neoliberal model of mental health was through its response to children's embodiment. The policy stated, "To ensure our children and youth have the best possible start in life and learn early how to cope with stress, we need to reach out to them to… [r]educe stigma by promoting equity and diversity, physical activity, healthy eating and self-esteem (Ontario Ministry of Health and Long-Term Care, 2011, p. 10)." While the promotion of equity and diversity is important, this statement seemed to me to be gesturing toward a view of embodiment diametrically opposed to body equity or body diversity approaches. As Rice (2007) has found, government-led efforts to promote "physical activity" and "healthy eating" among children in Canada only led to the increased stigmatization of children whose bodies did not meet the athletic ideal, especially fat and disabled children (pp. 165–167). Such programs are invariably unsuccessful in changing children's bodies, and in contradiction to the last point of this goal, they tend to lower participants' self-esteem, not raise it. As Harrison (2012) argues, promoting "healthy eating" and "fitness" among children represents an instance of biopedagogy (Wright, 2009), aimed at upholding state and the market interests in creating properly-embodied (slim, bounded, "healthy") neoliberal subjects, with the objective of preventing hypothetical future overuse of the health care and social welfare systems, and therefore excessive demands upon the state and private insurance (Harrison, 2012, pp. 329–331).

Private Individual and Family Responsibility

The notion of private individual and family responsibility was a key tenet of *Open Minds, Healthy Minds* (Ontario Ministry of Health and Long-Term Care, 2011) and the neoliberal model of mental health it promoted. One of the "principles" outlined in the document was "Person-directed services," which was explained as the belief that the knowledge of "people with lived experience of a mental illness or addictions, and their families" should inform policy and practice, and that they should have opportunities to make choices about "their personal care and support" (p. 9). One of the foundational principles of the social model of disability is self-determination in relation to social and interpersonal contexts: The social model was developed by people living in oppressive, segregated institutional settings in which their right to make decisions was seldom respected. The social model highlights the profound importance of the right to make choices about all facets of life, including where and how to live, about relationships, about whether to undergo medical treatment and about the course of that treatment. The model also emphasizes that people with lived experience must have the opportunity to shape policies that respond to their needs and interests. It appears that the principle that services should be "person-directed" as expressed in *Open Minds, Healthy Minds* did not truly call for the self-determination of people identified as having mental health difficulties.

A shift took place between the title of the principle, with its focus on the person identified as mentally ill and the explanation of the principle's meaning, which grants equal weight to the voice of the person and that of their family, in fact making no distinction between the two (9). What the policy does not account for is that in many cases, people identified as having mental health difficulties (like people with other kinds of disabilities) do not inherently have the same interests as their family members. As Davis (2006) points out, some family member advocates are supporters of CTOs, whereas many people identified as having mental health difficulties are opposed to them (p. 68).

As a result of the neoliberal shift, family members have been increasingly expected to take on functions that would have been undertaken by the state (Dobrowolsky, 2009, p. 6), including providing care and financial support for people identified as mentally ill. This has made the perspectives of family members increasingly influential in the policy development process, whereas the disenfranchised status of people labelled as mentally ill means that their perspectives and interests are often ignored (Goodwin, 1997, p. 100).

This way of conceptualizing a "person-directed" model of mental health care is driven by the ableist notion that people with disabilities do not have the same individual rights as non-disabled people. Any differences between the interests and perspectives of the person identified as having mental health difficulties and those of their family members are elided, and the person is located conceptually as belonging within a family context. In the context of a broader trend of cuts to disability support programs (Jensen et al., 2019), a potential rationale as to why these important differences are ignored and the voices of family members are given as much weight as those of people identified as mentally ill in experience-based policy advisement might be that neoliberal governments wish to encourage family members of disabled people to take on the responsibilities of providing shelter, financial support and other forms of assistance to individuals who might otherwise be dependent on public assistance. As Armstrong (2009) explains, according to this logic, the exclusion of people identified as mentally ill from state support is "justified on the grounds that there are lots of friends and family to compensate for the poverty of services and income" (p. 90). Not everyone can rely on these forms of support, as family members may be unwilling or unable to share their resources, which leaves many people vulnerable to the impacts of state retrenchment.

The liberatory promises held by the kinds of liberal, individual rights to which social model theorists laid claim have historically only been valid within the public sphere, and not within the family (Minow & Shanley, 1996, pp. 6–9). In the neoliberal context of contemporary

Ontario, it makes ideological and economic sense to discursively locate people identified as mentally ill within their families: people whose material survival has become dependent upon retaining the approval of their family members, whose voices have been silenced while being ostensibly represented by those upon whom they are forced to depend are unlikely to be able to mount effective challenges to their disenfranchisement (Fierlbeck, 2011, pp. 217) and are therefore unlikely to be able to make claims upon the state.

Private Responsibility, Social Services, Housing and Poverty

Like previous Ontario mental health policies, *Open Minds, Healthy Minds* identified the fragmentation of services across ministries as an ongoing problem (Ontario Ministry of Health and Long-Term Care, 2011, p. 6), but the document suggested that this difficulty could be overcome not through a restructuring of services but through an attitudinal shift toward "keeping [people labelled as mentally ill] at the centre and providing the support they need to direct their own care and build on their strengths" (p. 6). The policy identified the implementation of service integration across "health and other human services—such as housing, income support, employment and the justice system" as likely to lead to improvements in mental health outcomes, quality of life and a "lower per person cost of mental health and addictions services" (p. 8), again promoting the idea that social services could be a locus of cost savings.

Housing was one of the key "services" that *Open Minds, Healthy Minds* promised to include in its integration process. The document stated, "All Ontarians deserve access to the basic elements of a safe and healthy life – education, employment, income and housing – as well as opportunities to participate in meaningful ways in their community" (p. 7) and sought "[m]ore people living in safe, stable homes and fewer living in shelters or hospitals" (p. 7) as an outcome.

Unfortunately, the housing strategy outlined in *Open Minds, Healthy Minds* and discussed in further detail in the government's Long-Term Affordable Housing Strategy (Ontario Ministry of Municipal Affairs and Housing, 2010) focused on developing "measurements" of improvement and increasing the "flexibility" of funding provided to municipalities for housing (p. 12), rather than on taking responsibility for improving the state of social housing in the province as a whole. This focus was consistent with that of the province's general housing policy, through which some funding was provided to municipalities for their housing budgets, some funding was provided for the repair and construction of some housing units, and limited direct funding was provided to social housing tenants (Ontario Ministry of Municipal Affairs and Housing, 2010, p. 4), but these actions did not translate into overall improvements for many Ontarians in need of housing support. As of 2011, 616,930 (or 13.4%) of Ontario households were in core housing need, living in "unsuitable, inadequate or unaffordable housing." By 2016, the most recent year for which this data is available, these numbers had increased to 748,310 (or 15.3%) of households in core housing need (Statistics Canada, 2017a). The waiting list for rent-geared-to-income housing also increased during this period, from 156,358 households in 2011, to 171,360 households in 2015 (Ontario Non-Profit Housing Association, 2016).

As Grant and Westhues (2008) explain, access to good housing plays an important role in recovery (pp. 13–14), so the persistent exclusion of people with mental health difficulties from good quality housing represents a significant barrier to improving mental health outcomes and a persistent "risk factor" for those not already identified as having a mental illness.

The social determinants of health perspective shows that poverty and social exclusion contribute significantly to mental health difficulties, so the fact that *Open Minds, Healthy Minds* stated that the government was interested in promoting the development of "an Ontario where all people have the opportunity to thrive" (Ontario Ministry of Health and Long-Term Care, 2011, p. 4) might have initially appeared to be a positive development, but I argue that it was again telling of the government's neoliberal orientation. The fact that they hedged this otherwise strong statement about well-being and inclusivity by including the word "opportunity" is significant, and in line with the liberal/neoliberal ideology that individuals' unconstrained choices primarily determine the trajectories of their lives (Smith, 2011, pp. 31–32). By stating that these policies would provide everyone in Ontario with the opportunity to thrive, they implied that if a person did not thrive, this represented an individual failure, rather than a failure of policy. After all, all the government promised people was an opportunity—individuals were charged with the responsibility of managing themselves in ways that would allow them to take it up.

Roadmap to Wellness

Roadmap to Wellness (Ontario Ministry of Health, 2020) was released in 2020 by the ruling Progressive Conservative party. Like the policy it superseded, it is deeply rooted in neoliberal principles, but it represents a further intensification of the medicalized, individualized perspective upheld in *Open Minds, Healthy Minds*. The policy reiterates the same concerns about health care silos and a lack of continuity of services identified in previous policies. It suggests that the government's decision to eliminate LHINs and standalone health agencies (such as Cancer Care Ontario) and replace them with the Ontario Health "super-agency"—including a new Mental Health Centre of Excellence—would finally eliminate these persistent issues, despite the fact that previous reforms with similar objectives going back decades have not achieved this outcome (Lee, 2014; Mulvale et al., 2007). The creation of Ontario Health has been criticized as primarily driven by the goal of cost saving (LaFleche & Frketich, 2019).

Roadmap to Wellness targets specific populations, including “children and youth, Indigenous people, Francophones, first responders, students, individuals who are justice-involved and people experiencing homelessness” as well as “police and correctional staff.” The statement’s focus on specific groups of workers and the presence of several vignettes describing how access to medical treatment for mental health difficulties can facilitate better functioning in the workforce frame the policy as supporting people in Ontario to overcome their “personal” difficulties to become more economically productive workers.

Unlike the previous policy, *Roadmap to Wellness* does not engage with the social determinants of health, except in very specific situations. For instance, people labelled as having “severe,” “complex” and “moderate” mental health needs as well as people experiencing homelessness are identified as potentially requiring “supportive housing,” but the impact of housing on mental health more broadly is not recognized, nor are any references made to the housing needs of those who would not be targeted by specialized “supportive” programs. In fact, people labelled as having “low need” regarding mental health care are conceptualized as needing “early intervention and self-management services,” and “members of the general public” are said to need “prevention and promotion” services rather than support with respect to any of the social determinants of health. Social determinants other than housing are almost entirely unaddressed.

The policy’s primary focus is on the creation of the “Ontario Structured Psychotherapy Program” (OSPP). The OSPP promises to provide “evidence-based cognitive behavioural therapy for people living with depression and anxiety” in person, via telemedicine and online. While a headline in the policy statement claims that the OSPP “leverage[es] global best practices,” it then notes that it was inspired by one specific—and widely criticized (Cotton 2018)—program from the UK. As Dalal (2018) explains, the UK’s Improving Access to

Psychotherapy (IAPT) initiative is a CBT-based program rooted in "happiness science" and "wellness" discourses (p. 13–17). He argues that one of the underlying assumptions of CBT is that the problems people face are not rooted in the material world, but are caused by "the faulty way [they] think about things" (p. 24). Mackinnon and Murphy (2016) point out that IAPT participants often blame themselves, understanding their problems as evidence of individual pathology rather than as linked to the difficult social contexts they face under neoliberalism. Dalal (2018) describes the confluence between CBT-based mental health care and the political realities of neoliberal austerity:

> The actual implementation of austerity itself is devolved to managerialist bureaucrats who do the dirty work of decimating our public services and institutions. But the dirty work of making "cuts" and causing harm is made to look sanitary and rational by alluding to "cuts" as "savings"—and camouflaging it to make it look as if it is all taking place in the service of increased efficiency. These cuts then result in human distress, distress which is framed as a mental disorder. By this means managerialism and neoliberalism sanitize their activities and then, in a gesture of good will, offer CBT treatments for the unfortunates who are deemed mentally ill (p. 5).

In the same vein, the OSPP is specifically positioned as a means of addressing the "high prevalence of depression and anxiety among social assistance recipients," specifically "to support their return to work," again reflecting the economic focus of the *Roadmap to Wellness* policy. As Dalal's analysis reflects, this does not address the fact that social assistance recipients' distress is likely to be rooted in the profound inadequacy of the income rates provided by

Ontario's social assistance programs. It also obfuscates the reality that many social assistance recipients are unable to work, especially in the context of declining job quality and widespread employment discrimination against disabled people (as well as members of other oppressed groups, including trans and gender diverse people), nor does it answer the problems in the programs' design that make transitioning to work extremely difficult (Lahey et al., 2020).

The OSPP also emphasizes the collection of "data" as a means of assuring clients' "progress." As Cotton (2018) writes, in the IAPT program, the usefulness and accuracy of similar "data" is under question. *Roadmap to Wellness*' focus on "efficient" and technology-enabled recordkeeping also appears in its promise to standardize and link health records across the province—which could be problematic for those who have received stigmatizing labels (Stablein et al., 2015).

Conclusion

Open Minds Healthy Minds and *Roadmap to Wellness* each included a pledge to adopt evidence-based practices in health care, but an analysis of the content of the policy statements suggested that the governments that wrote these policy documents did not include any evidence informed by the social determinants of health perspective. Neither did they address the notion that mental health and mental illness could be conceptualized in ways other than strictly in accordance with the biomedical model. Perhaps deliberately, insights from the social and cultural models of disability did not appear anywhere in the policies. As Stone (2012) writes,

> In the polis, controlling the number and kinds of alternatives on the table is one of the most important techniques of issue framing. Keeping things off the agenda is as much a

> form of power as getting them on. If an alternative does not float to the surface and appear on the list of possibilities, it cannot be selected; to keep it off is effectively to defeat it (p. 253).

What *Open Minds, Healthy Minds* and *Roadmap to Wellness* defeated were alternatives to the biomedical model that call into question the increasing medicalization of the emotional/perceptual/cognitive difficulties and differences that more people are experiencing in this moment of increasingly severe stress and inequality. They also defeated the possibility of reaping the health benefits that accrue to everyone when social inequality is lessened (Raphael, 2001, pp. 232–235). Instead, *Open Minds, Healthy Minds* fixated on the creation of a province populated with effective neoliberal subjects who are as flexible, adaptable and self-reliant as possible. These subjects would take care of themselves and their family members, and ask the state for as little as possible. *Roadmap to Wellness* has persisted down the same path toward responsibilization and individualism in the face of worsening inequality and greater stresses for most. What these governments have failed to understand is that these very expectations are already causing many of the problems identified as mental illness. Ratcheting up these demands has and will only lead to worse outcomes for most people in Ontario, and especially for those who already face oppression and exclusion.

Chapter Five: Critical Theories of Disability and Madness

Introduction

In this chapter, I outline the disability and madness-focused critical theoretical perspectives that underpin this project. Here, I highlight some work in the areas of critical disability theory (including the social and cultural models of disability), disability justice and mad studies, each of which make a unique contribution to this project. As Russo and Beresford (2015) explain, what unites these perspectives is their development by and for disabled people:

> Disability has been transformed over the last generation by the emergence of new discourses to challenge longstanding dominant medicalised individual discourse. What has distinguished these emerging discourses is that the impetus for them has come from disabled people themselves. They have been based on experiential knowledge—people knowing about disability directly through experiencing impairment and being on the receiving end of disabling attitudes and barriers (p. 153).

The Social Model of Disability

Origins and Definition

The social model of disability was developed by disabled people in response to the overwhelming dominance of the medical approach to disability (Lang, 2001), which conceptualizes disability as a property of the dysfunctional individual body. While the terminology of the "social model of disability" was introduced by Mike Oliver in 1983 (Oliver, 1983), its initial formulation took place in the work of the Union of the Physically Impaired

Against Segregation (UPIAS, 1975), a UK organization founded by Paul Hunt in 1972 with the objective of promoting the self-determination and social inclusion of disabled people. In their statement on the "Fundamental Principles of Disability," UPIAS drew a distinction between impairment and disability. They defined impairment as a physical lack or defect pertaining to the body (such as a missing limb, or an organ that does not function correctly), and disability, which was caused by social organization that was non-accommodating and exclusionary of people with impairments (p. 14).

Critiques

The social model formulates disability as caused by the socially produced relationship between individuals with impairments and the social and physical environments with which they interact. From its creation onward, the social model of disability has often emphasized the experiences of people with physical disabilities, and as a result, it has been criticized as paying inadequate attention to the situation of people identified as having mental health difficulties. As Nabbali (2009) notes, the model's proponents have sometimes argued that "mental illness" is an individual medical problem that cannot be understood as equivalent to a physical impairment, and for this reason, have tended to exclude mental health issues from social model analysis (pp. 1–2). The social model has also been criticized on other grounds, including for the refusal of its proponents to engage with intersectionality (Rice et al., 2013), or to acknowledge embodied experience. The latter point was addressed by Thomas (1999) in her development of the social-relational model of disability (which accounts for the impacts of "impairment effects"), as well as by Withers (2013) in their articulation of the radical model of disability.

The Social Model and Mental Health

Social model theorists have predominantly discussed disability in terms of disabling environments and social arrangements with reference to people with physical impairments, but the model's location of problems in society rather than the individual is useful for people identified as having mental health problems. First, it attends to the fact that disabling environments and conditions—and not individual characteristics—produce disability. This renders the different ways of thinking, feeling and behaving that are sometimes associated with "mental illness" as not inherently problematic, showing that negative values are attributed to them through a process of social construction. In the present situation, the failure to accept the differences that are labelled as characteristic of "mental illness" may stem from the dominance of ideologies that value people only inasmuch as they function well as "productive" subjects in accordance with the dictates of the neoliberal economic system that is currently dominant (Nabbali, 2009, pp. 5–6). Kramer (1997) directly implicates the widespread prescription of psychiatric medication in this, calling it "cosmetic psychopharmacology," that is intended to fundamentally alter people's personalities to make them better able to function in advanced capitalism (p. 273). Similarly, LaFrance (2007) argues that the biomedical model of mental illness and the pressure to take medication that accompanies it leads to a regime of "self-management, [which], in turn, serves to maintain the status quo while producing more effective citizens" (p. 128).

When applied to the area of mental health, the social model of disability shows how the conditions in which we live are closely related to our mental health. Stoppard (2000) quotes one of the women who participated in her research on depression as follows:

> I still think that my problem would have been that I had no money, I don't even care for help. I know what my problem is. But if I went to the doctor, he probably would have said, well, you're depressed or something. And I probably would have said, yeah, and said, what's the use, whatever, you know. I know I am depressed and I don't know how you can help there. Are you going to give me some money? (pp. 188–189).

Disability studies and critical psychology scholars have shown that the reductionist, biological model of mental health is harmful in that it depoliticizes situations rooted in power relations by locating them not in culture, society or economics, but in physiological processes taking place inside individual bodies (Cosgrove & Riddle, 2004, pp. 128–129; LaFrance, 2007; Poland & Caplan, 2004, pp. 13–14; Stoppard, 2000, p. 308).

The Cultural Model of Disability

Definition

The cultural model of disability is related to the social model in that it understands disability as a social experience, rather than as directly caused by a biological deficiency. The cultural model understands the dominant meanings associated with impairment and disability as having been discursively constructed as representing deficiency or Otherness (Devlieger, 2005, p. 5), and seeks to change these discourses by embracing the lived experience of difference or disability as valuable in itself, and as something that should be celebrated and understood as meaningful, rather than erased or suppressed (Devlieger, 2005, p. 8). As Barnes and Mercer (2001) write, "Disability culture presumes a sense of common identity and interests that unite disabled people and separate them from their nondisabled counterparts" (p. 522). They argue that disability culture both recognizes and reflects back the experiences of disabled people, but also serves as a means of challenging the individualizing dominant cultural discourses about disability that tend to construct disabled people as dependent objects of pity, or as heroes who have overcome adversity (p. 524).

Deaf Culture and the Cultural Model of Disability

Perhaps the most well-known example of the cultural model of disability is found in the history of Deaf people. In Western countries from the mid-19th century onward, many Deaf people were subjected to eugenicist “oralist” education aimed at eliminating their signed language use and encouraging lip-reading and speech production. This was ostensibly intended to facilitate their participation in mainstream society and culture, but in practice, it served as an attempt to suppress Deaf culture (Baynton, 1998, pp. 4–7; Burch, 2000, pp. 444–450). Throughout the 20th century, Deaf people worked to gain the right to education and social and cultural participation in signed languages, and have as a result developed distinct and rich communities and cultures (Burch, 2000, pp. 450–461).

Madness and the Cultural Model

Similarly, mad, consumer/survivor/ex-patient and antipsychiatry advocates often argue that the experience of living with the types of differences often understood as “mental illness” can be regarded as inherently valuable. Conditions conceptualized within psychiatry as mental illness are sometimes cited as supporting artistic creativity (Kyaga et al., 2012). Members of the hearing voices movement argue that the experience of living with what would be termed as “hallucinations” by medical practitioners can be understood instead as “hearing voices and seeing visions." In this way, members of the movement challenge the pathologization of their perceptions, instead interpreting their voices and visions as personally or spiritually significant. Some have found that this reimagining of their "mental illness" has led to improvements in their lives, whereas mainstream psychiatric approaches were much less successful (White & Denborough, 1998).

Challenging Neoliberal Subjectivity

The cultural model of disability values ways of thinking, relating, feeling, moving, and being in the world that are different from dominant, normative standards, which are currently driven largely by neoliberal ideologies of the subject. The neoliberal subject embodies independence, self-containment, self-discipline and flexibility. In many instances, disabled people cannot embody these standards. For this reason, a concept of subjectivity as shaped by disability defies neoliberal ideology: As Devlieger (2005) explains, understanding disability as a cultural experience "hold[s] out a challenge to societ[y] to reflect on itself" (p. 9), as disabled people's refusal/inability to "fit in," by internalizing and adopting or adapting to normative social standards may provoke reconsideration of the value of dominant standards (or of the concept of normativity itself).

The Radical Model of Disability

Disability activist and theorist Withers (2012) developed their "radical model of disability" in response to the problems and omissions they identified in relation to previous understandings of disability. Withers lists the four key concepts in the radical model as follows: The inseparability of disability from other forms of oppression; the recognition of the arbitrariness of "normalcy";

the understanding of disability as political rather than biological; and the necessity of taking a "holistic" (rather than "universal") approach to accessibility (p. 107). Withers notes that the radical model "re-embeds disability with impairment" recognizing the "biological" as politically and socially constructed (2013, p. 8). In Withers' model, disability is understood as "a political label imposed on certain kinds of deviant people and used to control disabled people and the population as a whole" (2013, p. 8).

Through the radical model, Withers (2013) challenges the claim that trans and gender diverse people are non-disabled, noting how trans identities have been constructed as pathological through the array of DSM diagnostic categories that have been applied to gender non-conformity (pp. 14–22). They argue that trans people should understand themselves as disabled, recognizing otherwise-disabled people as allies (2012, p. 111; 2013, pp. 39–48).

Disability Justice

History and Other Uses

The phrase "disability justice" has a substantial history in critical disability research, theorizing, and activism. For instance, it has been used by Meekosha and Soldatic in relation to legal claims made by disabled people from the Global South and Indigenous communities within white settler states in response to impairments caused by the debilitating historic and ongoing structural violence of colonialism and capitalism (Meekosha & Soldatic 2011, p. 1389, 1394; Soldatic 2013, p. 748). According to Soldatic, Global North legal concepts of disability typically cast impairment as arising from "natural" causes, and therefore anticipate that seekers of disability justice wish to dismantle external barriers, rather than to address injuries caused by violent social, political and economic arrangements (2013, pp. 747–748). Theorists Asch and Fine have also taken up the term within the field of critical disability studies in psychology (Fine, 2019).

The Disability Justice Framework

In the context of this research, my use of the terminology of "disability justice" specifically refers specifically to the intersectional framework initially developed by members of the Disability Justice Collective and disability arts group Sins Invalid, who have identified disability justice as a "movement-building framework that would center the lives, needs, and organizing strategies of disabled queer and trans and/or Black and brown people marginalized from mainstream disability rights organizing's white-dominated, single-issue focus" (Piepzna-Samarasinha, 2018, p. 15). The disability justice framework's centring of intersectionality marks it as a critical intervention into the theories and practices that have often failed to account for the differences among disabled people, and that have not always recognized the interconnection of disabled peoples' struggles for recognition and access with other oppressed people's justice-seeking work.

Defined Through Activism

Sins Invalid challenges the idea that the framework should have a concise definition. Instead, as queer disabled people of colour activists, they describe disability justice as having developed from their work toward being recognized as "an essential part of humanity." Reflecting their intersectional perspective, they highlight the inseparability of the multiple dimensions of their activist work: As they "challenge settler colonialism, gender normativity and violence that targets trans people" they simultaneously "challenge able-bodied normativity" (Sins Invalid, 2019, pp. 5–6). As Mingus (2011) points out, unlike rights-based approaches emphasizing proximity to normalcy and validating existing social and political hierarchies, disability justice "embraces difference, confronts privilege and challenges what is considered 'normal' on every front." Mingus explains to seek disability justice is not to seek to "join the ranks of the privileged," but to "dismantle those ranks and the systems that maintain them" (para. 5).

Sins Invalid lists the 10 foundational principles of disability justice, capturing the multiple dimensions of the framework, emphasizing how struggles for the liberation of disabled people interlock with the struggles of all oppressed people. The principles are as follows: Intersectionality; leadership of those most impacted; anti-capitalist politics; cross-movement solidarity; recognizing the wholeness of each person; sustainability; commitment to cross-disability solidarity; interdependence; collective access; and collective liberation (2019, pp. 23–27).

Mad Studies

Definition and History

Mad studies is an area of critical theorizing, research and activism (Castrodale, 2015) focused on understanding madness and the experiences of mad people through the creation of "an array of counter-narratives" that challenge the dominance of the medical and psy discipline construct of "mental illness" (Voronka, 2019, p. 4). The terminology of "madness" is reclaimed from its pejorative use against mad people, signifying the rejection of stigmatization and a move away from medicalization (Beresford, 2020), as well as a claim to "dignity and pride [in] difference" (Menzies et al., 2013, Kindle Location 477). As an academic field, mad studies is recognized as having initially developed in Canada, but people now participate from around the world

(Beresford, 2020). As Menzies et al. (2013) explain in their introduction to the path-breaking book *Mad Matters*, mad and ally scholars, activists, and professionals are engaged in mad studies with the objective of

> … distanc[ing] themselves from the essentializing biological determinism of psychiatry whilst respecting, valuing, and privileging the Mad thoughts of those whom conventional psychiatry would condemn to a jumble of diagnostic prognostications based on subjective opinions masquerading as science (Kindle Location 299).

In this way, mad studies can be understood as incorporating antipsychiatry theorizing, scholarship and activism. Menzies et al. (2013) also explain that mad studies accounts for the social, political and contexts in which people experience distress (Kindle Location 299). They also advocate for a focus on real, practical concerns and difficulties, arguing that the work of mad studies is necessarily oriented toward the promotion of justice. They write:

> To stay relevant and grounded—and to look at psychiatry and society, and act accordingly, from the standpoint of those who encounter power and privation in their rawest forms—is the key practical, ethical, and political challenge confronting critical scholars, writers, and activists in the realm of "mental health." (Menzies et al., 2013, Kindle Location 659).

Origins in Activism

Mad studies' origins are recognized as rooted in mad activism. People identified as mad had long engaged in activism (Carlisle, 2004; Hervey, 1986; Lewis, 2006, p. 341; Reaume, 2002, pp. 408, 412–415), but in the 1970s the mad, consumer/survivor/ex-patient, and antipsychiatry movements were formed. Through these movements, groups of psychiatrized people and their allies formed activist and advocacy groups and began to create alternative publications promoting their perspectives, to advocate for legal changes that would respect their human rights, and to intervene with the psychiatric establishment to challenge the dominant conceptualization of mental health difficulties. Through these ongoing movements, activists have worked to resist the often harmful and alienating "treatments" offered by psychiatric services, and to push for the social acceptance of emotional, cognitive and perceptual differences (Blais, 2002, pp. 66–68; Burstow & Weitz, 1988, pp. 19–33; Jacobson, 2004, pp. 63–69; Lewis, 2006, p. 341; Morrison, 2003; Reaume, 2002, p. 415–424; Shimrat, 2013).

Challenging the Medical Model of Mental Health

One of the central objectives of mad studies is to counter the notion that "mental health" can be understood exclusively through a medicalized paradigm. Mad studies scholars have documented the means through which the psy professions/sciences—and especially psychiatry—positioned themselves as possessing the only valid framework for understanding mental difference and distress (Burstow & LeFrançois, 2014, p. 22l; Filson, 2016; Halinka Malcoe & Morrow, 2017, p. 4). As such, biomedical understandings of mental health are dominant within health policy and state apparatuses including the legal system and child welfare (Halinka Malcoe & Morrow, 2017, p. 4). This has resulted in diminished access to non-medical sources of support—often identified by service users as more helpful than medical, clinical interventions (O'Hagan, 2016, Kindle Location 339).

The dominance of the medical model of mental health serves as a means of denying and obfuscating the relationship between distress and harmful social, economic and political realities (Shimrat, 2013, Kindle Location 3392), or as Filson (2016) puts it, the "contexts that describe what happened to us rather than what is wrong with us" (Kindle Location 509). Connecting biomedicalism with neoliberalism Morrow (2017) explains,

> … Structural understandings of human suffering are abandoned in the call for "better" diagnoses, pharmaceutical solutions, and neurobiological research, rather than the radical systemic change envisioned by feminists, mental patients' liberation movement, and anti-psychiatry activists of the 1970s and 1980s (p. 46).

Menzies et al. (2013) describe how mad studies has also responded to the intensification of the medicalization and psychiatrization of survivors of violence, people experiencing distress, and people exhibiting differences through the construction and imposition of increasingly stringent and narrow behavioural norms that has taken place from the late 20th through the early 21st century.

The critique of the epistemic violence (Liegghio, 2013, Kindle Location 2896) of sanism and the invalidation of psychiatrized people has been a central project of mad studies. Josewski (2017) defines sanism as follows: "The structural forms of discrimination produced through hegemonic assumptions about rationality, normality, and madness that affect people with a mental health diagnosis" (p. 63). Mad studies perspectives challenge sanism, psychiatrization and medicalization, instead arguing that “mental health” and madness must be understood as social categories with specific political implications, conferring systematic advantages upon those classed as having “normal mental health” and disadvantages upon those labelled as “mentally ill” (Liegghio, 2013).

Importance of Survivor-Led Research

Survivor-led research “centralises [survivor] experiences, priorities, perspectives and beliefs about what heals and harms” (Sweeney, 2016, Kindle Location 1025). Landry (2017) describes the importance of survivor-led research in generating knowledge about experiences of madness and/or distress, noting that survivor-led research may better account for the interests of survivors (p. 1445) and may better reflect their agency (pp. 1446–1447), but cautions that “the vast majority of mental health and social service research in Canada does not involve service users beyond the role of research subject” (Landry, 2017, p. 1439). Sweeney (2016) argues that the rise of mad studies, with its emphasis on respecting survivor viewpoints, is an opportunity to support and develop survivor-led research (Kindle Location 1046), highlighting the importance of heeding the critiques of racialized and working class survivors such as Gorman et al. (2013), who have pointed out the dominance of white, middle class perspectives within survivor research, the mad movement, and mad studies generally (Sweeney, 2016, Kindle Location 1041).

Criticisms and Ways Forward for Mad Studies

The scholarly and activist work that comprises mad studies have been criticized on several grounds. For instance, Withers (2012) points out that ableism has been prevalent within mad and psychiatric survivor spaces, with scant recognition of the ways that medicalization impacts people outside of the realm of the psy professions (pp. 110–111). Intersectional analysis has often been excluded from and unwelcome within mad studies, which has centred and essentialized the interests and voices of white, middle class people from the Global North while marginalizing racialized people (Beresford 2020, pp. 1339–1340; Diamond, 2013, Kindle Location 1834; Russo, 2016, Kindle Location 1324). As Gorman et al. (2013) explain in "Mad People of Colour: A Manifesto," although racialized people have often faced resistance from white people when voicing their perspectives and highlighting the intersectional impacts of racism, colonialism and class oppression for racialized mad people within mad community, activist, and research spaces. Tam (2013) critiques white mad activists' invocations of dynamics of racist and colonial oppression as metaphors for their experiences, noting how they erase the real-world implications of structural oppression for racialized mad people as well as the specificities of the psychiatrization of racialized people (Kindle Location 6620–6686).

Gorman (2013) highlights the importance of understanding disability as a social relation rather than "a fixed ontological state," enabling the recognition of those disabled by the debilitating forces of structural violence. She argues that transnational approaches can address the problems of the "inattention to race and under-theorization of the global" within the field. Similarly, Snyder et al. (2019) explain that taking an intersectional approach to mad studies can reveal the complex political realities that shape experiences of madness, citing capitalism, patriarchy and racism as examples of the dynamics that must be addressed (p. 488).

Mad Studies and Gender Diversity

The experiences of trans and gender diverse people have been analyzed through the lens of mad studies. For example, Tosh (2017) argues that the psychiatrization of trans people and of gender variance more broadly are manifestations of psychiatry's power to pathologize non-normative ways of being as well as their failure to recognize the damage resulting from oppression, writing, "Pathologizing gender variance blames the victims of rigid, arbitrary social norms and individualizes what are really social problems of transphobia and cisgenderism" (pp. 260–261). Diamond and Kirby (2014) note that trans people are heavily psychiatrized and medicalized due to a convergence of factors pushing them into contact with mental health care: The requirement to receive a psychiatric diagnosis to get access to transition-related care; in the face of high unemployment and social exclusion, mental health labels may allow trans people to access ODSP; and people may perceive psychiatric diagnoses as validating the struggles they have faced (pp. 250–251). Tosh (2017) points out that work seeking to improve the situation of trans people cannot focus solely upon addressing the impacts of medicalization, as most trans people also face significant problems in regard to social and economic exclusion (problems that are compounded for those who are located at the intersections of multiple axes of oppression), so these issues must also be a focus of research (p. 271).

Conclusion

The theoretical perspectives that I have reviewed here are distinct but brought together by their overarching objective of promoting justice for people facing the oppression of medicalization and social exclusion. They are also united in their common origin as theories created by disabled and mad people in the service of their own liberation.

Chapter Six: Social Determinants of Mental Health

Introduction to the Social Determinants of Health

Definition

The social determinants of health perspective recognizes that “individuals of different socio-economic status show profoundly different levels of health and incidence of disease” (Raphael, 2010, p. 146). Bailey (2012) describes the social determinants of health as “the conditions into which people are born, grow, work and age,” and notes that social determinants play the largest role in causing health disparities (p. 11). For this reason, health promotion efforts aiming to change behaviours are unlikely to have the kinds of impacts being sought: According to Raphael (2010), the health impact of the social determinants is shown to “equal or exceed the influence of the so-called ‘lifestyle’ or behavioural risk factors such as tobacco and alcohol use, diet and physical activity” (p. 148). Positioning individuals as responsible for managing and mitigating the kinds of individual-level risk factors listed above while doing little or nothing to address the social and political conditions that play a much larger role in determining their health outcomes is a form of victim-blaming (Raphael, 2016a, p. 4).

History

There is a very long history of research demonstrating connections between health and socioeconomic status, and showing that differences in social status are universally associated with health disparities (Coburn, 2001, p. 49). For example, in his 1845 book *The Condition of the Working Class in England*, Engels introduced the term “social murder” (1892, p. 25)—now often described as structural violence (Mendenhall & Weaver, 2019, p. 26)—to describe how class-based oppression was the cause of the poor health and early deaths of many working class people:

> When one individual inflicts bodily injury upon another such that death results, we call the deed manslaughter; when the assailant knew in advance that the injury would be fatal, we call his deed murder. But when society places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death, one which is quite as much a death by violence as that by the sword or bullet; when it deprives thousands of the necessaries of life, places them under conditions in which they cannot live—forces them, through the strong arm of the law, to remain in such conditions until that death ensues which is the inevitable consequence—knows that these thousands of victims must perish, and yet permits these conditions to remain, its deed is murder just as surely as the deed of the single individual; disguised, malicious murder, murder against which none can defend himself, which does not seem what it is, because no man sees the murderer, because the death of the victim seems a natural one, since the offence is more one of omission than of commission. But murder it remains (Engels, 1892, pp. 95–96).

Mendenhall and Weaver (2019, pp. 26–28) discuss how Engels and many of his contemporaries, including path-breaking epidemiologists Virchow and Snow, engaged in the analysis of the social determinants of health even as a clearer distinction between medicine and the social sciences was being established. They explain that although this separation has in large part remained, there has always been some recognition of the impacts of the social upon health (notable examples including the Karks' development of the Pholela model of social medicine in

Natal, South Africa in the 1920s and the Whitehall studies of the health of British civil servants beginning in the 1970s). The term "social determinants of health" was coined by health researchers Doyle and Pennell in 1979, originally referring to the health effects of income, access to resources, as well as the effects of stable or precarious employment. The concept has since been significantly expanded to address many additional dimensions of identity, positionality and experience that have been shown to impact health (Raphael, 2016a, p. 8). Despite the ongoing presence of research on the social determinants of health—particularly in Canada (McIntyre et al., 2013)—the area has been largely overlooked within the areas of health promotion and disease prevention over the last four decades, with "biomedical and behavioural approaches" to health prevailing (Raphael, 2016a, p. 5).

The Canadian Political Context

Interventions seeking to directly address the social determinants of health have not been widely taken up within public policy in Canada (Raphael, 2016a, p. 7). Noting that the corporate sector in Canada has always had an unduly strong influence in the political realm within this country, Langille (2016) argues that policies to promote health via the social determinants have not been undertaken largely as a result of the imposition of neoliberal, "free-market" policies beginning in the mid-1970s. These policies have been driven by the interests of transnational corporations and their owners, promoted via reifying public discourses positioning neoliberalism as commonsensical and natural, and enacted in concert with right-wing neoconservative and neoliberal politicians whose campaigns are often funded by the corporations whose interests they represent (pp. 470–475, 479). While it is unlikely to be the only cause, the promotion of individualistic, neoliberal ideologies may have influenced the persistently inaccurate belief held by many Canadians (whether members of the public, politicians or those working in health care) that individual behaviours and choices have the largest impact on health (McIntyre et al., 2013, p. 2; Raphael & Curry-Stevens, 2016, pp. 562–564) as well as socioeconomic status itself (Raphael & Curry-Stevens, 2016, p. 573). The imposition of neoliberal policies has resulted in massive increases to income inequality, while social conditions, working conditions, and health outcomes have all deteriorated, as my later discussion will show.

List of Social Determinants in Canada

Raphael (2016a, p. 11) lists 16 social determinants of health recognized as particularly relevant within the Canadian context:[41]

1. Gender
2. Disability
3. Race
4. Immigrant Status
5. Indigenous Ancestry
6. Geography
7. Early Life
8. Education
9. Health Care Services
10. Income and its Distribution
11. Employment and Working Conditions
12. Unemployment and Employment Security
13. Social Safety Net
14. Housing
15. Food Security
16. Social Exclusion

Table 1: Raphael's Canadian Social Determinants of Health

Although lists of the social determinants of health typically share many items in common, other researchers and institutions have highlighted different factors. This may reflect different research or policy priorities as well as contextual differences. For instance, a 2003 list generated by UK researchers included several of the determinants listed above, but also included addiction and transport (Raphael, 2016a, pp. 8–9). My decision to take up Raphael's list of the Canadian determinants does not mean that I do not recognize the salience of other possible factors.

Previous research from Ontario has shown that sexual identity (Dobinson et al., 2003; Ontario Public Health Association, 2002) and gender identity (Gapka & Raj, 2003; Gapka & Raj 2004) are also key social determinants of health, and they are of clear relevance to this project. In this chapter, I discuss gender diversity as a dimension of gender, as well as throughout each of the subsequent social determinants. In my later discussion of the social determinants and well-being in Chapter Ten, I also consider sexual identity (Casey, 2019; Downing & Rosenthal, 2020) as well as social inclusion and community, which participants' stories showed had especially strong impacts upon their health and well-being.

Social Determinants of Mental Health

Defining the Social Determinants of Mental Health

While the social determinants perspective has tended to focus on the impact of social factors upon physical health problems such as cardiovascular disease, cancer, and diabetes (Compton, 2014, p. 419; Raphael, 2010, p. 151), it is also applicable to mental health difficulties (Goldner et al., 2011, pp. 47–52; Goodwin, 1997, p. 73). Structural inequality makes people who experience oppression vulnerable to insecurity, stress, and difficulty accessing the resources needed to ensure survival, much less a good quality of life (Goldner et al., 2011, pp. 46–49; Goodwin, 1997, pp. 73–76; Raphael, 2001, p. 227). Living with severe stress and inadequate resources often leads to negative mental health outcomes (Doyal, 1995, p. 16; Middleton & Shaw, 2000, pp. 1420–1421).

Similarities to and Differences from the Social Determinants of Health

Proponents of the social determinants of mental health often advocate for a model of mental health that accounts for individual psychological and biological factors as well as social determinants (i.e. Bailey, 2012 p. 13).Writing from their perspective as psychiatrists, Compton and Shim (2015) explain that the social determinants of mental health are essentially the same as those pertaining to physical health (p. 420), listing "racial discrimination and social exclusion; adverse early life experiences; poor education; unemployment, underemployment, and job insecurity; poverty, income inequality, and neighborhood deprivation; poor access to sufficient healthy food; poor housing quality and housing instability; adverse features of the built environment; and poor access to health care" as well-researched determinants of mental health within the United States. They write that the mechanism through which the determinants impact mental health varies, but may involve making "poor choices and adverse health behaviours (in large part owing to reduced options)" in ways that lead to health problems, as well as the results of exposure to stressors that cause physiological responses known to be associated with mental health difficulties (p. 421). They identify "public policies and social norms" as driving inequality and unjust outcomes in regard to the social determinants of health and argue that psychiatrists and physicians should lend their support to efforts to promote public policies to reduce inequality, but continue to insist that individual-level interventions can play a role in mitigating some of the impacts of inequality (pp. 421–422). Despite their disclaimer recognizing the impact of "reduced options", the framing of oppressed people's constrained actions as "choices" seems to me to reflect the victim-blaming stance of lifestyle health proponents who maintain a decontextualized focus on individuals.

Psychiatrization and the Social Determinants of Mental Health

Whereas medicalization represents the imposition of medical authority upon a growing number of aspects of life (Shapira & Granek, 2019, p. 497), Mills (2015) defines psychiatrization as a specific "genre" of medicalization through which "more and more of our lives come to be seen, globally, as concerns for psychiatry" (p. 217). She argues that research based on the medical model of mental health that retains a biomedical focus and a reliance on DSM constructs while simultaneously seeking to address social and political issues is problematic in several regards. First, it takes for granted the validity and universality of the medical model. Next, because the medical model "works to locate distress within individuals," this results in findings that are inherently biased in favour of individual-level interpretations. Further, there are "ethical issues in using oppressive tools to measure the effects of oppression" (p. 216). In addition, she points out that the psy disciplines have served as a tool for the management of the "social threat" posed by oppressed populations within society (p. 217), explaining that the interaction of psychiatrization with other dimensions of oppression (in this case, poverty) represents a "deadly synergy" that may only worsen people's problems (p. 19). Consistent with the feminist new materialist understanding that the embodied/physical and the social are not separable (Barad, 2007, p. 3), I believe that it is possible to conceptualize distress as an embodied experience that is simultaneously produced through social relations, but I share Mills' concern regarding the reification of distress as a medical entity. In the next section, I draw from a wide range of sources to discuss the impacts of the social determinants of health, including some medical model-based research, but I remain cognizant of Mills' warning.

The Social Determinants of Health, Mental Health, and Intersecting Locations

In this section, I undertake a brief discussion of each of the social determinants of health as identified by Raphael (2016a), with an emphasis on information pertaining to intersecting social locations, including gender diversity. To facilitate discussion, I have grouped the determinants into thematic categories. As noted, the 16 categories do not represent every possible determinant, and I engage in further discussion of additional relevant determinants in Chapter Ten of this dissertation.

Social Locations

Identity categories and social locations[42] are very important determinants of health, impacting every aspect of each person's life and their experiences in relation to each of the other social determinants. The intersectional nature of identity means that experiences can never be adequately represented with reference to a sole category of social location, but in this section, I bring specific determinants into focus while recognizing their intersections with other social locations.

Gender

In much of the research on gender as a social determinant of health, gender diversity is not taken into account.[43] In this discussion, I work to challenge the cisnormative perspective, incorporating research pertaining specifically to trans people, reflecting the reality of gender diversity. Gender has many impacts on health. Within the field of medicine, clinical trials and other medical research has often been conducted solely on cisgender men, with the results later generalized across the entire population, leading to potential problems for the majority of people excluded by that practice (Armstrong, 2016, p. 546). Cisgender women and gender diverse people often experience discrimination within the health care system (Phillips, 2005; Kcomt, 2019), with racialized people from these groups also subjected to the intersecting impacts of structural racism (Lena, 2019).[44]

Beyond medicine and health care, gender intersects with every social determinant of health. For instance, women are more likely to have to live on a low income than men, as women are overrepresented in the lowest paid, lowest status jobs, the gender wage gap is persistent, and women are more likely than men to experience precarious employment. As Umaigba (2017) notes, in Canada, these problems are even more likely to impact racialized, immigrant women (pp. 30–47). Women are also more likely to be subjected to workplace discrimination and harassment in the workplace (Homan, 2019, p. 487). Additionally, women face ongoing demands to do tasks of social reproduction, including childcare, eldercare and all forms of housework (Armstrong, 2016, pp. 552–555). Together these factors lead to health-damaging stress (Homan, 2019, p. 487). Homan's research has shown that men married to women experience better health as the beneficiaries of these sexist arrangements (2019, p. 507). In regard to individual lifestyle interventions, women are less likely than men to participate in physical activity (Denton et al., 2004, p. 2587), perhaps reflecting the fact that many women are structurally unable to engage in "healthy" behaviours that require access to resources including energy, time, money, and childcare (Armstrong, 2016, pp. 552–555). Other dimensions of social location necessarily intersect with these realities, meaning that people who are subordinated on the basis of gender as well as sexual orientation, race, disability, immigration status, indigeneity and so forth face interlocking complications.

Transgender people are among those subordinated on the basis of gender and therefore experience gender-based oppression. I will discuss the status of gender diverse people in relation to each of the social determinants, but I present some initial information here. Because transmisia is so pervasive (Downing & Przedworski, 2018), gender diverse people experience high levels of health-impacting stressors, including violence, homelessness, employment discrimination, precarious employment, unemployment, and poverty (Blosnich et al., 2017; Casey 2019; Downing & Przedworski, 2018; Giblon, 2016; Ross et al., 2018). Trans women face the impacts of sexism and misogyny as well as transmisogyny,[45] which means they face higher levels of criminalization, and homelessness, and deeper poverty relative to other gender diverse people (Downing & Przedworski, 2018, p. 343). As Bailey (2021) points out, the intersection of transmisogyny and racism results in a life expectancy of only thirty five years for trans women in the United States (p. 6). In her statistical analysis of transgender Ontarians' status in regard to the social determinants of health, Giblon (2016) found that in comparison with the general population of the province, despite few differences in levels of education and employment characteristics, "a substantially higher percentage of trans women reported annual personal and household incomes of less than $15,000, with an excess prevalence of 27.9% compared to cisgender men and of 14.4% compared to cisgender women." For trans men in comparison to cisgender men, the excess prevalence was 18.8%, but no excess prevalence was reported in comparison to cisgender women (pp. 78–80). Giblon explains that this indicates that "transitioning to male does not automatically confer the same socio-economic advantages seen in cisgender men" (p. 83).

Disability

As a dimension of social location, disability necessarily intersects with all other social determinants of health, but Wolbring (2011) points out that some discussions of the social determinants of health have often failed to take disability into account at all or have unfoundedly assumed that disabled people have substantially different needs from those of abled people. He describes how disabled people have been paternalistically excluded from consideration with respect to areas such as education, economic self-determination, and political decision-making, all of which would be self-evidently relevant to disabled people were it not for ableist assumptions (p. 318).

Employment and income are social determinants that are particularly significantly impacted by disabling social relations (Rioux & Patton, 2014). Disabled people face both the impacts of these unjust arrangements, including ableist discrimination affecting hiring, retention and evaluation; barriers including those in the built environment and those resulting from non-accommodation (Darcy et al., 2016), as well as impairment effects that can make work difficult or even impossible (Oldfield, 2014; Vijayasingham, 2018). Being unable to find employment, losing employment or experiencing increased employment instability often means that people will no longer have adequate income (Frier et al., 2018, pp. 540–542). This is especially true where disability income replacement programs offer inadequate levels of income support, as is the case in Ontario, where Ontario Disability Support Program (ODSP) rates leave recipients in poverty (Hamidian, 2019). This means that finding housing can be difficult for disabled people due to discrimination (Ontario Human Rights Commission, 2008) as well as a greater likelihood of being unable to afford the expense, while options are even further limited for those whose disabilities requiring them to have housing that meets physical accessibility standards, which is not a feature of most housing stock (Frier et al., 2018, p. 542; Spurgaitis, 2019). In Ontario, a lack of accessible infrastructure, a high prevalence of low income among disabled people, and pervasive attitudes of ableism within society also make disabled people vulnerable to social exclusion (Hande, 2019).

Several studies have found that trans people are more likely than cis people to be disabled, and to have multiple chronic health conditions (Downing & Przedworski, 2018, p. 341; Giblon, 2016), making the impacts of disability as a social determinant especially likely to impact their lives. Chin (2018) quotes Toronto performer, artist and community organizer Khor as explaining that disability inclusion and accessibility has become increasingly prominent within QTPOC (Queer Trans People of Colour) communities in part as a result of the work of disability justice activists and theorists such as Milbern, Mingus and Piepzna-Samarasinha (p. 12).

Race

Despite its clear salience, race was not initially included on Health Canada's list of the 12 determinants of health (Jacobs, 2011). It has subsequently been added as a 13th item, with the acknowledgement that "experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians" (Government of Canada, 2020). Yearby (2020) notes that although racism is manifest in many ways, structural racism—the ways that the systems in society are designed in ways that provide benefits to racially privileged people while simultaneously contributing to the oppression of racially subordinated people—is most closely connected with the social determinants of health because it accounts for the "mutually reinforcing" process through which systems of discrimination across all social determinants are maintained while discriminatory beliefs are simultaneously reinscribed (p. 521).

Racism causes disparities in health outcomes due to many factors. Due to employment discrimination, racialized people are more likely to work in lower status, lower wage jobs, which has direct negative effects of health (Galabuzi, 2016; Maness et al., 2021). In addition, earning an inadequate wage often means that people will be living on a low income, which also impacts health (Galabuzi, 2016). As a result of being more likely to have a low income and because of housing discrimination itself (Centre for Equality Rights in Accommodation, 2009; Alini, 2020), racialized people are more likely to live in housing that is of poor quality, or does not meet their needs (Springer, 2021). Resulting from these interlocking aspects of structural racism, the increasing racial segregation of neighbourhoods contributes further to the social exclusion of racialized people (Alini, 2020; Galabuzi, 2016). Racialized people also experience discrimination within the education system (Codjoe, 2001; Maness et al., 2021). The impacts of structural racism have been compounded across many generations (Maness et al., 2021). Trans and gender diverse racialized people encounter intersecting discrimination in relation to each social determinant of health (Wesp et al., 2019), including in regard to employment, education, housing, and health care (Howard et al., 2019; Lena, 2019).

In addition to being more likely to face health-damaging circumstances in relation to the kinds of determinants discussed above, enduring experiences of racism also have direct impacts on health. The “weathering hypothesis,” as first described by Geronimus (1992), posits that for Black people, the stress of living in a racist society causes a physiological inflammatory response that leads to a wide range of chronic physical and mental health problems. Recent research suggests that exposure to anti-Black racism during childhood is strongly linked with health-damaging inflammation (Simons et al., 2018). A meta-analysis by Paradies et al., (2015) showed that experiences of racism are related to poor physical health outcomes and even more strongly related to poor mental health (pp. 24–25). In addition to the indirect and direct impacts of structural racism and racist discrimination, racialized people also face bias in the health care system, further worsening health outcomes (Greenwood et al., 2020; Maness et al., 2021).

Immigrant Status

Castañeda et al. (2015) argue that the structural perspective of the social determinants of health provides better insight into the "broader health landscapes in which immigrants live" (p. 383), but the literature on immigration and health has been dominated by behavioural and cultural frameworks, positing immigrant health as matters of individual behaviour, or as influenced by immigrants' relationships to the customs, traditions and practices of their culture of origin and the mainstream culture of the receiving country (pp. 378–380). Lane et al. (2018) point out that in Canada the "healthy immigrant effect," is not universally applicable. In particular, refugees or forced migrants have worse health than other immigrants upon arrival, and are more likely to end up in poor health, facing higher risks of mental health difficulties, infectious diseases and death (pp. 1043–1044). 2SLGBTQQIA+ refugees are highly likely to experience mental health difficulties due to experiences of persecution prior to migration, and due to the intersections of minority stress on the basis of gender and sexual minority status with the stressors—including racist and xenophobic discrimination—encountered by refugees generally in the post-migration context (Fox et al., 2020; Kahn et al., 2017; Logie et al., 2016). In Canada, the Sexual Orientation and Gender Identity (SOGI) refugee assessment process can also be a source of stress, posing risks to those who are unable to construct a narrative consistent with IRB members' often stereotypical and ethnocentric expectations (Kahn et al., 2017; Murray, 2015).

In Canada's large cities, immigrants are more likely to live in neighbourhoods with higher rates of poverty than are non-immigrants. Neighbourhoods in which poverty is concentrated often have low quality, inadequate housing, as well as high levels of unemployment. There is often a lack of social services and other amenities (Galabuzi, 2016, p. 402). In instances where high-quality amenities are present, local residents who are more likely to be immigrants, racialized people, and lower income may still be unable to use them due to being pushed out by whiter, wealthier populations from surrounding areas (Scott, 2018; Smee, 2019). Immigrants who settle outside of urban centres face other challenges, as rural areas tend to lack health and social services (and especially culturally competent/culturally safe services), as well as employment opportunities (Caxaj & Gill, 2017; Patel et al., 2019). Culturally safe supports and services are recognized as especially important for the well-being of 2SLGBTQQIA+ immigrants (Hwahng et al., 2019; Logie et al., 2016), making settlement in areas lacking these services particularly problematic for sexual and gender minority community members

Immigrants face discrimination in employment, and those with foreign credentials are often unable to access to work in their fields due to policies requiring Canadian education and professional experience (Umaigba, 2017). Immigrants—and especially immigrant women of colour—are overrepresented in precarious employment (Premji, 2018; Umaigba, 2017). As Lane et al. (2018) point out, working in low status, low control jobs, facing racist and xenophobic discrimination, and experiencing barriers to the achievement of financial and lifestyle goals are all stressors that can contribute to health disparities (p. 1051). For 2SLGBTQQIA+ immigrants, access to employment can be further impacted by queerphobic and transphobic discrimination (Hwahng et al., 2019; Fox et al., 2020). Undocumented immigrants are excluded from access to many social programs, including income assistance, social housing, and health care coverage. They are also barred from access to formal employment, leading to exploitation within the labour market (Magalhaes et al., 2010).

Indigenous Ancestry

While Indigenous people have always lived on this land, the country of Canada was founded as a white settler colonial state, wherein white people were and are systematically privileged over Indigenous people (as well as non-Indigenous racialized people), who have been subjected to violence and exclusion. Some of the means through which genocidal violence against Indigenous people has been enacted by the Canadian state include the exposure of Indigenous populations to contagious diseases, both in the past and currently (Gordon et al., 2015; Kilabuk et al., 2019); the dispossession and displacement of Indigenous nations from their lands for the benefit of colonizers and the colonial state, and the concomitant imposition of the First Nations and Métis reserves and Inuit settlements systems; the refusal to honour the sovereignty of Indigenous nations, land claims, and the obligations set out within treaties, which has facilitated environmental racism and created continuing infrastructure and health crises in Indigenous communities; the economic marginalization of Indigenous people; the criminalization and suppression of culture (Czyzewski, 2011; Smylie & Firestone, 2016); the imposition of residential schooling (Czyzewski, 2011; Kim, 2019; Ristock et al., 2019; Smylie & Firestone, 2016), and the practice of removing Indigenous children from their families and cultures (Czyzewski, 2011; Ristock et al., 2019; Smylie & Firestone, 2016). Thus, colonialism itself should be considered a social determinant of health (Czyzewski, 2011; Smylie & Firestone, 2016).

For 2SLGBTQQIA+ Indigenous people, the imposition of Eurocentric ideologies of gender and sexuality has done further harm. Participants in a study by Ristock et al. (2019) about experiences of domestic violence among Indigenous 2SLGBTQQIA+ people explained how this impacted them. A lesbian trans woman participant stated:

> … At one time Two Spirited people, we had a special place in the community, but in modern times, we're looked on as trash even by our people, 'cause of the European mainstream influence… They've been Catholicized or assimilated by the Roman Catholic church, they've taken those values to heart and they look down on gender diversity and sexual diversity (p. 779).

A Two Spirit gay man had a similar perspective:

> You know, the Europeans have won in that respect. They took away our identity, our niche in our own community is gone. It's stripped away. It's hard, I would be lucky to find that in Canada, I think, to find a community where they go, oh you're Two Spirited. Wow. Welcome (p. 780).

Due to the impacts of colonialism as well as anti-Indigenous discrimination perpetrated by settlers, Indigenous people in Canada face difficulties in relation to many of the other social determinants of health. Indigenous people have a lower average income and are more likely to face unemployment than non-Indigenous people (Kolahdooz et al., 2015; Smylie & Firestone, 2016, p. 448). On average, Indigenous people have lower levels of education than the Canadian population as a whole (Bethune et al., 2019; Smylie & Firestone, 2016 p. 449), resulting from inadequate investment in Indigenous education, financial inaccessibility, and Eurocentrism and anti-Indigenous discrimination within the education system (Kolahdooz et al., 2015; Shankar et al., 2013). Indigenous people's access to health care is impacted by discriminatory structures as well as anti-Indigenous bias among health care workers: The deaths of Brian Sinclair in 2008 and Joyce Echaquan in 2020 resulted from medical negligence and misconduct motivated by anti-Indigenous bias (Petz, 2020). Indigenous people also face food insecurity at levels three times greater than those of the population as a whole (Smylie & Firestone, 2016, p. 449). Compared to non-Indigenous people, Indigenous people are four times more likely to live in overcrowded housing, as well as three times more likely to live in housing in need of significant repair work (Smylie & Firestone, 2016, p. 449). Indigenous people are also likely to encounter discrimination when seeking rental housing, leading to housing instability (Motz & Currie, 2019).

The disparities that result from colonialism and anti-Indigenous oppression are the cause of the reduced life expectancies and higher rates of physical and mental health difficulties that Indigenous people encounter (Bethune et al., 2019; Kilabuk et al., 2019; Kim, 2019; Smylie & Firestone, 2016, pp. 450–451). Colonial mental health research has often positioned Indigenous people as inherently pathological, spuriously blaming both culture and biology for any mental health difficulties that Indigenous people face, ignoring the impacts of colonial relations while also neglecting Indigenous resilience (Czyzewski, 2011, pp. 5–6).

Geography

Geography plays a significant role in shaping health outcomes. Within urban areas, segregation has negative impacts on health, with people living in neighbourhoods with lower socioeconomic status having less access to healthcare, as well as greater exposure to the health-damaging impacts of poverty, low-paying jobs, precarious employment and unemployment (McGibbon, 2016).

People living in rural areas generally report poorer health compared with those who live in cities (Lutfiyya et al., 2012; Patel et al., 2019; Wanless et al., 2010). Experiences of exclusion, discrimination and a lack of culturally competent/safe services may exacerbate this effect for racialized people, immigrants (Caxaj & Gill, 2017; Patel et al., 2019), and some members of the 2SLGBTQQIA+ community (Blodgett et al., 2017; Fisher et al., 2014; Kaplan et al., 2019; Whitehead et al., 2016). In contrast, Bethune et al. (2019) found the opposite to be true for First Nations and Métis people living off-reserve, possibly as a result of enabling a better connection to the land, community and spirituality. They also point out that urban Indigenous people frequently experience difficulties with housing access, instability, and quality (p. 177). At the same time, Ristock et al. (2019) found that some 2SLGBTQQIA+ Indigenous people felt that they did not belong and were not supported in their rural home communities (p. 778).

Although rurality is associated with many factors that impact health, including barriers to accessing health care, lower income, food insecurity, and a lack of access to social networks and supports (Caxaj & Gill, 2017), Wanless et al.'s (2010) research with older rural women found that these factors may play a less significant role in shaping health outcomes for this population than for older urban women, indicating that the relationship between rurality and health is complex.

Environmental contamination and destruction are further means through which health is impacted by geography. People living in proximity to sites of industry or resource extraction, waste management facilities, and other major polluters have higher rates of various cancers in comparison with those who do not live close to such activities. Due to pervasive environmental racism, these sites are often located near or within Indigenous and racialized communities (McGibbon, 2016).

Childhood and Education

Early Life

Childhood experiences are an important social determinant of health, exerting a large influence on health status throughout the lifespan (Gonçalves de Assis et al., 2012). Young children require high quality care, whether within the home or through early childhood education and care programs, but this is often unavailable due to a lack of government investment (Friendly et al., 2016; Moore et al., 2015; Raphael, 2016b, p. 220). Children's health is strongly related to their parents' socioeconomic status, which impacts access to material resources, "family resources" (such as parenting skills and parental engagement), and social infrastructure and supports. Low income is associated with higher rates of childhood physical and mental health difficulties, injuries, and lower school readiness (Raphael, 2016b, pp. 219, 227). A lack of access to needed resources during childhood is also strongly associated with negative health outcomes in adulthood (Maggi et al., 2010; Moore et al., 2015; Raphael, 2016b, p. 222–224).

Adverse childhood experiences, including experiencing or witnessing violence, abuse, and neglect, being bullied, or experiencing stresses associated with parents' problem substance use or mental health difficulties are associated with negative later life health outcomes

(Finkelhor et al., 2015). 2SLGBTQQIA+ children and youth, including those who are gender non-conforming, gender independent, gender expansive, gender creative or transgender face the stresses associated with living in a queermisic and transmisic society, and may also experience a lack of support, rejection or violence at the hands of their family members (Dysart-Gale, 2010; Hatzenbuehler & Pachankis, 2016; Michels & Kovar, 2020; Singh & McKleroy, 2011).

Education

In Canada, neoliberal disinvestment has diminished access to education (Davidson-Harden et al., 2009). At the post-secondary level, increases in tuition fees in concert with inflationary housing and food costs have rapidly outpaced earnings and student loan program limits, putting post-secondary education out of the reach of people with limited resources (Education for All, 2021). Low income, racialized and Indigenous youth are severely impacted by this problem (Education for All, 2021; Shankar et al., 2013). 2SLGBTQQIA+ students may also be impacted by these issues due to being more likely to lack access to parental support and to face employment discrimination (Bauer et al., 2011; Goldberg et al., 2019). Although efforts to improve equity within education in Canada are ongoing, the colonial, racist, ableist, queermisic and cissexist underpinnings of mainstream education systems (in the formal and hidden curricula, and within social relations between education personnel and among students) cause direct harm and remain an additional barrier to the success of Indigenous, racialized, disabled and 2SLGBTQQIA+ students (Codjoe, 2001; Martino et al., 2019; Shankar et al., 2013; Ungerleider & Burns, 2016).

Education has a strong impact on health, well-being and longevity. Improving equitable access to education would lead to substantial improvements in population health as well as reductions in social problems such as crime (Compton & Shim, 2015; Page-Reeves & Cardiel, 2016). People who have more education may have better health literacy, and are more likely to be able to find stable, higher-quality, well-paying employment. With higher incomes, people have better access to many of the other determinants of health, including housing, food, health care, and opportunities for social participation (Page-Reeves & Cardiel, 2016; Shankar et al., 2013).

Health Care

As Marmot (2017) writes, "… The key determinants of health are not what happens in hospitals… Health is not determined so much by what doctors do for patients, but by arrangements in society" (p. 686). McGibbon (2016) explains that health care is not always viewed as a determinant of health because increases in the availability of health care services often have minimal impacts upon population health. She argues that while this may be the case, a lack of equitable access to health care does have significant impacts on the health of marginalized groups and it should therefore be included in considerations of the social determinants (p. 491). In their study comparing the impacts of increased investment in primary care in the UK and Ontario, Cookson et al. (2017) found that the UK's equity-focused model led to improvements in health care access and health for people of lower socioeconomic status between 2007 and 2011, whereas in Ontario, investments did not have an equity promotion objective and gaps in health care access and health outcomes continued to increase during that time period.

Health care access is influenced by the other social determinants of health. As I discussed above, geography often determines access to health care. Health care providers' biases against oppressed people also impact access to health care. Poor people, racialized people, women, disabled people (including people labelled or perceived as mentally ill) and 2SLGBTQQIA+ people are less likely to receive appropriate assessments and referrals, often encounter discrimination within the health care system and may also avoid seeking care as a result. These impacts are compounded for those located at the intersection of multiple identities (Baker & Beagan, 2016; Giblon & Bauer, 2017; McGibbon, 2016, p. 492; VanPuymbrouck et al., 2020).

Similarly, while the "universal" health care system in Canada affords more equitable access than a private insurance-based health care system like that in the United States, persistent gaps in coverage remain. Many Canadians—especially those facing marginalization—lack coverage for orthopedic, prosthetic or mobility devices, dental and pharmaceutical care, as well as other necessary services often more readily accessible in the private market (Brandt & Kleiman, 2019; McClymont, 2015; McGibbon, 2016, p. 495).

Income and Employment

Income and its Distribution

Individual income and income inequality have both been found to have associations with physical and mental health (Auger & Alix, 2016; Compton & Shim, 2015, p. 422). The association between individual income and health is described as a "social gradient" (Eckersley, 2015, p. 121). In Canada, low income is linked with a wide range of mental and physical health issues and social problems, as well as earlier mortality among children and adults, while people with higher income have better health overall (Auger & Alix, 2016, p. 93). As I have explained, access to financial resources enables people to access education, suitable housing, better food, health care resources, and enables greater social participation. As a result of structural oppression and discrimination, oppressed people are more likely to have a low income than people who are privileged. The Ontario-based Trans PULSE study found that the majority of trans people surveyed were living in poverty, with a personal annual income of less than $15,000 (Bauer et al., 2010).

The connection between income inequality and health may be more complicated. Some Canadian studies have shown that income inequality is associated with poor self-reported health and mortality, whereas others have not observed that link. A study comparing data from the United States and Canada found that mortality rates increased with inequality levels in the United States, but found no relationship between inequality and mortality in Canada (Auger & Alix, 2016, p. 92). Noting that there is some evidence that income and income inequality are not universally predictive of health outcomes across all cultural and political contexts, Eckersley (2015) argues that these factors should be considered alongside other social determinants approach, to better account for the complexity of social relations. Some of the means through which inequality is thought to impact health are as follows: Inequality leads to a lack of social cohesion and solidarity, which has negative health impacts; people's perceptions of increasing inequality is a physiologically damaging stressor; and greater inequality causes a greater divergence of the interests of the wealthy and the poor, leading the wealthy to push for reductions in social spending. This reduces access to social services and infrastructure, leaving gaps that poor people are unable to fill with their dwindling resources (Auger & Alix, 2016, pp. 101–103). As a result of neoliberal policies, income inequality has been rising substantially in Canada since the 1980s, with market incomes remaining flat or even shrinking for the lower 60% of the income gradient, while the market incomes of the upper middle class and the wealthy have increased (Curry-Stevens, 2016, pp. 63–65).

Employment and Working Conditions, Unemployment and Employment Security

Employment impacts health in several ways. Secure, high status, well-paying jobs with good physical and interpersonal working conditions safeguard health, whereas jobs characterized by insecurity, low status, low pay or poor working conditions—including high strain, and psychologically or physically unsafe conditions—cause health problems. In Canada, employment quality has been on the decline since the 1990s, as employer expectations for productivity have increased (Jackson & Rao, 2016). This has taken place in the context of increased transnational competition enabled by neoliberal trade policies facilitating a "race to the bottom," where employers seek to lower employment costs by sourcing labour in deregulated, low-wage markets; or by using the threat of doing so as leverage against governments, unions and workers (Tremblay, 2016).[46] Among OECD countries, Canada has the highest proportion of tertiary education graduates (Statistics Canada, 2017b) and overqualification is a pervasive problem in the labour market (Jackson & Rao, 2016, p. 161)

Neoliberalism has also led to the rise of precarious work, which is a form of insecure employment that enables organizations to increase their "flexibility" and lower costs and risks by displacing them onto workers (Benach et al., 2014). To achieve this, organizations engage workers on short-term contracts, fill jobs through staffing agencies, or use technological platforms to distribute "gigs" to workers they often inaccurately classify as "independent contractors." Because precarious work often involves low earnings, poor working conditions and no access to benefits or entitlements, it poses significant risks to workers' mental and physical health (Benach et al., 2014; Umaigba, 2017, p. 17). As I have discussed, because of discrimination, racialized people and recent immigrants are overrepresented in precarious employment in Canada (Premji, 2018; Umaigba, 2017).

In addition to the stresses caused by the general decline of employment quality, 2SLGBTQQIA+ and gender diverse people face specific challenges in the workforce, encountering high levels of discrimination in hiring and on the job, leading to high levels of unemployment (Bauer et al., 2011; Davidson, 2016; Irving & Hoo, 2020; Ross et al., 2018, p. 9; Waite, 2020). Unemployment leads to increased stress and anxiety, and without access to income and benefits from employment, people are much more likely to face poverty and deprivation (Raphael et al., 2020). Irving and Hoo (2020) argue that the flexibilized neoliberal job market in Canada determines workers' employability via their perceived capacity to undertake "affective labour" to create positive feelings in managers, co-workers and clients. Because transmisia, transmisogyny and racism are pervasive, trans workers—especially racialized trans people and trans women—are often considered as incapable of fulfilling this function (p. 199).

Social Safety Net

The social safety net is made up of a range of supports provided by governments to help people to cope with changes in their lives (whether normative or unplanned). Income assistance programs are one part of the social safety net. In Ontario, the two main income assistance programs are Ontario Works (OW), which provides a very low level of financial support to people without other sources of income, and ODSP, which provides a slightly higher but still inadequate level of income assistance to eligible people with disabilities. Other social safety net programs include employment insurance, pensions, family benefits and credits, child care, health care and social services (Raphael et al., 2020, p. 45). As a result of neoliberal retrenchment, Canada has taken an increasingly individualistic, libertarian approach to the welfare state (Raphael & Curry-Stevens, 2016, p. 565), and spending on social safety net programs in Canada has substantially declined since the 1980s (Langille, 2016, p. 471), and is now lower than in the majority of other OECD countries (Raphael et al., 2020, p. 45). In addition to spending cuts reducing access to supports and services, Curchin (2017) explains that in recent decades, people receiving social safety net benefits have also been subjected to policies rooted in "libertarianism paternalism" that impose increasingly stringent and punitive behavioural requirements as a condition of receiving assistance (pp. 232–233). She argues that the assumptions about poor people underlying these policies disregard the reality of structural inequality, and are also contradicted by behavioural science research demonstrating that the kinds of "irrational" behaviour sometimes claimed to reflect a "culture of poverty" actually demonstrate the psychological impacts of the stress caused by resource scarcity.

The presence of a strong social safety net may mitigate some of the impacts of unemployment and employment insecurity by affording alternate means of accessing housing, food, income and other resources needed to support life, health and well-being (Benach et al., 2014; Tremblay, 2016), yet the Canadian social safety net does not adequately provide for these needs so it cannot fulfill this function. Without access to a safety net, life changes are more likely to lead to health-damaging stress and deprivation (Devasahyam et al., 2020; Reid & Herbert, 2005). In addition, as Fleming et al. (2019) point out, undertaking cost-saving measures in one part of the safety net often leads to increased spending in another.

The inadequacy of the social safety net in Canada has particularly negative impacts on marginalized people. For example, most provinces do not provide affordable child care, putting women at a greater disadvantage in the labour market, which in turn makes them more likely to require access to the income assistance programs that have also been subjected to cuts (Reid & Herbert, 2005). Disabled people may be unable to work due to impairment effects, but also encounter rampant inaccessibility, non-accommodation, and bias within the labour market (Darcy et al., 2016). Without access to employment, they are often forced to rely on income assistance programs that do not provide adequate support (Hamidian, 2019). As previously noted, gender diverse people also encounter a high rate of employment discrimination, making them also especially vulnerable to the inadequacy of income assistance programs.

Shelter and Food

Housing

Living in housing that is safe, suitable and affordable improves health (Ortiz & Johannes, 2018; Rolfe et al., 2020). In recent decades, housing policy in Canada has not been effective in improving access to decent housing, with the Federal government having disinvested from the creation of social housing and other forms of housing support in 1993. Beginning in the early 2000s and intensifying following the global financial crisis of 2008, the neoliberal housing and fiscal policies that enabled the financialization of housing in Canada exacerbated the problem of housing unaffordability (Kalman-Lamb, 2017; Walks & Clifford, 2015), resulting in a private rental and purchase market that has become severely unaffordable relative to household incomes across an increasing number of regional markets. As a result, more households are living in substandard, inadequate and unaffordable housing, and housing insecurity and homelessness have increased substantially (Bryant & Shapcott, 2016). These problems are compounded by dynamics of inequality and discrimination for members of structurally oppressed groups, including Indigenous, racialized, disabled and 2SLGBTQQIA+ people (Centre for Equality Rights in Accommodation, 2009; Knötsch & Kinnon, 2012; Motz & Currie, 2019; Ontario Human Rights Commission, 2008) The negative health and social impacts of housing instability and homelessness have been documented extensively and include a wide range of mental and physical health problems and early mortality (Bowen & Mitchell, 2016; Frankish et al., 2009; Johnson, 2010; Watson et al., 2016).

Food Security

Whereas food security—being able to access adequate amounts of nutritious and safe food to support health and activity (McIntyre & Anderson, 2016) is a determinant of health, many people face the opposing condition of food insecurity. McIntyre and Anderson (2016) define individual food insecurity as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so due to income constraints" (p. 295). Living in a state of food insecurity leads to reduced intake of nutritious food leading to inadequate intake of key nutrients (Tarasuk, 2016, p. 326). Through stress as well as the impacts of poor nutrition, a lack of access to enough nutritious food is linked to many health problems including growth stunting, hypertension, dyslipidemia, diabetes, back pain, arthritis, asthma, and mental health difficulties. It also worsens outcomes for people living with HIV (Tarasuk, 2016, pp. 331, 334).

Since their emergence in the 1980s, food banks and related community-based resources such as school nutrition programs and collective kitchens have become familiar presences across Canada, but they have not been shown to be effective in improving nutrition or reducing food insecurity, especially for those experiencing the most severe food insecurity or hunger (McIntyre & Anderson, 2016). Because inadequate income is the biggest risk factor for food insecurity, income support is recognized as a more effective means of addressing this problem (McIntyre & Anderson, 2016).

As is the case with the other social determinants of health, oppressed people are often more strongly impacted by food insecurity. Russomanno et al. (2019) identify employment discrimination leading to low income as a major contributor to the high levels of food insecurity experienced by trans people. Casey (2019) notes that food insecurity is also particularly high among bisexual people (p. 31). Single mothers and their children are especially vulnerable to food insecurity (McIntyre & Anderson, 2016, p. 304; Tarasuk, 2016). Indigenous people experience high levels of food insecurity as a result of colonialism. Environmental destruction by colonial governments and business interests and forced relocation with the imposition of the reserve system removed many people's access to traditional sources of food (Settee, 2018). Additionally, the cost of food in remote and Northern communities is extremely high, making it unaffordable especially to Indigenous people, who are more likely to experience poverty (McIntyre & Anderson, 2016, p. 296). Other rural residents are also impacted by the unaffordability and lower availability of food (Buck-McFayden, 2015). Levels of food insecurity are high for disabled people because of employment discrimination and the inadequacy of income replacement programs. Further, the kinds of chronic health issues that result from food insecurity are likely to exacerbate it, as health care expenditures reduce funds available for food costs, and efforts to "make ends meet" (for example, by growing and preserving food, working longer hours or spending time and energy to navigate support and charitable programs) are more difficult for people whose health is debilitated (Buck-McFayden, 2015; Pooler et al., 2019; Tarasuk, 2016; p. 333; Tarasuk et al., 2013).

Exclusion and Inclusion

Social Exclusion

Yanicki et al. (2015) explain that social exclusion constrains distributive justice, limiting the capabilities of certain groups of people (p. 125), while positioning them as less valuable than or "inferior to the dominant group" (p. 123). Galabuzi (2016) discusses what this means within the Canadian context:

> Social exclusion defines the inability of certain subgroups to participate fully in Canadian life due to structural inequalities in access to social, economic, political and cultural resources arising out of the oft-intersecting experiences of oppression relating to race, class, gender, disability, sexual orientation, immigrant status, and the like. Along with socioeconomic and political inequalities, social exclusion is also characterized by processes of group or individual isolation within and from key Canadian societal institutions such as the school, criminal justice, and health care systems, as well as spatial isolation or neighbourhood segregation (p. 391).

The problem of social exclusion has been exacerbated by the imposition of neoliberal economic and social policies that have destabilized lives and intensified exploitation while weakening and dismantling public goods (Galabuzi, 2016, pp. 390–391; Labonté et al., 2011; Yanicki et al., 2015). As my discussion throughout this chapter reflects, the health consequences of social exclusion are myriad. For trans and gender diverse people, social exclusion has been found to raise the likelihood of experiencing problematic substance use (Scheim et al., 2017), has been analyzed as a contributing factor in the criminalization of young transgender women (Hereth et al., 2021), and has been shown to increase vulnerability to contracting HIV and to experiencing mental health difficulties (Divan et al., 2016).

While he recognizes that social exclusion is in a dialectical relationship to social inclusion, Labonté (2016) argues in favour of the critique of social exclusion over a focus on the promotion of social inclusion. He points out that in political practice, an emphasis upon inclusion often serves as a means of validating existing social relations, marking oppressed people as problematic and in need of assistance to assimilate to the status quo while obscuring the dynamics and impacts of structural oppression (pp. 424–425).

Conclusion

This overview of the intersecting social determinants of health and mental health demonstrates the necessity of understanding health as in large part a product of sociopolitical arrangements, rather than a property of individual bodies decontextualized from their environments.

While this discussion has largely taken place in the register of the social, the theory of feminist new materialism shows how at every possible level of understanding and being, we are inextricable from our environments (Rice et al., 2021). With this insight, it is possible to understand how while, for instance, the political realities of race and geography are recognized as social determinants of health, environmental racism is simultaneously a reality of physics, chemistry and biology that creates dangerous entanglements, enmeshing teratogens, endocrine disruptors, and elemental poisons with the cells, tissues and organs of biological matter to further vulnerablize and debilitate often already impoverished racialized bodyminds while the racially and financially privileged insulate themselves from the immediate impacts of the systems that enrich them. In their articulation of the disability justice framework, Sins Invalid (2019) writes,

> We are in a global system that is incompatible with life. The literal terrain of the world has shifted, along with a neo-fascist political terrain. Each day the planet experiences human-provoked mudslides, storms, fires, devolving air quality, rising sea levels, new regions experiencing freezing or sweltering temperatures, earthquakes, species loss and more, all provoked by greed-driven, human-made climate chaos. [Disabled, queer, people of colour] communities are often treated as disposable, especially within the current economic, political and environmental landscapes. There is no way to stop a single gear in motion—we must dismantle this machine (pp. 18–19).

The social determinants of health perspective is also political, environmental, physical and embodied, revealing the necessity of promoting equitable access to environments and material and social goods that instantiate and sustain health and well-being. As Sins Invalid's insights reflect, this is vital for all, but especially for those whose health is negatively impacted by their absence, including trans and gender diverse communities who are structurally disprivileged in relation to so many of the determinants.

Chapter Seven: Feminist Perspectives – Intersectionality and New Materialism

Introduction

Although intersectionality and feminist new materialism are perspectives emerging from distinct traditions within feminist thought, they are deeply compatible. As I will describe, both are rooted in materialist frameworks, albeit in differing ways. Further, they share an emphasis upon the importance of addressing complexity and multiple levels of analysis, from the structural, through individual experiences within context, to relations between and within people and their environments.

The perspectives also have a congruent orientation to the notion of objectivity—recognizing that a description of reality will always be inherently partial and constrained by the positionality of the person doing the describing, which requires researchers to carefully consider the ethics of the framing and focus of their work (Barad, 2008, p. 361). In this way, they also require the acknowledgement of the positionality of the researcher. In fact, as Rice et al. (n.d.) point out, Barad's diffractive method requires the researcher to recognize the impacts of their interventions, both upon the research and upon themselves. Jackson and Mazzei (2012) note that researchers do not straightforwardly interpret an external entity, but are more accurately understood as "install[ing] [them]selves into a situation in a blurring of what 'happens' and how [they] make sense of what happens" (p. 130).

In this chapter, I outline the histories, main concepts, applications relevant to this project, as well as the methodological implications of the two perspectives.

Intersectionality

The Genealogy and Definition of Intersectionality

As Black, women of colour, and Indigenous feminist theorists and activists have long noted, sexism is not the only or central basis of oppression. Because of this, any form of feminist thought that does not account for the impacts of race, class, sexuality, gender identity, ability, citizenship and other determinants of social location is one that serves only those women who inhabit locations of privilege with respect to those determinants. An "additive model of oppression" (Collins, 2000, p. 18) was often applied in early attempts to understand the impacts of multiple forms of oppression: A woman of colour would be conceptualized as "doubly oppressed" as a result of her marginalized locations with respect to gender and race.

To more accurately describe the dynamics of oppression in the lives of those facing their impacts along multiple axes, Black feminist legal scholar Crenshaw named and introduced the theory of intersectionality (1989, 1991). Crenshaw utilized the metaphor of being hit by traffic in an intersection to illustrate the multiple and particular ways in which Black women are affected by racism and sexism:

> Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars travelling from any number of directions, and sometimes, from all of them. Similarly, if a Black woman is harmed because she is in the intersection her injury could result from sex discrimination or race discrimination. … [It] is not always easy to reconstruct an accident: Sometimes the skid marks and the injuries simply indicate that they occurred simultaneously, frustrating efforts to determine which driver caused the harm. In these

> cases the tendency seems to be that no driver is held responsible, no treatment is administered, and the involved parties simply get back in their cars and zoom away (1989, p. 149).

Thus, as Rice et al. (2019) explain, intersectionality describes how the social locations of race and gender, as well as class, disability, and sexuality "are mutually shaped and interrelated with broader historical and global forces such as colonialism, neoliberalism, geopolitics, and cultural configurations to produce shifting relations of power and oppression" (p. 409). Brah (2020) notes that intersectionality addresses the multiple levels at which these forces are manifest, "operat[ing] both at the social level and at the level of the physical body and the psyche" (p. 54).

Although some have claimed that the theory's origins are found in early European feminist theorizing,[47] intersectionality is recognized as being rooted in a long history of Black feminist thought documenting the effects of facing multiple dimensions of oppression (Alexander-Floyd, 2012; Carbin & Edenheim, 2013; Gines, 2011; Rice et al., 2019). Other Black feminist theorists have worked to further develop the theory and related concepts. For instance, Collins' notion of the "matrix of domination" revealed how "oppression cannot be reduced to one fundamental type, and that oppressions work together in producing injustice" (2000; 18).

Focusing on the lived implications of injustice, intersectionality is a materialist, structuralist theory, but it has also been read alongside complementary theories from across a wide range of perspectives (Rice et al., 2019), including those founded in poststructuralism and feminist new materialism or feminist studies of science—such as Haraway's notion of "diffraction" and Moser's concept of "interference" (Lykke, 2010, p. 84).

Developments and Contestations in Intersectionality Theory

Applicability and Coalition-Building

Since the initial formulation of intersectionality, some have claimed the concept as applicable only to Black women's experiences, whereas others have argued that it describes the operation of power across all dimensions of social location. Nash (2008) has argued that some framings of intersectionality as universally applicable have sought to "re-ma[ke] the analytic apart from Black women's bodies," asking, "[W]hy would an analytic centered on Black women not be palatable or desirable as a field-defining analytic?" (p. 17). As Carbado et al. (2013) argue, the idea that a theory centered on the experiences of Black women cannot be applied more widely reflects the white supremacist notion that Black women are "too different" (from the white, male subjects typically positioned as representing "normalcy" or "universality") to be centred within a theory that has broad relevance (p. 305). Applying intersectional analysis to privilege resists the tendency to view them as default, normalized, unmarked categories. Many proponents of intersectionality theory have taken the position that it is universally applicable, describing the relationship between oppression and privilege and locating people (and groups) at specific positions relative to these dynamics along multiple axes (Brah, 2020, p. 54; Cho et al., 2013; Levine-Rasky, 2011; Lorber, 2011).

Claims that intersectionality overemphasizes differences and promotes divisiveness among people with shared interests and some elements of shared identity (Zack, 2005) have largely been superseded by the recognition of intersectionality as facilitating coalitional work across difference to resist oppression (Ferguson, 2010; Hirschmann, 2013).

Disability, Madness and Intersectionality

Intersectional theorizing been extended to understand how multiple dimensions of power shape the experiences of people across all social groups, although this has not always been undertaken in ways that account fully for every salient axis of oppression. For example, disability has not always been consistently integrated into intersectional analysis: In their discussion of the ways that the story of the 1984 police murder of Eleanor Bumpurs, a poor, senior Black woman who had physical and mental health disabilities has been taken up within intersectional research, Erevelles and Minear (2010) point out that even critical race feminist theorists omitted disability from their analysis. They note that this exclusion is especially problematic given the high prevalence of disability among racialized and poor people (p. 128). They suggest that intersectional analysis should be deployed in ways that "foreground the historical contexts and structural conditions within which the identity categories of race and disability intersect" (p. 131). This would enable the recognition of how the social locations are shaped in relation to each other and within a specific historical and political context.

When anti-racist, postcolonial and transnational feminist theorists centre the analysis of the situation of people located at the axes of multiple vectors of oppression in relation to political histories and structures that result in their pervasive social, political, cultural and economic exclusion and subjugation (Erevelles, 2011, p. 131; Erevelles & Minear, 2010, pp. 129–134), their work often engages with issues of disability and distress. For example, McClintock (2001) analyzed the way that the ascription of "madness" was used as a means of controlling and policing boundaries between the colonized and the colonizers in her discussion of the role played by the occupation of space in the psychiatrization of racialized women in apartheid South Africa. As Nash (2019) points out, working across intersectionality and transnationalism is a means of creating space for the development of new and generative relationships between Black and women of colour scholars and their theoretical projects (p. 110). As I describe in Chapter Five of this dissertation, proponents of the theory and praxis of disability justice have similarly developed an intersectional analysis of the oppression and debilitation of racialized, queer, disabled people. Morrow (2017) argues that intersectionality should be a constituent part of mad studies, in that it has the unique capacity to account for the ways that sanism interlocks with other dimensions of oppression. She argues that bringing the perspectives together enables researchers to "foreground the structural contexts in which mental distress occurs and to stretch our understanding of what is considered acceptable human experience" (p. 46).

Gender Diversity and Intersectionality

Intersectional analysis also extends to the understanding of the experiences of trans and gender diverse people. As Wesp et al. (2019) explain, cisgenderism—which they define as the ideology that "denies, [devalues], and pathologizes" those whose gender identities differ from those assigned to them at birth—is a structure of domination that intersects with heterosexism, sexism, racism, colonialism and white supremacy to shape the lives of trans and gender diverse people (p. 288). They explain that because intersectional analysis reveals the ways that hierarchies of privilege and oppression are constructed through the creation of categories of difference, it can reveal the ideological foundations of naturalized relations of dominance, which includes the subordination and exclusion of trans and gender diverse people (p. 289). They point out that because intersectional approaches often aim to centre the "embodied knowledge" and experiences of people located at the nexus of multiple oppressions in the service of social justice, the theory promotes research aimed at the liberation of trans people, who often face multiple dimensions of oppression (p. 289).

Typologies and Depoliticization

Since the introduction of the theory, several typologies of intersectionality have been developed, starting with Crenshaw's (1991) formulation of structural, political, and representational intersectionality (p. 1245), and moving through McCall's (2005) widely-cited and adopted categorical model, in which she identifies the "intracategorical," "anticategorical," and "intercategorical"[48] approaches to understanding and operationalizing intersectionality theory within social research. This use of the theory as a tool for the management of complexity within research—whether or not that research is compatible with the critical orientation of the theory's original formulation—has been criticized as a move toward the depoliticization of intersectionality, as well as contributing to the erasure of Black women from a theory centred on their experiences (Alexander-Floyd, 2012). Puar (2012) describes the use of intersectionality rhetoric in the absence of a challenge to oppressive power relations as representing "diversity management" in research (p. 53). Some critics of intersectionality argue that the theory is not well-defined and that its uses lack coherence and consistency (Nash, 2008), and it therefore often serves as a "buzzword" (Davis, 2008). Illustrating this point, Erel et al. (2011) have noted that invoking the terminology of intersectionality without actually engaging in political analysis or working toward the liberation of oppressed people seems to be used by some researchers as a means to "instantly politically correct [their] output, the pain-free way" (p. 72). Similarly, Nash (2019) has argued that the institutionalization of intersectionality has moved it away from its initial objective as a means of "theorizing the complexity of structures of domination," (p. 118) positioning it instead as something that "adds value" within academic programs and to those seeking employment therein (while this same dynamic simultaneously and problematically encumbers Black feminist academics with the assumption that their work engages the theory) (p. 110).

Methodological Considerations and Intersectionality

The application of intersectional theory in research has been a contentious topic. In line with the notion that the theory applies exclusively to the experiences of Black women, some have argued that it is not appropriate to apply the theory to other subjects (Alexander-Floyd, 2012). Following Cho et al. (2013), I would argue that an intersectional analysis can be undertaken within research to understand the complex interplay of oppression as well as privilege across locations and identities.

The nature of "identity" itself is also contested within intersectionality theory. Some argue that the theory essentializes categories such as gender, race and class (Anthias, 2013a), or that the theory does not adequately attend to the structures that shape people's experiences and positionalities (Anthias, 2013a; Anthias, 2013b). Rice et al. (2019) argue that "identities" (as well as similar categories including "subjectivities, structures and processes") might be more accurately conceptualized as "working truths" with a "dynamic, unstable" basis rather than as immutable facts. They note the importance of attending to the shifting manifestations of power that shape them (p. 414).

Intersectionality has been widely taken up across an expanding range of qualitative and quantitative research that has used many methods, from arts-based research to statistical analysis. This particular project is informed by Morrow's (2017) perspective, which claims that "central to intersectionality is the foregrounding of lived experience, that is, people's own descriptions of living various intersections" (p. 47). The purpose of intersectionality theory—whether it can be straightforwardly taken up as a means of dealing with complex research questions, or if its orientation toward the promotion of justice for oppressed people should be upheld as primary—has been widely debated. So too has been the question of precisely how to undertake intersectional research. Regardless of method, Brah (2020) notes that there is no shortcut to intersectional analysis:

> It's not just about mentioning three or four words, and saying "yes, I'm doing intersectionality" – it's really looking at grounded analysis of these different axes. We can't always do all the axes at the same time anyway. But it needs a lot of hard work (p. 54).

This project is informed by the argument of Rice et al. (2019), that although the theory's usefulness as a means of managing complicated data is helpful, its social justice focus is of primary importance. As they contend, "every dimension of a research project is an opportunity to work toward social justice" (p. 418).

Feminist New Materialism

Origins and Definition

While the term "new materialism" was created by DeLanda and Braidotti in the late 1990s (Dolphijn & van der Tuin, 2013), the feminist new materialist perspective originates across a broad range of critical perspectives including environmental feminism and feminist and critical studies of science (Alaimo & Hekman, 2008, pp. 4–5; Fausto-Sterling, 2000; Hird, 2004, pp. 3–6; Krieger, 2005) as well as critical naturalism and critical realism (Gunnarson, 2013, pp. 4–5). Aranda (2019) explains that the “new”-ness of the perspective is defined in contrast to what are sometimes understood as the “static” perspectives of historical materialism and deterministic understandings of materiality within Western theoretical traditions (p. 4). As Anderson (2020) notes, new materialist perspectives resonate with Indigenous worldviews emphasizing the interrelatedness of people with the “lively, relational, sentient world” (p. 209). Similarly, Ravenscroft (2018) argues that “Indigenous materialisms” (p. 354) reveal the instability of Western categories of ontology and identity.

Feminist new materialism challenges deterministic and dualistic conceptions of subjectivity, embodiment, epistemology and ontology through a recognition of the vitality of matter, and the “intra-activity” of the material and the discursive (Barad, 2003, pp. 810–811, 820). It has been identified as a “turn” within theory, in this case responding to the dominance within feminist thought of perspectives rooted in postmodernism/post-structuralism (Alaimo, 2008; Aranda, 2019; Colebrook, 2008, p. 52), which tended to conceptualize matter as “the end product of linguistic or discursive acts” (Barad, 2007, p. 151), or as something unreachable and unknowable except through language. Feminist theorists working within the perspective of new materialism argue that social constructionist theories of embodiment have replicated the very mind-body dichotomy they sought to elude, replicating the Cartesian devaluation of the body by denying its being (Dolphijn & van der Tuin, 2013, pp. 105–106; Grosz, 1994, pp. 6–10; Kirby, 2008, pp. 220–221).

Further, because some postmodernist/poststructuralist feminists have tended to take up an “anti-biological” stance (Ahmed, 2008, p. 24) and have refused to acknowledge the materiality of embodiment, the territory of the body has been largely—and problematically—ceded to biological determinists, whose work often supports oppression and inequality (Tremain, 2002, p. 39). Alaimo (2008) explains that direct engagement with matter reveals biological determinism as nonsensical, given the instability and mutability of the body, arguing that feminists must engage with biology so as to challenge regressive and objectifying conceptualizations of bodies (p. 241).

As a feminist posthumanist perspective, new materialism reveals the lie of the bounded, rational human subject that emerged with the Enlightenment and from which most people have been excluded—post-humanism seeks to decentre the subject (Braidotti, 2013), understanding it as unbounded, situated, embodied and intra-active within environments (Dolphijn & van der Tuin, 2013, p. 97). Hekman (2008) points out that new materialism has "not abandoned the insights of the linguistic turn," but that the perspective reveals the interplay between the conceptual and the material, facilitating an understanding of the material world, but one mediated through concepts and technology (pp. 109–110). New materialism enables us to understand the world beyond the limits of "the human," accounting for "connections between sentient and nonsentient beings, objects, technologies, even attachments to memories or desires" (Aranda, 2019, p. 4).

Central Concepts

Intra-Action, Agency, Becoming and Subjectivity

Barad (2007) draws from the "philosophy-physics" (p. 97) of Bohr to outline a new materialist approach to ontology, which she describes as "agential realism" (p. 26). For Barad, the kinds of "separate individual agencies" presumed by the concept of interaction do not exist. In contrast, Barad proposes the notion of "intra-action," or "the mutual constitution of entangled agencies" (p. 33) to describe how agencies only emerge in relation to one another, as components come together as entanglements, the elements changing and becoming through the intra-action. As she explains, "phenomena are the ontological inseparability of agentially intra-acting components" (p. 33). In this way, everything is interconnected and in constant flux, part of the same unfolding "cascade experiment" (Barad, 2007, p. 394). At the same time, Barad recognizes that power is not diffused evenly across these entanglements. This results in what Aranda (2019) describes as an "uneven distribution of agency across objects and subjects" (p. 5). As an example of this, Tuana (2008) describes the Hurricane Katrina disaster as resulting from the "consumption and refuse practices" of (some) humans, resulting in "material-semiotic interactions" that led to changes to natural and built environments, which in turn had devastating impacts on (other) humans (p. 196).

In addition to agency and power relations, this insight has implications for subjectivity, embodiment and identity. As Barad (2007) writes,

> There is no discrete "I" that precedes its actions. Our (intra)actions matter— each one reconfigures the world in its becoming—and yet they never leave us; they are sedimented into our becoming, they become us. And yet even in our becoming there is no ''I'' separate from the intra-active becoming of the world (p. 394).

Jackson and Mazzei (2012) argue that the new materialist perspective shows that subjectivity is not stable, but is produced through the kinds of intra-active entanglements described by Barad (p.

117). Rice et al. (2021) explain that what might be conceptualized as "human bodyminds" must not be understood as static or bounded, but as

> … continuously changing in their ongoing interconnectedness with an ever-dynamic world. This means bodyminds are conceptualized as always dynamically in a process of becoming different from other bodies and from what they were previously; that individual experiences of difference are never separable from the social and material contexts in which they materialize and are lived (p. 97).

Hekman (2008) recognizes the embeddedness and mutability of the subject, but points out that because new materialist ontology accounts for the ways that meaning and matter are co-constitutive (as I will discuss below), it also accounts for the social importance of identity, or "a core sense of self." She explains that human bodies obtain their identities from "social scripts" available within their society (p. 113). In this way, some bodies are accorded the status of subject, whereas others are marked as "deviant," as "subhuman" (p. 115) or may even go entirely uncounted (p. 113). Hekman argues that to improve the material lives of those marked by these forms of exclusion, existing scripts can be resisted, and existing "body/language connection[s]," rearranged (p. 115).

Natureculture and Posthumanism

Feminist new materialism challenges the boundaries between the natural and the cultural, the human and the non-human. In this way, Dolphijn and van der Tuin (2013) follow Haraway in describing nature and culture as "naturecultures" (p. 48). As Barad (2007) explains further, the cultural/ideational and the material are "mutually articulated" (p. 152) and cannot be separated (p. 3). The recognition of the cultural—and therefore the human—as inseparable from the material gives rise to a "more-than-human" (Fullagar, 2017, p. 253; Tuana, 2008, p. 196) orientation, which recognizes the entanglements that produce us in and through our environments, via the intra-actions taking place at all levels, from the structural to the subatomic. This posthuman—or "anti-human" (Colebrook, 2008, p. 74) view accounts for the complexity of these intra-actions and clarifies these relationships. Barad (2007) explains:

> What constitutes the "human" (and the "nonhuman") is not a fixed or pre-given notion, but nor is it a free-floating ideality. … The very practices by which the differential boundaries of the "human" and the "nonhuman" are drawn are always already implicated in particular materializations. The differential constitution of the "human" ("nonhuman") is always accompanied by particular exclusions and always open to contestation (pp. 141–142).

The Agency and Vitality of Matter

Feminist new materialism emphasizes the fluidity, changeability and emergence of matter (Grosz, 1994, p. 191; Hird, 2004, pp. 56–62; Shildrick, 2009, pp. 25–27), understanding it not as fixed or inert, but as "dynamic, lively and emergent" (Aranda, 2019, p. 4). Barad (2015) describes matter as "not mere being, but its ongoing un/doing" (p. 411). Responding to Barad's (2007) contention that "bodies" and "environments" are co-constituted through intra-action (p. 170), Colebrook (2008) argues that instead of devaluing or ignoring it, recognizing the "dynamism" of matter, including its impacts upon human lives and human history, will allow us to better respond to our materiality (pp. 63–64).

Applications

Feminist New Materialism, Disability and Madness

Revealing the inseparability of the material and the ideational, the feminist new materialist perspective shows how bodyminds do not consist of separable pieces—and indeed, that bodyminds themselves are inseparable from the natural-cultural-technological environments with(in) which they intra-act. Through the lens of feminist new materialism, disability and madness can be understood as arising through "the relationship between [bodyminds] and worlds" (Rice et al., 2021, p. 100). Fritsch (2015) explains that the "essence" of disability should not be regarded as a property of a bodymind or as something inherent in a non-accommodating environment, but as the result of particular entanglements: Using Baradian terminology, she describes disability as "an historically-specific onto-epistemological materialisation of intra-active matter" (p. 52). In line with Hekman's (2008) discussion of the importance of resisting damaging social scripts, Fritsch argues that disability should be reimagined as desirable, creating space for new understandings/experiences of disability and difference (2015, p. 55). Even as it facilitates the recognition of both the existence and the desirability of disability and of madness, the feminist new materialist perspective also resonates with disability justice perspectives addressing the conditions and relations of debilitation, as Tuana's (2008) comments on the "viscous porosity" (p. 200) of bodies intra-acting with toxins, stressors and unsurvivable conditions demonstrate.

A new materialist perspective reveals how the dominant, binaristic ways of understanding bodies (as abled/disabled, sane/mad, etc.) are limiting as well as inaccurate (Shildrick, 2008, p. 44). Considering the agency of matter can illuminate the lived complexities of disability and madness, including experiences of episodic or fluctuating disabilities, which are often "affected by countless known, suspected, and unknown factors" (Alaimo, 2008, p. 250). This illustrates the continuous interplay of agencies in shaping disabled and mad embodiment.

A feminist new materialist approach can demonstrate how experiences of mental difference and distress are always and at once thoroughly embodied and thoroughly social and political. For example, the topic of psychiatric medication has been addressed from feminist new materialist perspectives, with some theorists considering it as revealing the inseparability of the physical and the mental (Trivelli, 2014). Wilson (2008) contends that in concert with psychotherapy, SSRI and SNRI antidepressants can promote "a profound, long-lasting, organic empathy" (p. 385). As Rice (2018) notes, a task for feminist new materialist readings of scientific literature is to attend to productive possibilities while also recognizing and challenging the reproduction of dominant ideologies (p. 541). In this way, it is problematic that Wilson's commentary does not engage with any of the critiques as to the efficacy and iatrogenicity of these classes of drugs, nor are her conclusions consistent with recent research findings demonstrating their empathy-impairing effects (Rütgen et al., 2019).

Gender Diversity

In similar ways to disability and madness, feminist new materialist perspectives are also particularly relevant to gender diversity. Responding to Stryker's (1994) comments on the construction of trans people as "unnatural," Barad (2015) argues forcefully that no body is “natural,” arguing that “materiality in its entangled psychic and physical manifestations is always already a patchwork, a suturing of disparate parts” (p. 393). As Jagger (2015) explains, the binary system of human gender is not an “immutable, ontological difference,” but the result of material-discursive “boundary-making practices” (pp. 323–324). Latham (2016) argues that insights from new materialism reveal that gender is complex and multiple (p. 349).

Some researchers have analyzed gender confirming health care policies and practices through a new materialist lens. They have found that the gender binarism of many such programs is indefensible given the multiplicity of gender (Irni, 2013, p. 44; Latham, 2016, p. 363). They have also argued that expanding access to gender confirming care is of vital importance for many members of trans and gender diverse communities, regardless of whether they conform to the (often transphobic and gender stereotype-driven) expectations of clinicians, noting that denying access to care makes trans people vulnerable in many ways. Irni (2013) explains that while transition-related hormone replacement therapy is often interpreted through the lens of technoscience, it must also be understood through a social lens, as intra-acting with health care systems that vulnerableize trans clients (p. 44). Latham (2016) explains further:

> For trans people seeking medically supervised body modifications, clinical treatment pathways are often composed of barriers: geographically sparse, financially expensive, psychologically intrusive, emotionally harmful, administratively difficult, just to name a few. On top of that, it is trans people who are expected to produce a narrative in line with clinical sex-gender, and not the other way around. What would it look like if clinicians supported trans people’s sense of themselves, including those of us who do not

> experience our bodies as repulsive or asexual, yet still desire to physically change (in some ways and perhaps not all)? (p. 363).

Methodological Considerations in Feminist New Materialism

The question of how to apply the insights of feminist new materialism within research has been answered in several ways. Drawing from Deleuze and Guattari's concepts of the nomad and of deterritorialization, Andersson et al. (2020) contend that new materialist perspectives are particularly compatible with a case study—or "case-assemblage"—approach, which is spontaneous, responding to "the flow of affect," or intra-actions connecting researchers, subjects and environments. At the same time, they note that most research projects are territorialized, shaped by predetermined research questions among myriad other constraining factors. While this does not mean that a new materialist analysis cannot be undertaken, they suggest that processes and outputs will be limited by traditional methodological biases (pp. 6–7).

Jackson and Mazzei (2012) apply a new materialist lens to their research with post-secondary faculty members, showing how concepts such as Barad's notions of diffraction (which addresses how discourses materialize, rather than how they function or circulate [Jackson & Mazzei, 2012, p. 130]), the agency of matter, and intra-activity can reveal the otherwise obscured forces shaping the faculty members experiences. For example, they address the relationship between a Black woman faculty member and her students within the physical space of her office, which became a haven for students of colour, challenging white supremacist norms within the institution (pp. 125–128). They also describe how what Bennett (2010) would call the "thing-power" of a working class white woman faculty member's suit, which they read in line with the discourse of the “power suit” (Jackson & Mazzei, 2012, pp. 132–133) as intra-acting with her body in the context of an academic conference to produce her as someone who belongs (pp. 128–129). Adapting the work of Barad, Jackson and Mazzei (2012) list four key questions for research informed by new materialism:

1. In what sense are social relations produced and what does this production entail?
2. What is the nature of the processes that “shape” these relations?
3. What is the relationship between the material and discursive dimensions of power relations?
4. How are we to make sense of the nature of power dynamics? Of materiality? (p. 132)

Aranda (2019) argues that researchers addressing topics pertaining to health and health care from the perspective of feminist new materialism should

> Focus on untangling the multiple relations of practices, networks, assemblages held together sometimes precariously, but in turn often holding together larger categories of inequalities, gender, age or sexuality (p. 7).

The Compatibility of New Materialism and Historical Materialism

In this project, I bring together a range of critical perspectives to understand the experiences of trans and gender diverse people. While the compatibility of most of the perspectives is clear, new materialism has sometimes been considered as incompatible with analytics rooted in historical materialism (Andersson et al., 2020), such as the social determinants of health, for instance.

Here, I explain how my engagement with the perspective retains a critical focus, recognizing the impacts of power relations even as the complexity of agency is acknowledged.

Critical theorist Lettow (2017) argues that some new materialist understandings of agency as inhering in both the human and the nonhuman "equate all forms of material agency" and therefore cannot account for power relations (p. 107), as evidenced in what she described as the posthumanist construction of a monolithic "we" that "submerges relations of difference, power and domination" (p. 111). She argues that critical materialists should resist these forms of new materialism, but concludes that a new materialism that aligns with historical materialism in recognizing the impacts of asymmetric power relations could be considered as a "true critical theory" (p. 118).

Like Lettow (2017, pp. 114–118), Choat (2017) notes that many new materialist critiques of historical materialism have unfairly mischaracterized the latter perspective's understandings of agency, science and ontology, inaccurately positioning it as anthropocentric and positivistic. Choat also calls upon those taking up new materialism to engage with historical materialism, arguing that the perspectives can be read together in helpful ways, pointing out that in comparison to post-structuralism, new materialism is more compatible with historical materialism in that both perspectives engage with science, materiality and agency (p. 1040). She argues that putting historical materialism into conversation with new materialist perspectives can help to counter the potential flattening of power dynamics that have sometimes impacted new materialist analyses (pp. 1036–1037). Aligned with these perspectives, Hekman (2008) notes that new materialist ontology can be understood as rejecting relativism and upholding a normative stance, seeking to understand and evaluate material consequences (pp. 109–110).

As a new materialist theorist, Coole (2013) posits that the theory is compatible with historical materialism, noting that new materialist perspectives can facilitate political analysis through the micro to the macro, highlighting the complex interactions and interconnections of systems and structures (p. 453). To do this, new materialist analysis can engage with “everyday visceral experience” to bring meaning to the relationship between the material/embodied and the embedded power structures that enable and constrain (p. 465–466). She points out that new materialist perspectives are often criticized as overemphasizing unpredictability and chance, but counters that the perspective can—and should—also account for the impacts of “inertia and more or less enduring continuities—such as patterns, path dependency, institutions, systemic logics” (p. 453) in which power is often concentrated, and notes that a new materialist analysis can usefully reveal instabilities within and around that which might otherwise be assumed to be solid or even invulnerable (p. 453).

Throughout this project, I engage in an analysis rooted in new and historical materialist perspectives to understand participants’ experiences across multiple levels, from material embodiment through the systemic and structural (Coole & Frost, 2010, p. 32). For trans and gender diverse people, the new materialist perspective may be particularly resonant, as it challenges the transphobic claim that because gender is socially constructed, the meanings of bodies can be entirely resignified through culture. While the resignification and expansion of gender and its markers is a valuable goal, it cannot be understood as erasing or invalidating the need for access to gender confirming therapies and procedures. For instance, taking hormone replacement therapy often impacts appearance, but it may also lead to changes in affect, self-concept and self-acceptance, and these interact in complex ways within a social world that promotes a two-sex system (Irni, 2013, p. 48). It does a disservice to trans and gender diverse people to suggest that the myriad physical, emotional, personal and social changes that can accompany physical transition could be achieved just as well through a hypothetical shift in cultural norms (especially given that such a shift has not yet taken place, and that it is not within the capacity of any individual to effect it).

Conclusion

With an understanding of identities and social locations as "working truths" (Rice et al., 2019, p. 414) rather than immutable essences, when the insights of intersectionality are brought together with the feminist new materialism's understanding of the material-discursive, the two perspectives can provide an in-depth account of complexity and change, addressing the multiple levels at which phenomena operate within the world. Their recognition of the interplay between—and the inseparability of—the political, the social, the embodied and the material are especially helpful in illuminating the experiences of differently situated trans and gender diverse people, whose own vitality is often met with hostility within institutions and structures.

Chapter Eight: Narrative Research and Digital Storytelling

Combining Narrative Interviewing and Digital Storytelling to Liberatory Ends

I hoped to amplify the perspectives of gender diverse people through this research. To do this, I considered a range of participatory methods and settled on a mixed methodology bringing together narrative interviewing and digital storytelling, two methods that place participants' stories at the centre of the work. The project was designed to accommodate participants who wished to engage with the more traditional research methodology of interviewing as well as those who were interested in participating in digital storytelling, which—as an arts-informed method—is time- and resource-intensive and may not be of interest to all prospective participants (Mannay, 2016, p. 95). As Brockmeier (2001) explains, the medium of narrative can vary, taking place across "language as well as imagery, sound, spatial construction, or a combination thereof" (p. 255). My intention in uniting these methodologies is to bring forward new perspectives on an issue that tends to be dominated by medicalized discourses that obscure its social, cultural and economic dimensions: As Jerome Bruner (2008) writes, "Narrative … not only shapes our ways of communicating with each other and our ways of experiencing the world, but it also gives form to what we imagine, our sense of what is *possible*" (p. 45). According to Bathmaker (2010), a narrative approach embraces complexity, and can "reveal ambiguity rather than tidy it away" (p. 2). He explained that because narrative methods involve thick description to bring "real life" into focus, narrative research "may call into question dominant narratives that do not match the experience of life as lived" (p. 3). Each participant in this project has a unique perspective and experience. Each has goals and dreams. Each is entangled in complex webs of relationships, ideologies, regulations and material conditions, with some possibilities facilitated and others forestalled by their circumstances, their capacities, and the ways they are recognized or misrecognized by others. Each has agency, but agency cannot be disentangled from those webs. Each has resilience, but resilience does not equate to unilateral transcendence.

Stories and Subjectivity

Squire (2013) writes that there are conflicting perspectives on subjectivity within the field of narrative research, noting that "the agentic, storytelling subject of the experience-focused tradition, [is] at odds with the fragmented, culturally produced, 'postmodern' subject of more culturally oriented analyses" (p. 65). As a result of this, as Squire et al. (2013) point out, due to the clash between the humanistic and postmodernist/poststructuralist perspectives in which narrative and story-based methodologies are rooted, explanations as to why and how they have the power or agency to promote social change are often muddled or vague (p. 7). At the same time, they note that practitioners of these methods nevertheless aim to "do useful and innovative work across the contradictions" (p. 5). I argue that taking up a new materialist perspective may be a means of both resolving this theoretical tension as well as accounting for the means by which stories can cause change. As discussed previously, new materialism offers a robust explanation for the relationship between the material and discursive, which it holds as inseparable and intertwined aspects of being and life. A new materialist perspective recognizes matter itself as agentic (Barad, 2003). Following Tamboukou's (2013, p. 99) reading of Braidotti's (1991) work on the materiality of ideas (Braidotti, 1991, pp. 124–126) as it applies to narrative, and drawing from the insight of Squire et al. (2013) that Deleuzian narrative methodologies have sought to show how individual narratives are part of "networks of narrative meaning distributed across the material world, not fixed to a single biographical subject" (p. 4), I want to also suggest that narratives or stories are agentic, and therefore the stories of the people who participated in this project can be both manifestations of their agency and agentic in themselves. Telling a story is an action, as is interpretation, retelling, reading or listening. Stories can make change through their telling, and through their affective power to activate understanding, empathy and the desire to know and do (Andrews, 2012; Bold, 2011, p. 30; Rice et al., 2020a). They invite questions about why they were told and what they might mean. In this way, stories have the power to reshape the strands forming the webs in which each of us are entangled, weaving new possibilities from the threads, twists and knots.[49]

The kinds of stories told by the people who participated in this project are shaped by the discourses that circulate around the topics in question, but also exceed and transcend them, showing the limitations of the ways that "trans mental health" has been framed, as well as the impacts of widespread transmisia, and a lack of services and other necessary resources. Through their stories, participants also highlight their insights about what can be done to address these problems as well as the work they are undertaking to improve equity and make life better for members of the gender diverse community and other oppressed people.

While personal narratives are stories told by individuals, they are situated within social and cultural contexts, including in relation to the canonical stories and conventional story forms of a culture (Brockmeier, 2001, pp. 248–253; Bruner, 2002, p. 31; Phoenix, 2013, pp. 73–75). This means that research participants can be understood as invoking "key narratives" (Phoenix, 2013, p. 75) to construct meaning and manage researcher perceptions. Griffin & Phoenix (2016) also refer to these stories as "master" or "dominant" narratives (p. 14). Similarly, Low et al. (2017) note that a storyteller will refer to what is culturally available to them, and will also be shaped by "subtle, imaginary and unconscious meanings" (p. 40). As they write, "Understanding listening as a mode of collaboration and interpretation also asserts the singularity of the other as comprising a complex personhood in need of interpretation, rather than a narrow identity" (p. 40). They explain that interpretation necessitates understanding storytelling subjects as exceeding discrete and legible social identities (recalling McCall's "anticategorical" approach to intersectional analysis [2005, pp. 1773, 1775–1780]), as well as accounting for one's own complex personhood. I will return to this notion in my later discussion of "voice" and listening.

Narrative Methodologies

Diversity of Narrative Research Methodologies

Riessman (2013) writes, "There is no single way to do narrative research, just as there is no single definition of narrative" (p. 259). Narrative research is a broad field comprising many approaches. As Squire et al. (2013) point out, "In social research, 'narrative' … refers to a diversity of topics of study, methods of investigation and analysis, and theoretical orientations. It displays different definitions within different fields, and the topics of hot debate around these definitions shift from year to year" (p. 3). There are several divisions in the field. As I noted earlier, these begin with the disparate theoretical foundations found within narrative research, particularly between humanist and poststructuralist (including psychoanalytic) approaches (Squire et al., 2013, pp. 3–5, 7–8, 10–11). There are several distinct areas of focus within the field of narrative inquiry, including Labovian event-centred narrative inquiry that focuses on how a specific incident is recounted, with an emphasis on language use (Johnstone, 2016); experience-centred narrative research that may use various types of narratives including personal stories, visual materials and objects or actions, to capture a subject's life experiences (Squire 2013, pp. 49–50); and narrative research that analyses dialogue to reveal the social and cultural functions of stories (Squire et al., 2013, p. 6). Narrative approaches also vary in scope, where some narrative researchers have advocated for a "small story" approach emphasizing detailed linguistic analysis of everyday interactions, while others have adopted a "big story" approach (Squire et al., 2013, p. 8). "Big stories" comprise wider-ranging and reflective autobiographical narratives, often produced through interviewing (Freeman 2006, p. 131; Phoenix 2013, p. 72). Researchers may also choose to combine these approaches (Griffin & Phoenix, 2016). According to Wells (2011), narrative "link[s] the micro- and macro-levels of analysis" (p. 10), which can make the approach particularly useful for an intersectional research project that addresses social issues across multiple scales of analysis.

A "Big Story" Approach

This interview-based portion of this project looks at "big stories" told by participants in response to open-ended interview questions with a specific focus. Freeman (2006) explains that participating in an interview may not be a typical daily experience in most people's lives and the big stories that emerge in the course of an interview are different from those that might arise throughout the course of everyday life. Those who advocate for the analysis of naturalistic and spontaneous "small stories" have often criticized the kinds of stories elicited within an interview setting as non-immediate and edited, and therefore dangerously prone to error and exaggeration (Bamberg, 2004, pp. 355–356; Freeman, 2006; Helsig, 2010). At the same time, despite its putative "naturalism," I would argue that the "small story" is also a story and it is therefore by no means guaranteed to be honest or free of errors. In contrast to detractors of the "big story" approach, Freeman (2006) has argued that telling big stories offers participants an opportunity to engage in reflection and to consider their experiences in relation to other parts of their lives and in a broader context. Thus, the interview creates a space for participants to examine their experience with some remove from the immediate circumstances they encountered, and therefore engage in "interpretive reflection that goes beyond the vicissitudes of the moment" (p. 137).

Socioculturally-Oriented, Expressivist Narrative Research

Following Squire (2013), I take a "socioculturally-oriented" approach to narrative, interpreting individual "experience-centred" personal stories as imbricated with and illustrative of broader social and cultural dynamics, including political contexts and cultural scripts. Squire pointed out that this approach to narrative research "serve[s] the important contemporary function of allowing personal narratives of identifications to come into congruence with broader narratives of trauma and conflict, through the storying of memory and history" (p. 66), and clarified that this approach may de-emphasize elements concerning structure to focus on a specific theme (p. 48). Squire also notes that researchers undertaking this type of narrative research move away from a strict focus on narrative content itself to bring in information about the social and cultural context that underpins participants' experiences (p. 49). This approach dovetails with Freeman's (2003) formulation of the "expressivist" approach to narrative, where the content of the story itself is the focus. Freeman contrasts this with the "productivist" approach that analyzes how the story is told and what that means about the person (or people) speaking.[50] Given that this project orients to the social rather than to the psychology of the individual, I thought that the socioculturally-oriented, expressivist approach would work best for the purpose of considering what the personal experiences of the participants in this research can reveal about how mental health and mental health care are organized, how the social determinants of mental health apply in the context of gender diverse communities, and what could or should be changed to improve the lives of community members, while at the same time maintaining the emphasis on voice that narrative approaches tend to centre. As Squire (2013) writes, "Spoken personal testimony is indeed a strong cultural currency, with powerful effects…" (p. 53).

Thematic Analysis of Narratives

The analysis of narrative can take several forms. As discussed above, Labovian event-centred narrative research typically involves structural analysis (Riessman, 2008 p. 75), which explores *how* people tell their stories and construct meaning. It considers the mechanics of storytelling itself, investigating how the form of a statement or utterance impacts meaning or reflects something about the context of the speaker's intentions, life or a political situation. In contrast, I chose to engage in what Riessman (2008) identifies as thematic analysis (p. 51), which focuses "on 'what' is said rather than 'how,' 'to whom' or for what purposes" (p. 53). As Riessman points out, this type of narrative research approach has much in common with grounded theory methodology, in that theorizing derives from the source material rather than being imposed from external sources.

Interestingly, Riessman's name for this approach matches the label that Braun and Clarke (2006) developed in their work to name and formalize the analytic process in which many qualitative researchers engage when looking for "emergent" themes in their data. They explain that when undertaking thematic analysis, researchers study their data for meaningful patterns relevant to their research question. In this case, I used an organic (Braun & Clarke, 2016, p. 740; Clarke & Braun, 2018), inductive and recursive (Braun & Clarke, 2006, pp. 83–84, 86) approach, reading within and across interviews and digital stories to identify codes and consolidate them into themes, which I then refined. When I identified new patterns in the data, I returned to previously analyzed data and conducted additional analysis so as to ensure consistency. In accordance with the theoretical frameworks applied in this research—the social and cultural models of disability, disability justice, the social determinants of mental health, as well as intersectionality, feminist new materialism; perspectives which Braun and Clarke (2006) would likely classify as "contextualist"[51]—the themes that I have identified in the data include both semantic and latent content (p. 85).

Braun and Clarke point out that their formulation of thematic analysis is compatible with many qualitative methodological approaches and is widely used across many disciplines, and the approach is therefore "essentially independent of theory and methodology" (2006, p. 78). I bring together the two formulations of "thematic analysis" in this project, nuancing Braun and Clarke's method with Riessman's (2008) and Squire's (2013) emphasis on upholding the integrity of narratives while developing insights across cases and in broader contexts. As Squire (2013) has pointed out,

> Experience-centred narrative analysis … is distinguished by its attention to the sequencing and progression of themes within interviews, their transformation and resolution. Thus, it foregrounds the specifically narrative aspects of texts' themes (p. 57).

Following Fine (1992), Braun and Clarke (2006) caution against approaching qualitative research from a "naïve realist" (p. 80) perspective by seeking to straightforwardly "give voice" to participants, pointing out that just as the thematic analysis framework highlights that themes do not passively "emerge" from the data, so does it clarify that the "voices" of participants are significantly modulated by the researcher's choices. As Fine writes, to fail to acknowledge the subjectivity of the researcher is to "accomplish a subtler form of ventriloquism" (1992, p. 215). In the case of this project, it is necessary that I state that I chose who to interview, I selected a semi-structured interview format and decided what questions to ask, I decided who would participate in the digital storytelling component of the project, I transcribed and coded the interviews and constructed the themes, then I wrote this dissertation. Wells (2011) explains that narratives do not simply "speak for themselves" (p. 43), thus the interpretive process is necessary. At the same time, any interpretation is necessarily limited by the bounds of the researcher-interpreter's knowledge and positionality, such that some interpretive possibilities are forestalled and other interpretations that storytellers may not have intended and may not endorse will arise. As much as my objective is to provide a forum for participants' stories, I must acknowledge that the selection, framing and interpretation reflects as much about my perspective and objectives as does the content of participants' utterances themselves. The reliability (Golafshani, 2003) of the data can be checked across participants' narratives as well as against other cultural discourses (Squire, 2013, p. 57). Sikes (2010) argues that narrative researchers must ensure that "unruly" data is not smoothed, and should avoid misrepresenting participants' complex experiences by "cut[ting] and slic[ing]data … to fit the story (p. 18).

Narrative Coherence, Context and Interpretation

As Squire (2013) points out, not all narratives are "coherent." Some might be interpreted as fragmented, contradictory and unresolved (p. 60). Hyvärinen et al. (2010) explain some researchers may prefer to engage with more straightforward accounts, and must therefore be careful to include "challenging cases," while avoiding the pitfall of imposing what they understand as “coherence” (p. 10). The notion that “good” stories should be linear, consistent and complete can be understood as rooted in ableist and colonialist ideologies privileging normative ways of communicating. Thus, seeming “incoherence” can arise as a result of a gap in understanding due to differences in experience and social location/positionality between a researcher and a narrator/storyteller. As Trahar (2013) cautions, “All stories are composed in a context, replete with history and with culture. … The person/s hearing, ‘receiving’ the stories may be in or from a different context” (p. xi). Trahar argues for the importance in narrative research of accounting for the positionality of the researcher, the relationship between the researcher and the narrator, as well as the context in which the narrative was told (p. xii). Taking a sociocultural approach to narrative research enables me to bring additional information into conversation with the stories shared by the people who participated in this project, but this does not mean that my interpretations are necessarily “correct,” or that other interpretations would be invalid. At the same time, as Sikes (2010) points out, despite such disclaimers, I am—at least in essence—presenting my interpretations as a “legitimate and authentic” account of the experiences of the participants (p. 15).

Researching Across Difference

Bamberg (2007) argues that analyzing a narrative does grant the researcher neither access to the past experiences of the narrator, nor to the narrator’s thoughts about their experiences. All the researcher has access to is “talk” (p. 171), wherein narrators,

> [E]stablish … what the talk is about … and simultaneously the particular social interaction in the form of particular social relationships. And in the business of relating

> the world that is created by use of verbal means to the here and now of the interactive situation, speakers position themselves vis-à-vis the world out there and the social world here and now (p. 171).

In this way, narrators and interlocutors work together to achieve understanding, to position themselves relative to dominant or counter discourses, some of which may be shared and others of which may not. In my experience with this project, interviewing participants who I may have known socially, or who may have had similar educational and social experiences to me in many regards, most of our discussions felt comfortable for me. Participants' stories often resonated with my expectations, but there were also many surprises. Even so, during moments where I felt that gaps in understanding or communication had arisen I generally had the sense that we were on familiar terrain together and that I understood the participants' perspectives. I wondered at the time and now whether participants shared this sense of familiarity—often I perceived that they did, as I had a sense that we were "really getting along," or that the interview even felt similar to a talk with a friend, but this was not always the case. Occasionally, the interactions felt strained or confusing.

In particular, the last interview I undertook felt less comfortable than others had. My final interview was with Nina, a participant who came to the GTA from the Philippines and stayed as an undocumented immigrant. Nina experienced difficulties with substance use, and had been in an abusive relationship that broke down, which left her homeless. A police interaction alerted the immigration authorities to Nina's presence and precipitated a removal process. Nina had made a claim for refugee status that was under review at the time of our interview. Throughout the interview, Nina stated repeatedly that she believes that Canada is a fair country and shared her appreciation of the assistance from social, health, and legal services that she had received. She also expressed faith that her refugee claim would be accepted and she would be permitted to stay. As a critical social researcher, I was concerned about Nina’s situation and I felt doubt that her claim would be accepted as well as confusion as to why she might express such strong support for a country that had been unwelcoming of her in many regards. (I undertake a political analysis of Nina’s statements in this regard in Chapter Ten.)

As Bamberg (2007) explains, narrators are always “engage[d] in making past actions accountable from a particular (moral) perspective for particular situated purposes” (p. 170), but these purposes may be obscure to the listener. Low et al. (2017) write, “listening is grounded in a regard for the other as an unknowable and complex psychic subject, and a willingness to think with them despite one’s inevitable failure to understand” (p. 55). At the same time, Massey (2010) notes that even in a seemingly “strange” encounter, there is always some familiarity (p. 45), and Mannay (2016) cautions that because “insider” researchers have previous knowledge of a topic, they may be less able to perceive or challenge their own preconceived ideas or understandings (p. 30). My relatively less comfortable experience with interviewing Nina highlighted the sense of ease that I had felt at most times during the previous interviews, and underlined the importance of maintaining awareness of the discourses/ideas that I share with participants, as much as those that I felt I would have to work to understand. The experience also foregrounded the necessity of recognizing how my identification or lack of identification with a participant and their circumstances might shape my response to their stories.

Researching Sensitive Topics

Hydén (2013) posits that "sensitive topics" are defined relationally, through power relations, and through cultural norms. In regard to relationality as well as power relations, I anticipated that given my positionality as a non-binary psychiatric survivor, the topics at the centre of this project might be viewed by participants as more safe or familiar to address together than they might otherwise have been. Further, I noted that several of the participants shared other similarities with me, being somewhat close in age, having attended the same universities, or being fellow graduate students. Hydén (2013) also mentions that when addressing sensitive topics participants sometimes perceive themselves as inferior to the researcher.[52] This can be because the research focuses on topics or experiences that participants may find embarrassing or shameful, or because their experiences or social locations are devalued within the culture. Hydén explains that these feelings can lead participants to avoid disclosing information that they might otherwise have felt comfortable sharing (p. 225), but points out that this can be mitigated by employing strategies such as also discussing positive experiences, as well as co-determining the structure and content of the interview (pp. 225, 227). In this project, although the semi-structured interview format imposes some limitations, at the beginning of each interview I advised the participant that they could skip any of the questions, and that they were free to discuss topics other than those listed on the interview schedule. Additionally, the final question on the schedule asked whether they had anything else they would like to say. Many participants availed themselves of these opportunities.

Concerning cultural norms, the relative "sensitivity" of the topics of being trans, genderqueer, gender non-conforming or non-binary, as well as of having experiences with mental health care is constantly shifting and is highly context dependent. In recent decades (at least in “mainstream” Western culture) both topics have become relatively less stigmatized, and more people are now “open” about these dimensions of their lives. That noted, both topics are still intensely personal and must be approached with sensitivity. While these issues may be more generally “up for discussion” in the culture and more people are choosing to speak freely about their personal experiences, many people still prefer to keep their experiences private. For instance, some of the participants in this project do not disclose their gender history to others (outside of confidential interactions such as a research interview), nor do they typically discuss their experiences with mental health care. As Lorde (1984) observed, there is often a sense that people who belong to oppressed groups somehow “owe” their stories to others—and particularly to the privileged—or have something akin to a moral obligation to tell all, to educate at their own expense to attempt to earn the basic respect and recognition that really should have been a given. As Lorde writes,

> Whenever the need for some pretense of communication arises, those who profit from our oppression call upon us to share our knowledge with them. In other words, it is the responsibility of the oppressed to teach the oppressors their mistakes. I am responsible for educating teachers who dismiss my children's culture in school. Black and Third World people are expected to educate white people as to our humanity. Women are expected to educate men. Lesbians and gay men are expected to educate the heterosexual world. The oppressors maintain their position and evade responsibility for their own actions. There is a constant drain of energy which might be better used in redefining ourselves and devising realistic scenarios for altering the present and constructing the future (pp. 115–116).

When designing the interview schedule and undertaking interviews, I sought to counter both this dynamic and the dominant cisnormative approaches to telling stories of gender diversity, as discussed earlier.

Narrative in Relation

Phoenix (2013) notes that “research interviews are ‘relational spaces’ where the researcher and the narrator establish their entitlement to talk on subjects they recognize to be controversial” (p. 75) and explains that one way that this can happen is by making a “claim to category entitlement” (p. 79), which is an assertion that the speaker belongs to a group with advanced knowledge of the topic. Making this kind of claim can also be defensive, intended to protect the speaker from being perceived negatively by the interlocutor (Phoenix 2013, pp. 79–80). This played a role in my project, especially in regard to my own claims to knowledge of and association with the gender diverse community. During the screening phase, I had disclosed to all prospective participants that I self-identify as a genderqueer or non-binary femme, but the issue sometimes arose again before, during or after interviews, when participants would ask me why I had chosen to research this topic. In response, I would briefly tell them my story of having experienced biomedically-focused mental health treatment as a teenager, and mention how my own identity as a queer person with an uneasy relationship to the gender binary made me interested in learning about the historical and ongoing construction of queerness and gender variance as mental health problems. When I made these disclosures, I would be cautious to ensure that I acknowledged the ways in which my experiences and identity were not necessarily equivalent or similar to those of the participant, in an effort to ensure that I was simultaneously perceived as having some relevant personal experience and a commitment to addressing problems in the areas of mental health care and the social determinants of mental health—especially for gender diverse people—but not as claiming knowledge or experiences that I did not have. As Knibb (2013) explains, it can be helpful when researchers acknowledge that they do not have a full understanding of participants' experiences, but are "listening as a narrative inquirer" (p. 25). By doing this, I hoped to establish a claim that I could validly address these issues as well as to build trust with participants.

Interview Recruitment and Selection

Narrative research projects typically have relatively small numbers of participants, to facilitate in-depth engagement with the stories of participants, which can be better presented holistically and cohesively if there is a more manageable number (Squire 2013, pp. 54–55). In addition, it can be difficult to recruit large numbers of participants for studies that address sensitive, personal or upsetting topics (Squire 2013, p. 55). Wells (2011) points out that "[m]any widely cited narrative papers—particularly those designed to illustrate a method of narrative analysis—involve an *n* of 1" (p. 20). She notes that in-depth analysis rarely requires more than five participants. I chose to work with more participants to enrich the possible transferability of the findings across intersecting positionalities and contexts. For these reasons, I initially aimed to recruit seven to ten interview participants, of whom five would be asked to participate in a digital storytelling workshop. I decided to conduct individual interviews because the format lends itself to the socioculturally-oriented narrative approach, with its emphasis on interpreting across unique narratives. Additionally, the emotionally-charged, sensitive and private nature of the issues that form the focus of this project meant that participants would likely be more comfortable and forthcoming speaking in private with a sole interviewer, rather than within a larger group (Kruger et al., 2019).

I recruited participants over Facebook and Twitter, from within my personal networks, and also used snowball sampling. Because I had a limited reach on Twitter, most of my participants came from Facebook. Like many people, my personal networks mostly consists of people around my age, from the areas where I have lived, who have similar educational backgrounds. With permission from group moderators, I was able to post my advertisement in several relevant Facebook groups (Queering and Trans*forming Mad Studies; Mad Studies; The Empowerment Council; CDSSA; CDSA-ACEH; Trans Pride Toronto) and it was also shared by 99 individual accounts. This represents potential exposure to many thousands of people. My primarily online recruitment resulted from a limitation imposed at the research ethics review stage, which prohibited me from reaching out to the community organizations with which I was involved to help distribute my call for participants, in the interest of avoiding potential conflicts or undue influence.

Following the distribution of the advertisement, I received 30 expressions of interest and reached out to all prospective participants with a preliminary questionnaire designed to allow me to understand whether the prospective participants’ experiences were relevant to the project and to enable me to select as wide a range of participant identities as possible. For example, did the prospective participant identify as trans, genderqueer, non-binary or gender non-conforming? Had they ever been in contact with any type of mental health care in the province of Ontario? As screening progressed, I found that some prospective participants were not able to book an interview with me due to scheduling and travel constraints. In the end, I was able to schedule and complete interviews with 13 participants, each of whom received an honorarium of $25.

Name	*Age Range*	*Race/Ethnicity*	*Gender*	*Class/Income*	*Location*
Alesha	Early 20s	White	Femme binary trans woman	Middle class background, graduate student	GTA (Greater Toronto Area)
Alexandra	Early 30s	White	No gender identity label	Middle class background, receiving ODSP	Eastern Ontario
Bryce	Early 20s	White	Non-binary	Low income background, receiving ODSP	Eastern Ontario
Francis	Late 20s	White	Not cis	Middle class background, graduate student	Central Ontario
Hermione	Mid 20s	Mixed race Chinese	Transfeminine	Low income background, graduate student	GTA
Io	Late teens	White	Genderfluid, transfeminine	Low income background, low income	Southwestern Ontario
Mark	Late 20s	White	Male	Middle class background, professional career	GTA
Miriam	Early 40s	White	Woman who is trans	Middle class background, receiving Ontario Works	Eastern Ontario
Nina	Late 30s	Filipina	Trans woman	Middle class background, unhoused and engaging in	GTA

				survival sex work	
Quinn	Late 20s	Mexican	Genderqueer, gender non-conforming	Middle class background, graduate student	GTA
Ray	Early 30s	White	Male, transmasculine	Working class background, professional career	GTA
Reuben	Early 20s	White	Cis male	Low income background, professional career	GTA
Sandy	Mid 20s	Algonquin, White	Trans woman	Middle class background, undergraduate student	Eastern Ontario

Table 2: Interview Participants

I attempted to select participants with as broad a range of identities and experiences as possible, and was partially successful in achieving this goal, with a wide range of gender identities represented as well as people from a variety of class and socioeconomic backgrounds. At the same time, post-secondary students were overrepresented among participants, reflecting the makeup of my social network. Similarly, most participants were in their 20s and 30s, with only one person in their 40s represented, which means that no perspectives from older people are included, which is a significant gap as gender diverse people from older cohorts may have had significantly different experiences with mental health care given the breadth of the changes that have taken place in regard to medical/psy professional and general understandings of gender identity across recent decades. To ensure that this is accounted for, I have incorporated literature on this history throughout my dissertation. Additionally, the majority of participants in the project were white, and while one participant was Indigenous, two were Asian and one was Latinx, no Black people volunteered to participate in the study, which is a problematic omission given the intersections of anti-Blackness, transphobia, misogynoir (Bailey, 2021), and transmisogyny.[53] To address this, I have tried to bring in other materials pertaining to these topics, and to maintain awareness of the omnipresence of anti-Blackness, and its position as a fundamental organizing principle of North American society (Walcott, 2019).

Interview Structure and Technique

Interviews used a semi-structured format, which is typical for the type of narrative research undertaken in this project (Squire, 2013, p. 55). My interview schedule was designed to pose "truly open-ended questions" (Wells, 2011, p. 24), to encourage storytelling and to provide each participant with an opportunity to speak from their perspective about how the issues under consideration had arisen throughout multiple areas and times of their lives. Some questions focused on life experiences and circumstances that led participants to come into contact with the mental health care system, what participants' experiences were in the mental health care system (including interactions with medical staff, experiences with pharmacological and other interventions, interactions with other service users). Based on my background research about Ontario's mental health policy, trans health care access, the medical model of mental health and the social determinants of mental health, I asked questions specifically intended to solicit responses pertaining to these topics rather than only focusing on mental health encounters, or stories concerning experiences with mental illness, distress or difficulty (Appendix A). This was intended to allow participants to explicitly consider their experience in relation to social determinants of mental health and to think about how dimensions of privilege, oppression and power have impacted their experiences. Questions asked participants to consider positive and supportive experiences as well, undertaken both in the interest of collecting data about what has been helpful for participants, and in response to Hydén's (2013) insight that focusing exclusively on difficult or painful experiences during an interview may cause participants to experience distress (p. 225). The penultimate question on the interview schedule asked participants to share their understanding of what could promote their well-being in the mental health care system and in society generally. I had intended for interviews to last about 1.5 to two hours, but several exceeded this time as participants engaged in wide-ranging discussion of many facets of their experience. Most interviews took place face-to-face, in locations of the participants' choosing, whether that was my home, my office on the York University campus, participants' homes, or another private location of the participants' choosing. Due to travel and scheduling limitations, a few interviews took place over Skype, using the video call functionality. In-person interviews were recorded on a digital voice recorder, and the voice content of the Skype interviews were recorded using Skype Call Recorder.

I transcribed the interviews verbatim using Transcribe by Wreally, combining manual typing as well as respeaking using Dragon NaturallySpeaking. In keeping with the socioculturally-oriented, expressive approach to narrative, I ensured that all speech and relevant notations of "contextual clues" (i.e. laughter, crying) (Wellard & McKenna, 2001) were accurately recorded, but extraneous elements such as the precise timing of the speech as well as details such as coughing were not, as my focus is with the content of the narrative rather than with its precise linguistic elements (MacLean et al., 2004). After each transcript was complete, I sent it back to the participant to verify their accuracy and allow an opportunity to retract information they would prefer not to have included in the research (Birt et al., 2016), letting them know that they could make changes or deletions as they wished. Most participants were satisfied with the transcripts, with only one participant requesting minor changes in the interest of ensuring anonymity. In this case, I saved the requested changes to the transcript and deleted the previous version. I then loaded all finalized transcripts into NVivo, and coded them using an inductive, iterative process informed by the thematic analysis approach as described above.

Digital Storytelling

Digital stories are short digital videos, typically between two and five minutes long, telling a personal story by pairing a spoken script with images and sounds chosen by the storyteller (de Jager et al., 2017; Lambert, 2013; Rice et al., 2015; Rice, 2020). I chose to combine interviewing with digital storytelling to enable participants to have an opportunity to frame their own stories in ways of their choosing, which I think is especially important given that this project is undertaken with members of an oppressed group. The digital stories that were produced as part of this project are as subject to my re-framing and analysis as the interview data, but could also be directly accessed and interpreted by other viewers.

In this project, I followed the digital storytelling methodology of the Re•Vision Centre for Art and Social Justice at the University of Guelph, Ontario (Rice & Mündel, 2018; Rice, 2020). The Re•Vision Centre methodology is informed by an understanding of stories as deeply intertwined with experience, identity and community:

> Stories not only carry ideologies and discourses, they also author us and give us the means to author ourselves. We live the stories that get planted in us and we also live the stories we plant in ourselves. This cross-fertilization—of stories seeded by others and stories germinated by us—is what allows us to cultivate distinct subjectivities and shared identities; to create and express difference even as we create and express community and culture. This brings us to an important reason we have invested in storytelling: stories make us vulnerable to ourselves and others, make us ask questions about who we are and who we should be, make us take risks, go to uncharted places, and rethink ourselves in relation to others and the world (Rice & Mündel, 2018, p. 224).

The Re•Vision Centre's methodology incorporates practices from the Centre for Digital Storytelling (CDS) in Berkeley, CA (Rice et al., 2015; Rice, 2020). The CDS approach to digital storytelling suggests that storytellers pair spoken narration, sounds and music with a series of still images, especially archival photographs (Lambert, 2013, p. 38), but the Re•Vision Centre's methodology is more expansive: Participants are invited to use archival photographs and video as well as sounds and music, and are also supported to take new photographs, shoot new video, or create artistic visual and auditory representations for inclusion in their story using physical and/or digital media and techniques. Like the approach of CDS, the Re•Vision Centre's methods are intended to enable even novice technology users to create high-quality videos that express their creative visions for their stories. To achieve this, workshops are facilitated by trained academic facilitators alongside practicing artists. I was trained as a workshop facilitator by the Re•Vision Centre (then called Project Re•Vision) when I was a Co-Investigator on the 2015 research grant, Through Thick and Thin: Investigating Body Image and Body Management among Queer Women, which took place in collaboration with Rainbow Health Ontario, and was funded by the Women's College Hospital's Women's Xchange program (Lind et al., 2018; Rice et al., 2018; Rice et al., 2020d; Rinaldi et al., 2017; Rinaldi et al., 2020).

Digital Storytelling Recruitment and Selection

The stories created for this project were completed at a two-day digital storytelling workshop, where the participants worked with me, three paid professional facilitators and a volunteer technical assistant to create their stories.

To select digital story workshop participants, I asked each interview participant if they might be interested in creating a digital story during a three-day, in-person workshop to be held the summer after the interviews took place. From among those who expressed interest, I invited several prospective participants, chosen to represent as wide a range of experiences, social locations and identities as possible. Five of the potential participants were available to attend on the weekend that the workshop would be held. Each of the five workshop participants received an honorarium of $100, in recognition of the substantial time commitment that the workshop required. The workshop was held June 24-26, 2016, at York University in Toronto, in the main Critical Disability Studies program classroom in Vari Hall, as well as a smaller room in a nearby building where sound recording was completed. Three participants were from the GTA, and two were from Eastern Ontario, ensuring that experiences from across the province were represented. Eastern Ontario-based participants were provided with some financial assistance for travel. The Re•Vision Centre provided their REDLAB mobile media lab (including six MacBook Pro computers loaded with professional audio and video editing software, two microphones, a digital SLR camera, and storage media) free of charge for this project.

Name	*Age Range*	*Race/Ethnicity*	*Gender*	*Class/Income*	*Location*
Alexandra	Early 30s	White	No gender identity label	Middle class background, receiving ODSP	Eastern Ontario
Hermione	Mid 20s	Mixed race Chinese	Transfeminine	Low income background, graduate student	GTA
Quinn	Late 20s	Mexican	Genderqueer, gender non-conforming	Middle class background, graduate student	GTA
Ray	Early 30s	White	Male, transmasculine	Working class background, professional career	GTA
Sandy	Mid 20s	Algonquin, White	Trans woman	Middle class background, undergraduate student	Eastern Ontario

Table 3: Digital Storytelling Workshop Participants

The Digital Storytelling Workshop

The Re•Vision methodology intends to break down the binary between researchers and participants, "exposing the illusion of researcher impartiality" (Rice et al., 2018, p. 4). Thus, the methodology emphasizes the importance of workshop co-facilitation with members of the group being researched, which is also an informal member-checking strategy (Lincoln & Guba, 1985,

p. 314), and a means of helping make the workshop experience itself more genuinely reflexive of the perspectives and knowledge of community members. For this workshop the co-facilitators were Bridget Liang, a mixed race Chinese Canadian transfeminine person who is a fiction writer and an academic researcher with previous digital storytelling training with the Re•Vision Centre; Kiley May, a Hotinonhshón:ni Mohawk Two Spirit transgender woman who is a storyteller, dancer, actor, photographer and activist; and Erin MacIndoe Sproule, a white, cisgender woman who is a photographic and video artist and academic researcher, as well as a professional facilitator with the Re•Vision Centre. The technical assistant was Sylvain Roy, a white, cisgender man who has extensive experience with providing technical support and education to users of a wide range of digital technologies.

Before the workshop, each participant was provided with an information package (Appendix B) including the workshop schedule, an information sheet about CDS' "Seven Steps of Digital Storytelling" (Lambert, 2013, pp. 53–69), guidelines for preparing for the workshop including creating a first script draft and suggestions for potential visual materials to bring, and a list of URLs linking to sample digital stories completed in previous digital storytelling workshops that I had co-facilitated, shared with the permission of their creators.

The workshop opened with a presentation and discussion that I developed in consultation with Liang and May (Appendix B). We shared the preliminary results from the interview phase of the project, to reflect back participants' knowledge and perspectives on gender diverse people's mental health care experiences. During the presentation, we also screened some sample digital stories as well as a short film created by co-facilitator May.[54] To help create a space welcoming of stories transcending typical media representations of these issues,[55] participants were asked to express their perspectives concerning how these topics and experiences are typically represented, and what other kinds of representations they would desire. After a break for lunch, participants had an opportunity to work on their draft scripts and storyboards with facilitators, then we moved into a story circle where participants who wished to do so shared their draft scripts with the larger group and received feedback if wanted. At this stage, several participants made some changes to their stories. When the story circle ended, some participants continued to work on their scripts and storyboards and developed ideas for visuals with facilitators, and others began their audio recordings. Most audio recordings were complete at the end of the first day of the workshop. The second day began with a Final Cut Pro video editing software tutorial, led by Re•Vision Centre facilitator McIndoe Sproule. This represented an opportunity for facilitators to learn how familiar participants were with the technology and to gauge the level of support required by each participant (Lambert, 2013 p. 81). Following the tutorial, outstanding audio recordings were completed, and the rest of the day comprised open studio time, where storytellers worked with facilitators to create their visuals (including scans of hand-drawn art, filmed first-person testimony, a set of Claymation-inspired photographs of plasticine figures, a time-lapse video of a burning candle). Storytellers then used Final Cut Pro to pair their completed visuals with spoken scripts and other sounds. By the end of the day, each participant had completed a rough cut of their digital story, and with the consent of participants the five completed stories were screened to the group. Participants were invited to provide instructions for additional editing, and I completed the edits and captioned the finalized stories after the workshop. Each participant was provided with a digital file of their finalized story.

Digital Stories and Participant Privacy

The digital storytelling participants chose to include identifiable information in their completed stories, including their names, voices, and images revealing their faces and other identifying details. For the purpose of maintaining participant privacy, I have chosen to incorporate stills from the stories and descriptions of their content in this dissertation (Chapter Nine), rather than providing direct access to the stories themselves. In the case of one storyteller, I have also had to alter the still images to obscure identifiable faces. Because the stories closely reflect the identities and experiences of five of the interview participants, viewers of the stories may be able to connect the identities of the storytellers with those of the interviewees. In this way, it is not possible—or even desirable—to treat the stories as isolated artefacts. Maintaining storyteller privacy allows me to incorporate content from the stories into specific participants' narratives, which allows for a richer and thicker analysis and discussion.

Digital Storytelling as a Participatory Method

Mannay (2016) explains that while "gold standard" participatory research would include participants at every research stage, budget and time limits often mean that participation is restricted to the stage of data production (p. 22). In the case of this project, the constraints associated with undertaking dissertation research meant that the participatory dimension of this project was limited to digital story creation. Nevertheless, digital storytelling is recognized as a participatory method (de Jager et al., 2017), oriented toward "progressive social change" and located in the traditions of "multimedia self-representing practices" such as photovoice, video and digital memoir, and participatory video (Matthews & Sunderland, 2017, pp. 5, 55–56). Vivienne's (2011) work with transgender digital storytellers in an Australian city highlights the method’s potential to support members of marginalized communities as “everyday activists” by amplifying their stories and voices (p. 53). Besides providing opportunities for self-expression, digital storytelling also supports participants to develop greater familiarity with digital media, including sound recording, photographic and video equipment, as well as digital video editing software (Matthews & Sunderland, 2017). It can also serve as a means of building community among members of marginalized groups (de Jager et al., 2017; Low et al., 2017).

Digital Storytelling as an Arts-Informed Research Method

The digital storytelling methodology empowers storytellers to exert a high degree of control over how they present their own story, positioning them as knowers, makers of meaning, and as creators of art (Alrutz, 2013; Hull & Katz, 2006; Vivienne & Burgess, 2013). Social research methods that involve the creation of works of art are recognized as making several unique contributions, highlighting the interpretive nature of research, enabling the creation of artistic works that can promote deeper understandings, and promoting reflexivity among those who engage with the works created (Goldstein, 2008). Lambert (2013) explains that the CDS model of digital storytelling takes an “expressive arts facilitation” approach, where creative work is not subject to judgement, grading or valuation (p. 73). This is consistent with the “arts-informed” approach to research, rather than the “arts-based” approach, which emphasizes the artistic quality of research outputs rather than their use as a means of self-expression and creativity (Knowles & Cole, 2008, p. 32; Piirto, 2002; Rolling, 2010, p. 105)

As Brushwood Rose and Low (2014) explain, the “craftedness” of multimedia or digital stories within the workshop setting must be recognized. Length limitations are imposed, and there are also technical limitations in regard to availability of materials as well as the degree of available facilitator support. Mannay (2016) cautions that participatory visual methods are not exempt from the issues around power relations that impact all research encounters, and that researchers must account for the impacts of these dynamics while engaging with participants and while analyzing outputs (pp. 46, 51–58). Following the Re•Vision methodology, I encouraged participants to tell a story of their choosing, and to come to the workshop with a draft script as well as visual materials, sounds and music. At the same time, the issue or theme to be addressed by storytellers was largely predetermined. In this case, I asked storytellers to address something relevant to the issues at the centre of this project, although the specifics as to what particular story to tell and how to tell it were left open, as the variety of the completed stories shows.

As Lambert (2013) notes, media representations often influence storytellers, which can lead participants to tell stories that may reflect their beliefs about "how media should function—as high-impact action drama or happily resolved melodrama" (p. 19) more than it does the contours and complexities of their personal experiences or perspectives. In addition to form, stories can also be impacted by the content of mainstream media, especially by "scripts" that privilege some stories over others—for example, the idea that disability is burdensome and tragic remains the most common way of presenting stories on this subject (Matthews & Sunderland, 2017, p. 74). Digital and multimedia stories created in line with the Re•Vision Centre methodology are explicitly intended to speak back to mainstream representations, particularly of difference (Rice et al., 2015). The inclusion of a presentation sharing interview data with workshop participants exposed those creating digital stories to the perspectives and experiences of fellow participants as well as to the normative perspective of the researcher and co-facilitators. The intervention was designed to surface the knowledge of oppressed people and support the creation of counter narratives that can challenge problematic dominant representations (Rice et al., 2015). That noted, the power of ideology is such that storytellers and interpreters of stories remain embedded in cultural contexts and may not always be conscious of the influences shaping the stories or their interpretation (Matthews & Sunderland, 2017, pp. 75, 123, 125).

In the story circle following the discussion of the presentation, participants can choose to receive and respond to feedback from fellow participants and facilitators, who often work collaboratively to tweak a script or imagine possibilities for visuals and sounds (Matthews & Sunderland, 2017, pp 16–17).[56] During production, storytellers often work together and help each other, sometimes even literally lending their voices to their fellow participants' audio recordings. Facilitators help participants to realize their creative ideas and to become more familiar with the digital technologies used in this kind of storytelling. In this way, the stories created reflect the collaborative process and the shaping forces of technology, as well as the individual perspective of the storyteller (Brushwood Rose & Low, 2014, p. 32). Additionally, because storytellers choose if, when, and where their stories can be shared with audiences, and are also given copies of their finalized stories, the content of their stories may also be influenced by what they wish to share with a variety of potential audiences (Low et al., 2017, p. 89; Luttrell & Chalfen, 2010, p. 199; Matthews & Sunderland, 2017, pp. 9, 17).

From my perspective, the workshop for this project went exceptionally smoothly. It felt like participants and facilitators got along very well and that the workshop experience was as successful as the completed stories themselves. Post-workshop interviews with participants in Re•Vision digital storytelling workshops suggest that feelings of being supported and welcomed are often experienced by participants undertaking storytelling work following this methodology, enabling the formation of an "affective community" (Nash, 2013, cited in Rice et al., 2020).

Given the apparently high degree of comfort and trust among participants and facilitators, it was unsurprising to me that many participants worked collaboratively, contributing significant work to several of each other's stories.

That noted, my perspective is necessarily limited and it is possible that the dynamic was not as comfortable for each participant as I perceived (and hoped) it to be. Because my methodology did not involve any post-workshop interviews or surveys, my insight into this is limited to my personal perceptions as well as comments that participants made to me at the time of the workshop. It is also important to point out that the collaborative nature of the digital storytelling workshop can sometimes have the effect of silencing or excluding certain stories, especially those that do not conform to cultural norms for stories (such as unhappy or negative stories, stories that may seem incoherent, and stories that remain unresolved) (Low et al., 2017, p. 67). Aware of this tendency, the workshop co-facilitators and I were careful to reiterate to participants that they were in charge of the form and content of their stories, and they were free to reject, accept, or put their own spin on any suggestions or contributions from facilitators or participants.

Analysis of Digital Stories as Visual Narrative Data

As with the interview data, I have also used a thematic analysis approach to interpreting the archive of digital stories created through this project. As Bold (2011) points out, narrative is not limited to speech or writing:

> Narrative may involve or consist of other communication media such as drawings, photographs, poetry, plays, video recordings, interview scripts, *ad hoc* conversations and

> sequential observations. It includes gesture, body language, visual images and different media effects (p. 30).

Drawing from Rose’s critical visual methodology (2001), Riessman (2008) writes that the kinds of images that might be included in a narrative project—including film and video—can be read and interpreted in similar ways to written texts (p. 142–144). Rose’s (2012) methodology for visual analysis comprises three sites: First, the site of the image’s production; Second, the image itself; Third, the site of the image’s audiencing (pp. 19–21). Rose also proposes three modalities that cut across each of the three sites, as follows: The technological modality; the compositional modality; and the social modality. As Rice and Mündel (2018) note, the visual can be a subject of theorizing, writing, “The shift from text-based to image-based theory invites us to interrogate what is possible to learn from images and how these media might shape our thinking” (p. 221).

For the purpose of applying this methodological framework to narrative research projects, Riessman (2008) describes the sites as follows:

> The first [site] interrogates how and when the image was made, social identities of image-maker and recipient, and other relevant aspects of the image-making process. The second [site] interrogates the image, asking about the story it may suggest, what it includes, how component parts are arranged, and use of color and technologies relevant to the genre (e.g., a photograph, painting, or film). The third [site] is the “audiencing” process—responses of the initial viewers, subsequent responses, stories viewers may

> bring to an image, written text that guides viewing (e.g., captions), where the spectator is positioned, and other issues related to reception (p. 144).

Riessman also points out that the three sites are interrelated, and are typically addressed as such within narrative research (2008, p. 144). As I described above, my analysis of visual data is similarly bounded by the limits of my knowledge, experience and social and cultural location (Mannay, 2016, pp. 63, 81).

Voice and Listening[57]

Digital stories, like other visual research methods, are a means of capturing rich and thick description, as storytellers have the opportunity to determine (in large part) how their story is told through words, sounds and images (de Jager et al., 2017, pp. 2548, 2550; Mannay, 2016, p. 23; Matthews & Sunderland, 2017, p. 39). Riessman (2008) explains that visual methods "disrupt the investigator's control and authority over the meanings of images" (pp. 143). The utility of digital stories as a means of preserving and promulgating the "voice" of participants is well-documented in the literature (Lambert 2013, pp. 7, 127; Matthews & Sunderland, 2017, p. 1). That noted, the notion that researchers can use any technique or methodology to unproblematically "give voice" to participants is dubious. Stories are subject to interpretation by researchers as well as audiences, and are therefore subject to the potential of misinterpretation or misuse. For example, Overboe (2007) explains that due to the pervasiveness of ableism, when disabled people tell their stories they are caught in a bind between the restrictive, paternalistic medical gaze and the work of literary theorists who spectacularize disability. He notes that social researchers are equally implicated in this dynamic, writing that they "lasso us around the neck (effectively silencing us), pull us down to the floor, and, under the auspices of giving us ‘voice,’ interpret our stories, and consequently, our lives” (2007 p. 275–282).

In their discussion of undertaking digital storytelling with (and as) disabled people in a project challenging ableism in health care, Rice et al. (n.d.) explain that the feminist new materialist concept of “diffraction” or “interference” reveals how researchers, research tools and audiences intra-act with “data” such as digital stories (p. 3). These intra-actions lead to the emergence of differences in diffractive patterns that researchers can read into (p. 8). Rice et al. note the importance of recognizing that participants have their own objectives in telling their stories, and these may exceed or diverge from researcher expectations (p. 11).

Rice et al. (n.d.) also point out that audiences also engage with stories for their own purposes, which may be opposed to the intentions of the project or of participants/creators (p. 11). Similarly, Low et al. (2017) caution that the emphasis on “voice” may obscure the fact that multimedia stories (such as the digital stories created through this project) cannot be straightforwardly understood as a means of making participants’ stories directly accessible to audiences. They write,

> [V]oice can oversimplify representation, forgetting that there is no sidestepping its complexities despite the sense of immediacy provided by video, photo or audio technologies. We have many stories, perform many selves, and draw upon many modes of self-inquiry and narration, all shaped by available symbolic systems and conventions and limited by our own self-knowledge (p. 15).

Instead, Low et al. (2017) suggest that the process of creating multimedia stories—which involves attending to and engaging with others' stories as much or more than creating one's own (p. 50)—emphasizes the importance of "tak[ing] listening seriously" (p. 21). Drawing from the work of Spivak (1988) and Gordon (2008), they develop an "intersubjective model of listening" with which a researcher can account for their own positionality while recognizing and attending to that of the storyteller, analysing both the affective impacts and the "formal qualities" of a text such as a digital story (Low et al., 2017, pp. 24, 39). Citing Cavarero's theory of "narrative reciprocity" (2000), Low et al. (2017) explain that the subjectivities of tellers and listeners require and shape each other (pp. 37–38), with both shaping meaning. Matthews and Sunderland (2017) similarly suggest that digital stories should be engaged through a practice of "political listening," where the listener's positionality can be regarded as "the ground of communication" and what the speaker says is "the figure emerging against that ground" (p. 6). To hear a story is to engage in the work of interpreting the story. Thus, the listener is never neutral, and must recognize the ways in which their relationship with dynamics of power shapes what they can hear and understand (p. 125).

The importance of listening is underlined by Dreher (2012), who explains that in neoliberal democracies, "offers of voice"—including opportunities to participate in digital storytelling projects—abound, but typically amount to "empty consultation" where those sharing their voices seemingly speak into a void, their perspectives and concerns going unheeded (pp. 158–159). She argues that to "ensure voice that matters" (p. 166), listening must be emphasized.

Resisting Fragmentation

As within other forms of narrative research, the question has arisen of how and whether to interpret across an archive of digital stories. LaMarre and Rice (2016) note the value of "retain[ing] … participants' ordering of their story and their choices in linking the audio and visual elements" so as to "attend to participants' original conceptualization … of the narrative" (p. 24). Matthews and Sunderland (2017) suggest that storytellers may not wish to have their stories "fragmented" and decontextualized, citing a participant in the Patient Voices project as stating, "Once we're happy with our story, we don't want some researcher to dismember it, and just take the bits they like." Further, Brushwood Rose and Low (2014) reveal the insights into both the individual storyteller's experiences and their social location that can be gained by considering each digital story on its own terms:

> The crafting of the multimedia story is both motivated by the emotional and personal terrain of each participant, but also by the political dynamics of representing their social worlds. Considering the choices participants make in creating these multimedia narratives—why did Ming employ a picture of hands rather than a face?— … can reveal a great deal about the personal as well as socio-political dynamics of representation (p. 38).

For these reasons, in addition to doing a thematic analysis across the archive of stories, I also describe each story in its entirety.

Impacts of Digital Stories

Digital storytelling's capacity to counter stereotypes is recognized as particularly strong (Beltrán & Begun, 2014). Visual images like digital stories are also lauded for their capacity to touch audiences emotionally and provoke empathy for others (Mannay, 2016, p. 45). At the same time, as Rice and Mündel (2019, p. 125) point out, research methodologies like digital storytelling have been criticized as potentially depoliticizing. Due to their nature as first-person accounts, often of difficulties or struggles, stories have been characterized as rendering political issues as exclusively personal, and as not reflecting or responding to the broader dynamics at work within the seemingly individual story (Freund, 2015, pp. 115–129). Further, the positioning of personal stories in any form as inherently more powerful than other kinds of information has been challenged as mistaking the provocation of immediate affective responses (such as empathetic sadness or anger) for the raising of consciousness and the spurring of subsequent political action oriented toward changing the circumstances in which the story arose (Matthews & Sunderland, 2017, pp. 44–45). Although the Re•Vision methodology is careful to foreground the political and social context of the topic addressed within the storytelling workshop, in response to these concerns, I have sought to frame the stories created through this project both as creative works and as political artifacts.

Chapter Nine: Identities and Experiences

Participant Stories

Because the narrative methodology I am using emphasizes the importance of presenting participants' stories in a way that avoids taking "snippets of a response" from each in order to create a broad and generalized conclusion (Riessman, 1993, p. 3), in this chapter I describe each participant's intersecting identities and present an overview of each of their stories. As with the rest of this work, the framing of participants' stories necessarily reflects my interpretation and filtering as well as the focus of the project and the trajectory of the interview questions.

These overviews are intended to more holistically capture the stories that participants shared, but cannot be understood as pure representations of their experiences or even of the stories they shared with me during this research project. As Jackson and Mazzei (2012) point out, these stories are not "a stable or seamless whole," and although they may "appear unified" (Kindle Location 227), stories like the ones I offer here must be recognized as constructed in service of a purpose. In this case, my intention is to provide readers with the kind of "background" information to which I had access while engaging with specific elements of the information they shared with me. While recognizing these limitations, my objective in offering these stories is to facilitate a better understanding of the contexts of participants' lived experiences and intersecting identities as their voices appear throughout the following chapters.

In this chapter, I also include still images and summaries of the digital stories completed by the participants who took part in the digital storytelling workshop.

Alesha

Alesha was a white femme-binary trans woman in her early 20s. She used she/her and they/them pronouns and described herself as a panromantic, demisexual, demislut ladydyke. Alesha was a spiritual person, whose pantheistic orientation to the world informed her way of coping with difficulties. She came from a middle class background, with parents who worked in professional jobs, and was raised in a large GTA city. At the time of our interview, she was a graduate student at a GTA university who was in the process of applying for scholarship funding, and was dealing with anxiety and depression as well as a difficult relationship with alcohol, coping with many triggers due to stress caused by a labour dispute at her workplace. She was living in an anti-oppressive student co-operative house, but she was exploring the possibility of moving in with a potential queerplatonic partner.

They explained that they had been feeling depressed for a long time, when they stumbled across some images of trans women on a social media site and started to consider whether they might be trans themselves. With resources from their parents' private insurance, they started looking for a counsellor and also applied to the long waiting list at CAMH as they explored this possibility. After several unproductive counselling attempts, they were able to access useful services at a 2SLGBTQQIA+ health centre. Alesha also found support in their friendships and partnerships, but with the exception of her aunt, their family was generally unsupportive. Alesha hoped for changes to the world that would enable trans people to live their lives free of oppression.

Alexandra

Alexandra was a white person in her early 30s. She used she/her pronouns and did not identify with any specific gender identity label, believing that labels could not encompass her whole personhood. Alexandra lived with her wife—also an artist—in a basement apartment decorated with beautiful paintings, drawings and sculptures that they had created. She had been raised in the same Eastern Ontario city where she still lived. Her family of origin was middle class, but Alexandra had been living on a low income as an adult, and began to receive ODSP because she faced discrimination in the job market due to her gender. Additionally, stress-inducing jobs were also inaccessible to her due to their non-accommodation of her mental health disabilities, which further limited her employment options.

Many of Alexandra's contacts with mental health services were focused on obtaining gender confirming care. Some of these encounters were extremely abusive, and most were generally unhelpful. Seeking a letter of support for gender confirming surgery, Alexandra saw many psychiatrists and social workers before her endocrinologist ultimately referred her to a doctor who would perform the procedure on an informed consent basis without a support letter. Later, Alexandra developed a supportive relationship with a chaplain at a local university, who provided mental health and spiritual counselling. She next came into contact with mental health care when she sought support for her ODSP application, and was referred to a psychiatrist who she understood as helpful in assisting her to manage her feelings of anxiety and depression without excessively medicalizing or depoliticizing her situation.

Alexandra explained that she has had a strong interest in politics throughout her life, and understood many of the difficulties that she faced as rooted in capitalism. She envisioned a world where people have the freedom to be and express who they are and have their material and emotional needs met.

Alexandra's Digital Story: Untitled

Alexandra's story addresses her experiences of control and abuse at the hands of a doctor she had to see when trying to gain access to gender confirming treatment, questioning the positioning of medical doctors as gatekeepers of gender, identity and embodiment. [Content Note: Alexandra's story contains descriptions of medical abuse and sexual assault.]

Alexandra, a tall, thin white person with long blonde hair, wears a light green dress with a black floral pattern. She stands in front of a yellow wall, speaking directly to the camera and gesturing with her hands as she explains, "I knew my diagnosis before ever having a visit. Only transsexuals were allowed to transition. I needed to transition, therefore I was a transsexual" (Figure 2).

Figure 2: Alexandra's testimony

As we scan across an intricately detailed hand-drawn image that Alexandra created, showing her younger self contemplating her memories and thoughts (Figure 3), Alexandra describes how she worked on figuring out how to reinterpret her past experiences through the lens of this label.

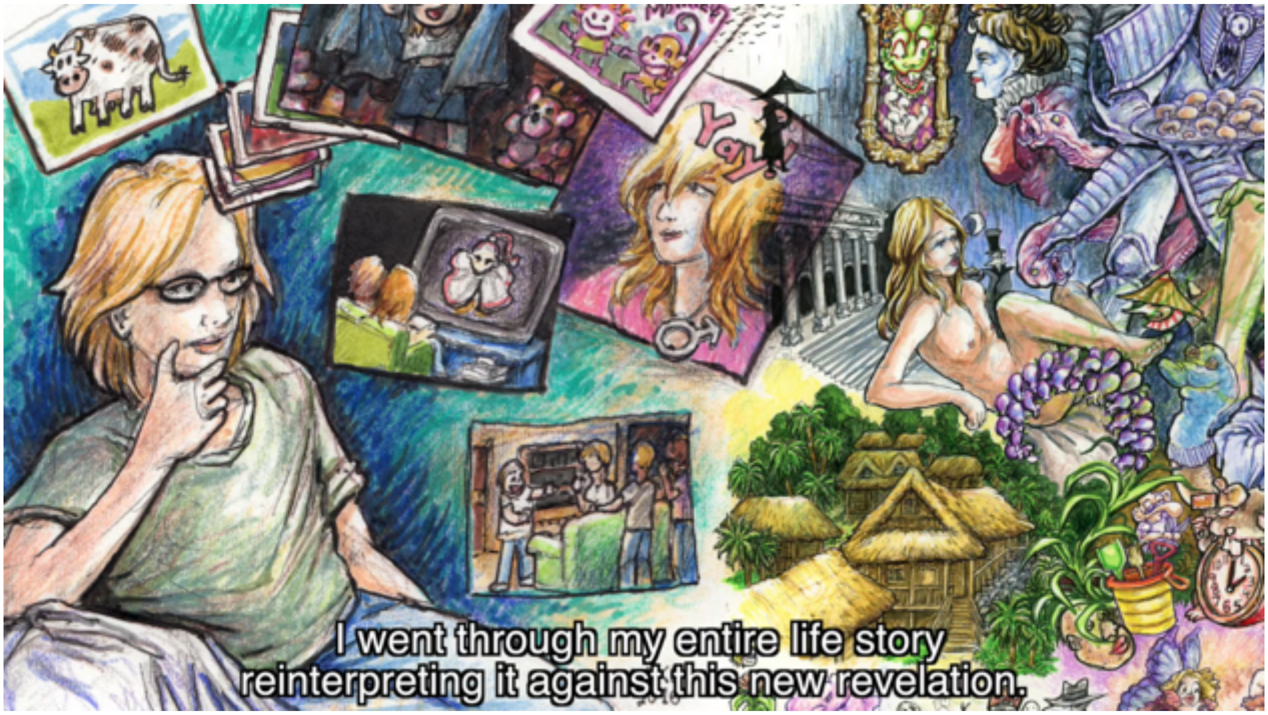


Figure 3: Alexandra's drawing

We cut back to Alexandra's testimonial as she explains that in seeking access to gender confirming medical procedures, she went to a doctor whose very first question to her was, "So, what do you think about when you masturbate?" Alexandra states that the invasiveness and specificity of the sexually-focused questioning only increased after that, wryly joking, "Jesus! Can't anything be between me and my hand? Anyway, I'm stuck seeing this one-man locker room for a full year..." She then explains that she was ultimately able to access hormones without the assistance of that doctor, and realized on her own that the label of "transsexual" did not describe her experience, realizing that she might just be trans, or a perhaps a really effeminate gay boy (Figure 4).

Figure 4: Alexandra jokes about her gender identity

Alexandra recounts that when she explained to the doctor that she had decided to have an orchidectomy, the doctor told her that her plans were "preposterous." She acts out his incredulous reaction as he informed her that he would only give her a letter approving her for "sexual reassignment surgery," and not the procedure she wanted. She mimics his outraged body language and facial expression as she quotes him: "Think of how many men you could fuck if you had a vagina! If you were a woman with a penis and no balls, you'd be a freak. No one would ever love you." Alexandra comes back to her own voice as she says, "Not true, by the way" as a photograph from her wedding to her wife (who is also an artist, and who made the couple's ornate wedding gowns and headpieces) flashes onto the screen (Figure 5).

Figure 5: Alexandra's wedding

Alexandra continues, explaining that the doctor then informed her that he had outed her as trans to a male patient who was seated in the waiting room. The doctor gleefully told her that the patient agreed that he would "fuck" Alexandra, but when he asked him if he would ever consider dating her the patient had replied, "No! Never!" The doctor told Alexandra that this would be her "fate" if she refused to have vaginoplasty. Alexandra explains that she was a "poor-as-shit" student without the time or money to file a complaint, and that she did later undergo the procedure she originally wanted. She then notes that she later learned that the doctor had been charged with sexually assaulting some of his patients, subjecting them to sadistic and humiliating assaults: "Sodomizing them with toilet brushes and leading them around the room with their nuts in a leash." Alexandra concludes, "I was not surprised. This is what happens when you turn doctors into the gender police."

Bryce

Bryce was a white non-binary person in his early 20s, who used he/him and they/them pronouns. He was raised in several smaller towns in Eastern Ontario and then moved to a larger city in the same region, where he lived with a group of housemates in an apartment, but his housemates were generally inconsiderate and Bryce hoped to move out into a bachelor apartment on his own soon. Bryce described a difficult childhood, where he grew up in poverty and experienced physical and emotional abuse and neglect by family members, but pointed out that some of them were experiencing their own mental and physical health difficulties. As a teenager he also experienced several difficult and tumultuous relationships with friends and romantic partners.

They initially came out to some friends as non-binary and masculine when they were in their mid-teens, and experienced some support but also faced harassment at school and online and decided to stop disclosing for some time, but a few years later they eventually came out as transmasculine to all of the people in their life and experienced largely neutral and positive reactions, including from family members whom he had expected to be unsupportive.

Bryce was not able to finish high school because he had repeatedly moved between school districts and had trouble maintaining enrolment. He had difficulties finding work as a result of discrimination. Due to his mental health difficulties he was on ODSP. He planned to work toward earning his high school diploma by attending adult classes, and hoped to attend college for a business program. Bryce dreamed of having opportunities to educate people about trans issues and mental health, and to do suicide prevention advocacy.

Francis

Francis was a white person in their late 20s who did not identify with gender identity labels or classifications, but was comfortable with describing themselves as “not cis.” They used they/them pronouns. Until they were in graduate school, they were never exposed to the idea that trans men, genderqueer or non-binary people existed. They explained that they had experienced confusion and discomfort in when fellow queer community members and romantic partners had applied labels to them that they did not choose for themselves, and they ultimately determined that no label could adequately capture their experience.

Francis grew up in a small town in the GTA. Their father was abusive and their parents got divorced when Francis was 10. After the divorce, Francis lived with their mother, who had hoarding tendencies, leading to social isolation. Francis’s mother worked full-time in an administrative assistant role and always stated that she had very little money, so Francis’ day to day experiences were in some ways similar to those of a person from a low income family, but they later learned that their mother did have adequate financial resources but had a hard time spending money. Due to having accrued significant savings, Francis’ mother was later able to fully fund their university education, which Francis recognized was a privilege.

Francis first received mental health care services at age 10, when their mother set up counselling sessions for them as an outlet for coping with the divorce and their father’s previous abuse. Francis found these sessions helpful. At age 15, Francis again came into contact with mental health care when their family doctor labelled them as having an eating disorder. Francis found support with queer and trans communities in person and online, as well as in fandom communities. At the time of our interview, they were attending graduate school at a university in Southern Ontario, where they were able to access some mental health support, which was particularly helpful in regard to accessing accommodations.

Hermione

Hermione was a mixed race Chinese transfeminine queer person in her mid-20s. She grew up in a Southern Ontario city and was attending graduate school in the GTA at the time of our interview. She used she/her and they/them pronouns. Her parents divorced when she was four years old. Her mother was a qualified teacher who moved to Canada from China and faced employment discrimination, so the family was low income. Hermione stated that these stressors contributed to her mother's later development of serious mental health difficulties. Hermione was born with some physical differences and was subjected to several invasive surgeries intended to normalize her appearance, which was traumatic, making later medical care difficult for her. She was also in a serious car accident at age three, which left her with scarring, and she was a fat child who faced weight and appearance-related bullying at home and school.

Hermione had realized that they liked boys at age 10, but only realized that this meant that they were queer a few years later. They started to become involved in role playing games, fandoms and fanfiction, all of which involved queering popular culture. Their counsellor also helped them to connect with a local queer youth group. During their undergraduate degree, Hermione began to wonder if they might be autistic so they sought an assessment through their university's disability services office but the assessor disregarded the difficulties and barriers that they mentioned and told them that they were "normal." When they later decided to seek access to gender confirming medical treatment, they were simultaneously diagnosed with gender dysphoria and autism. Hermione was out as a transfeminine person to their father, but not their mother. Most of their social support came from their large group of friends, including two close friends with whom they shared an apartment.

Hermione was generally able to access queer-positive OHIP-funded therapy on a consistent basis as a young adult, which she found helpful in addressing her feelings about gender and sexuality, as well as her traumatic experiences, but she explained that she had recently aged out of eligibility for youth-focused services, and was seeking access to therapy to address her recent experience of having been sex trafficked by a romantic partner. Hermione was involved in writing and doing performance art focused on trans, queer and disability issues and identities. To support herself and supplement her graduate student funding she did a lot of short-term contract and temporary work, but had not been able to access stable work due to facing employment discrimination as a transfeminine and autistic person. She envisioned a world where the myth of meritocracy could be replaced by genuine opportunities for oppressed people.

Hermione's Digital Story: Roadkill Trans Woman

Hermione's digital story is a creative response to the cultural and material devaluation of racialized, poor trans women. She uses the figure of the zombie to enact a vision of power and vengeance in the service of justice for oppressed people. [Content Note: Hermione's story contains slurs, descriptions of assault, and fantasy violence.]

Hermione's story opens on a shot of their hands against a black backdrop, their metallic and glittery green nail polish shining in the light as they manipulate a plasticine figure in a matching hue of green. In a voiceover, Hermione begins, "There once was a trans girl named Beryl who wanted to be famous," explaining that Beryl dreamed of becoming a performer.

Figure 6: Hermione describes the impacts of intersecting oppressions on Beryl's mother

She continues that Beryl grew up in a poor family, with a mother who had become abusive after suffering violence and marginalization due to sexism and racism (Figure 6). But Beryl found support and community in a queer youth performance troupe, where her being "weird, disabled, fat, mixed Chinese and trans" was celebrated (Figure 7).

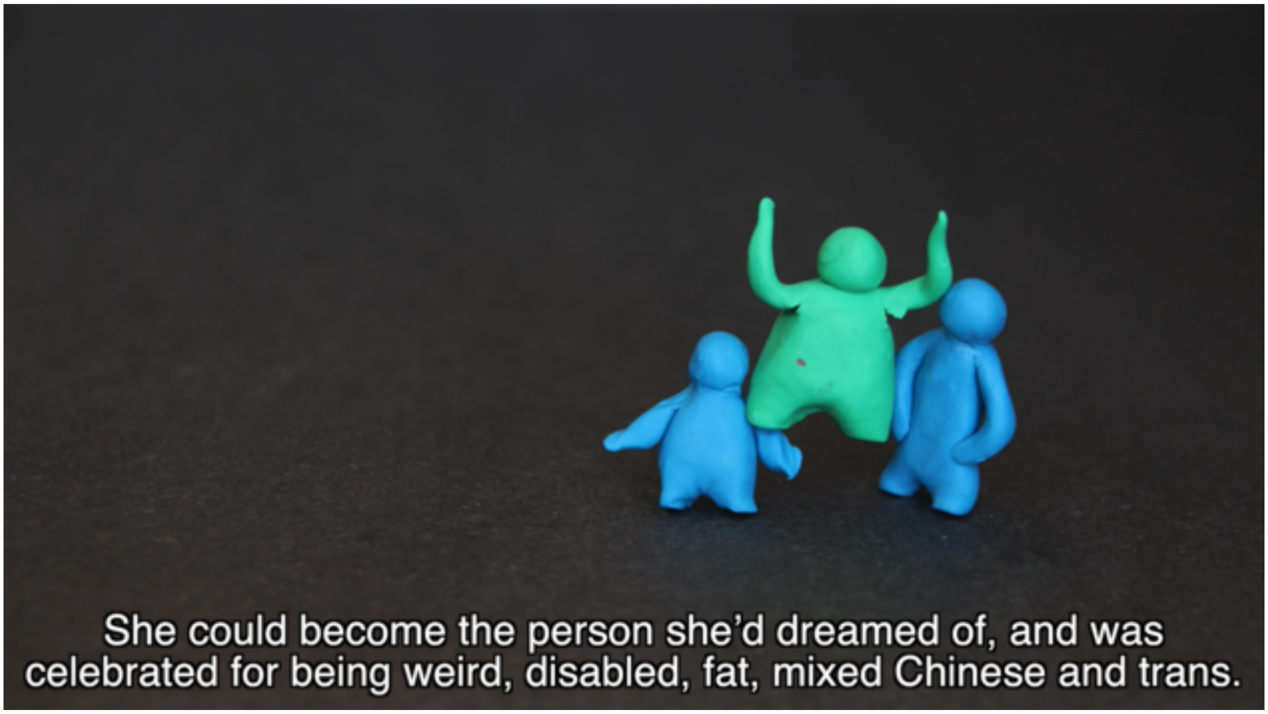


Figure 7: Beryl and her friends celebrate her identities

Hermione explains that Beryl had difficulty finding housing and work, and had to go on social assistance. Although she had support from her fellow performers, the stress of dealing with systemic oppression continued to take its toll. We hear different voices speaking hateful words and microaggressions as Hermione invokes Crenshaw's original metaphor of intersectionality by showing the Beryl figure being run over repeatedly by toy vehicles, her body becoming increasingly damaged and a stereotypical car crash sound effect repeating each time she is hit (Figure 8).

Figure 8: Beryl is hit by a bus at the intersection of racism and transmisogyny

Hermione returns to the main narrative arc of the story, explaining, “One day, when Beryl was walking in her neighbourhood, some men in a sports car saw her. She looked like a good target, so they threw a glass bottle at her head. She fell into the road and… Yeah.” But although Beryl had been killed, “she had dreams, and a little death wouldn’t stop her.” She rose as a zombie, bent on revenge against her murderers. She tore open their car and confronted the men, who screamed in terror and clung to each other (Figure 9) but continued to launch slurs and invective at Beryl, who quickly dealt with them.

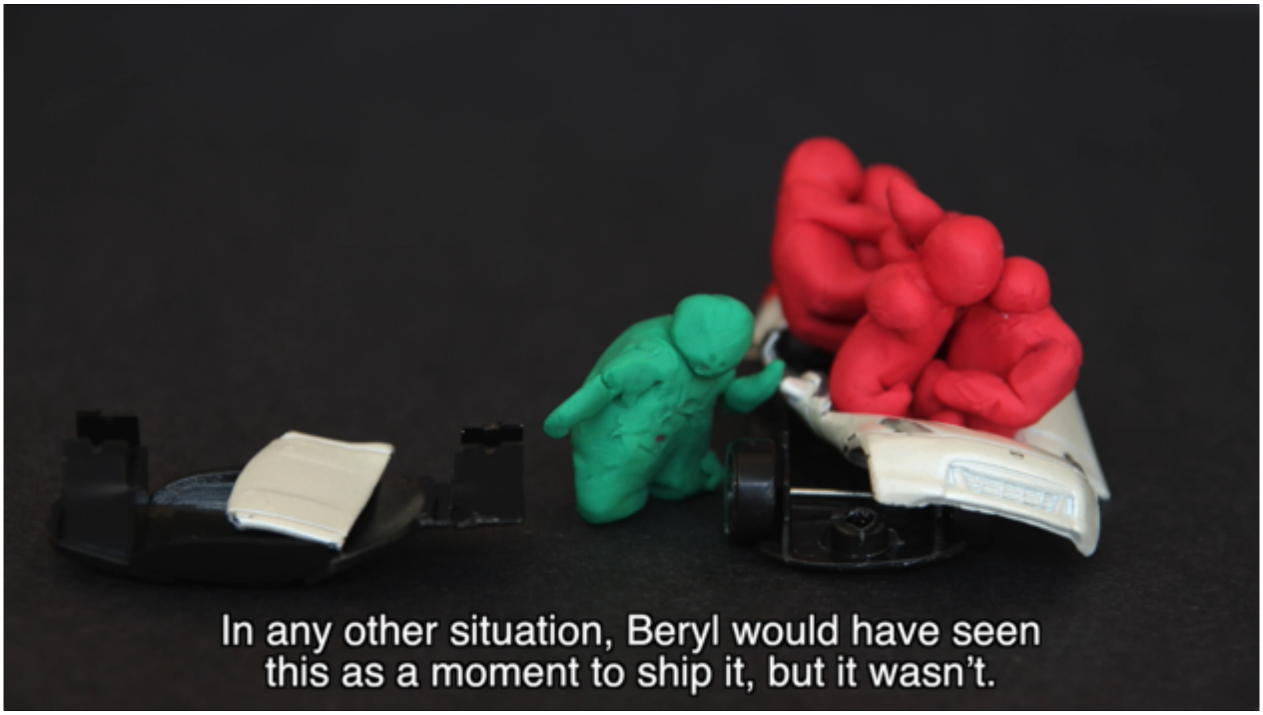


Figure 9: Beryl seeks revenge against her killers (and decides not to ship it)

Hermione explains that Beryl then went on to get revenge against everyone who had harmed her in the past, eating the worst ones and biting the others, transforming them into zombies. But these zombies had unusual characteristics, becoming prosocial and committed to equity. Hermione explains that while the one percent did oppose this transformation, they were eaten (Figure 10). Hermione cackles as she concludes, "And they were delicious."

Figure 10: Zombies cooperate to eat the one percent

Io

Io was a white, genderfluid transfeminine person in their late teens. They were pansexual and panromantic, and used they/them and she/her pronouns. They had grown up in a Southern Ontario city, in a low income family led by their grandparents. At the time of our interview, they were living with their grandparents, having moved back home after completing their first year of university studies in a GTA city. The next school year had already begun, but Io was not able to afford to return to the university, having experienced intense financial hardship during the previous year as a result of a labour dispute that had significantly extended the academic year. Io was seeking employment but had not been able to find a job because of transphobic discrimination, which meant that they were not able to afford their hormone replacement therapy.

Io initially identified as gay during high school, but when she later learned about the concepts of pansexuality and genderfluidity, she felt that they much better represented her identity. She was generally open about her sexuality, but had not yet come out to her grandparents about her gender as she was concerned that she may be rejected and would not be able to independently support herself at that time. She explained that living at home was also stressful due to a lack of privacy.

Io was a poet, activist and writer. She advocated for broad changes to education to make accurate information about gender and sexuality available to everyone, as well as for an expansion to funded gender confirmation health care. She imagined a world where everyone had secure access to basic needs such as housing and health care, which would enable everyone to better care for themselves and the community. Through her work, she critiqued homonationalism while making links with anti-colonial and anti-capitalist politics to promoting a more authentic understanding of the experiences of LGBTQ+ communities.

Mark

Mark was a white man in his late 20s. He did not identify with the label of "trans," but would use it in limited circumstances for the purpose of clarity. He used he/him pronouns. He grew up in a city in Western Canada, in a middle class family. Mark realized that he was male at age 11. When he was a teenager, he had found that the queer community in his hometown was not supportive. As an adult, Mark had some connections with the queer and trans communities, but was generally not public about his gender history, mainly spending time in mainstream spaces. He had witnessed (and spoken up about) some transphobic instances in the workplace, but did not feel that he had been directly impacted by transphobia at work.

After working in Western Europe where medical care for trans people was much more advanced and accessible, and human rights protections afforded to trans people were stronger, Mark hoped that the CAMH gender identity clinics would be defunded and closed, and that Canadian institutions would learn from the European example in regard to health care accessibility and quality.

Miriam

Miriam was a white woman in her early 40s. She identified as a woman who is trans rather than a trans woman because she did not wish to imply that being trans was the entirety of her identity. She used she/her pronouns, and was Jewish and a lesbian. She had grown up in a large GTA city, but was attending a university in a city in Eastern Ontario for religious studies toward becoming a rabbi. Miriam identified herself as a geek, with a lifelong interest in technology. Prior to discovering her religious vocation, she had a 20-year career in the field of information technology.

Miriam had realized that she was likely transgender as a teenager in the 1990s, but she had to do lot of emotional work over a long period of time to be prepared to begin transition. By the late 2000s, she made the decision to transition. When she came out, her wife immediately ended their marriage and Miriam had to move in with friends. She started to see a psychologist for her transition, which led to severe financial hardship. Her friends, her mother and religious institutions were able to provide her with some financial and material support. Many of her interactions with health care—transition focused and otherwise—were invasive and insensitive, and she faced significant bureaucratic barriers stemming from government and institutions' mishandling of her identity documents.

At the time of our interview, Miriam was looking into pursuing testing for autism and ADHD, as part of her journey of self-knowledge. Miriam used humour and wit to cope with stress and to defuse uncomfortable interactions in the health care system and beyond. In addition to working on her religious and rabbinical studies, she was writing a book chapter on transgender issues for a psychology textbook. She advocated for better, informed consent-based access to respectful health care for trans people.

Nina

Nina was a Filipina trans woman in her late 30s. She used she/her pronouns. She initially came to Canada in the late 2000s to visit some friends from her hometown who had moved to the GTA. She developed supportive relationships in the 2SLGBTQQIA+ and drag communities in a queer neighbourhood in the GTA, and came out as a trans woman, deciding to stay in the country as an undocumented immigrant while undergoing gender confirmation interventions. She did not have access to publicly funded health care, but was able to access some hormone replacement therapy with the assistance of friends and community members. Nina felt comfortable in the queer neighbourhood community and was extremely concerned that she would be forced to detransition if she were to return to the Philippines, as she would not be able to get employment there as a trans woman. In addition, although some of her family members back home were largely supportive, her father and brothers disapproved of her appearing in public as a woman. At the time of our interview Nina was working as an escort, but she previously worked as a florist and aspired to become a social service case worker or a city bus driver.

Until she began using substances to cope with the pressures of her escorting work and then became involved with her abusive ex-partner, Nina stated that she had not experienced mental health difficulties at any previous time in her life. At the same time, Nina expressed gratitude for the support she had received from community-based health, social service and legal organizations, noting how her city's sanctuary city policy had helped her. With the assistance of a legal aid lawyer, Nina was making a refugee claim which she was very hopeful would be approved.

Quinn

Quinn was a Mexican genderqueer, gender non-conforming person in their late 20s. They used they/them pronouns and primarily identified themselves as a feminist. They lived in a GTA city where they were attending graduate school. They initially came into contact with mental health care at age 15 in their hometown in Mexico, having been sent to a therapist after coming out as queer to their parents. They explained that the therapist quickly informed them that there was nothing wrong with them and proceeded to address their problems with their parents. During their undergraduate degree in the GTA, they sought and received a diagnosis of gender dysphoria from their family doctor and were offered a referral to CAMH but declined it because they were planning to attend a graduate program in another Ontario city. Quinn then learned that the CAMH program was quite restrictive and that they would likely have to misrepresent their story to access services, so they decided to get a referral to an endocrinologist who worked on an informed consent basis instead. They had to wait several months for an appointment, but used that time to advise their family of their decision to take hormone replacement therapy. Although their mother was initially concerned, their family was generally quite supportive.

The endocrinologist was helpful, assisting Quinn with making decisions about reproductive options and educating their mother about the health impacts of the treatment.

Around this time, Quinn also saw a private therapist specializing in gender issues to discuss some of their concerns about their experience of gender dysphoria, and to undergo a readiness assessment and get a support letter in case they would need it for bureaucratic purposes, such as to change their identity paperwork. The fees were covered by Quinn’s union-based health insurance. Quinn received informal support from friends in person and online, and was involved in several fandom communities. Their graduate research addressed equity issues around employment, and they were interested in basic income as a possible means of improving social equality.

Quinn’s Digital Story: Trans as Disability

Quinn’s digital story, *Trans as Disability*, explores the connections between being trans and being disabled, urging viewers to break down the barriers of transphobia, sanism and ableism that harm so many.

The story opens with an animation of a comic book cover, zooming in to the inside contents, hand-drawn panels featuring Quinn’s black and white line art, on rough-textured artists’ paper. In the first panel, a figure lies on a chaise longue, gesturing while speaking to another figure who is seated in an armchair, holding a notepad and pen. Quinn’s voiceover begins, “I thought I wasn’t fucked up enough to be trans, I told my therapist…” (Figure 11).

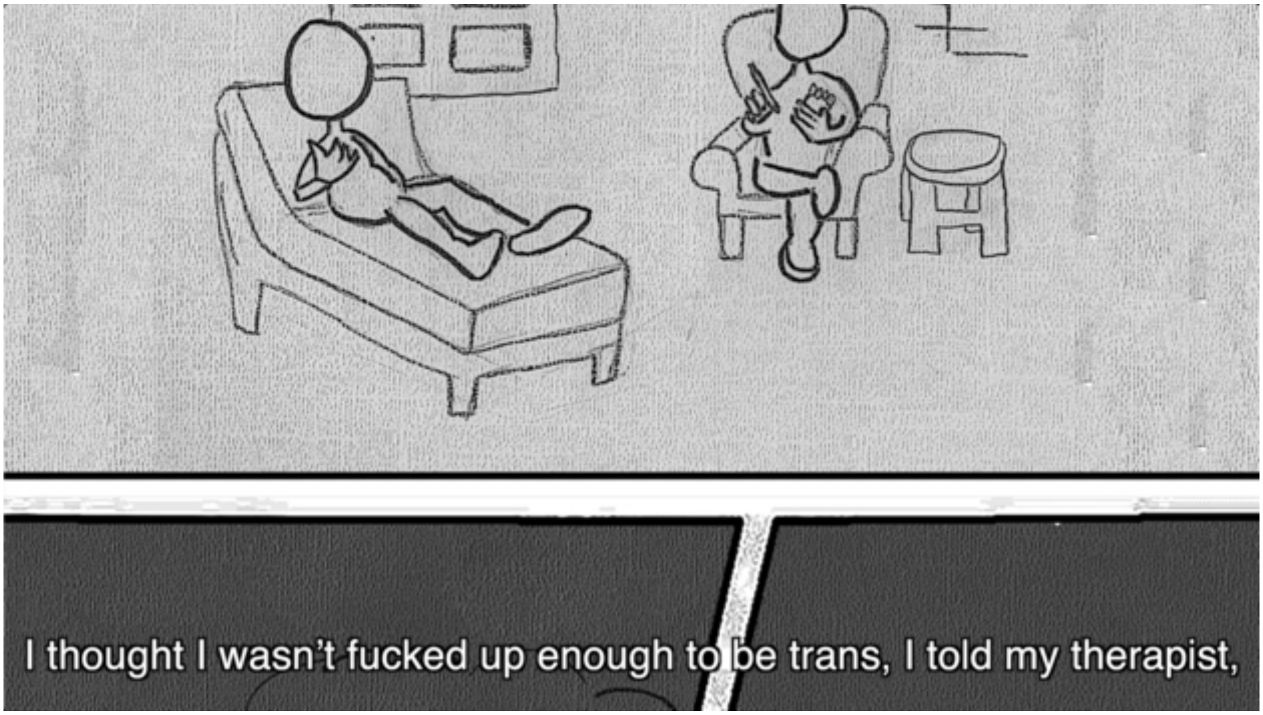


Figure 11: Quinn's therapy session

Quinn explains that despite this, when they were 12, they had been too depressed to attend school for three months as we scan across the next panels, showing a figure with long hair dreaming of an idealized masculine physique, then looking upset and crossing their arms over their chest as they awaken back to reality (Figure 12).

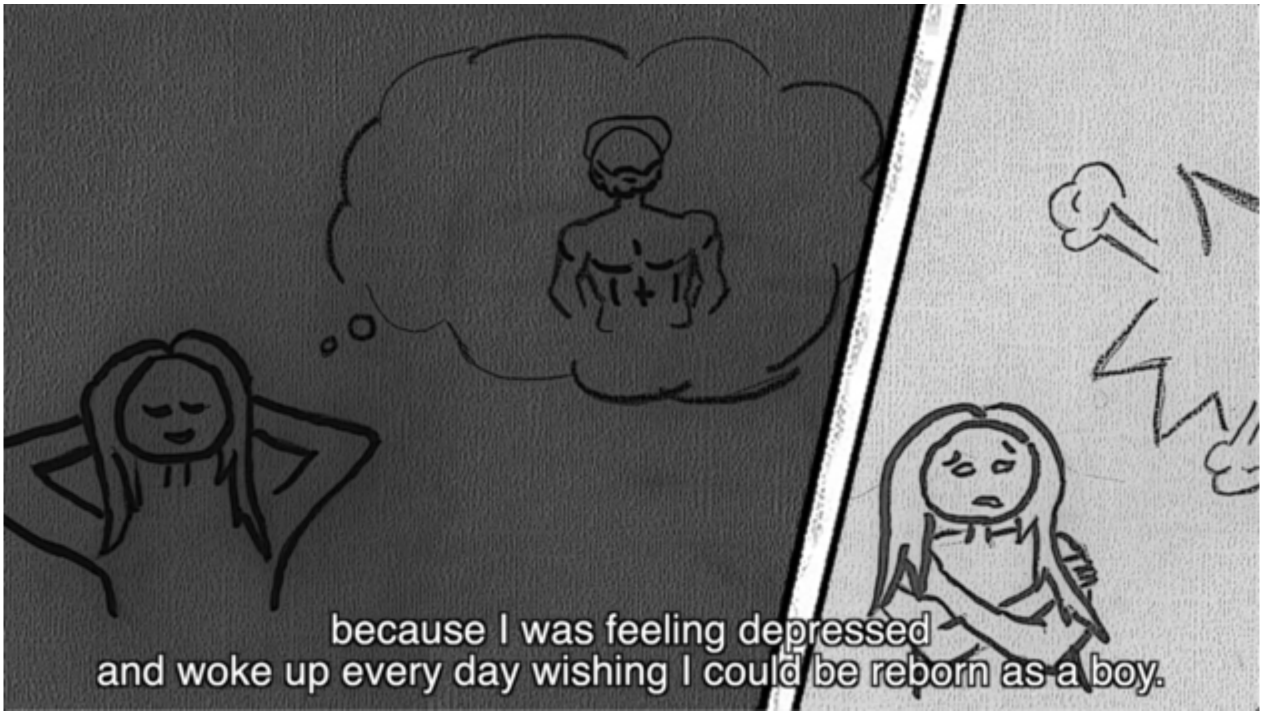


Figure 12: Quinn wishes to be reborn as a boy

They explain that although they had periodically struggled with depression, they did not consider themselves to be someone with a mental illness because they were able to function well enough. The figure from the first panel is shown with a perturbed facial expression, holding a large trophy while standing in front of a wall of awards, diplomas, certificates and medals. We scan to the next page, where we see a hand holding a remote control, flicking through images from the movies *Boys Don't Cry*, *Dallas Buyers Club*, *Dressed to Kill*, *Psycho*, *Hedwig and the Angry Inch*, *Sleepaway Camp*, *The Silence of the Lambs*, and *The Danish Girl*, as Quinn explains that media narratives are dominated by representations of profoundly distressed and suicidal transgender people. Quinn continues, "I wasn't that dysphoric, I wasn't that depressed. Not fucked up enough to be trans, I thought."

They explain that they only began hormone replacement at age 29, noting that this happened around the same time that they initially encountered critical disability studies. They quote disability scholar and activist A. J. Withers, “Trans people are disabled… The distinction between trans people and disabled people is problematic because it implies that trans and disability are separate and distinct, erasing those people who are otherwise-disabled.” We move to a panel showing the figure inside a circle outlined in black and white at the centre, wearing a transgender symbol on their shirt. The rest of the panel is divided by black and white spokes coming out from the circle, each division featuring a separate image of a disabled person. By refusing to identify themselves as disabled, Quinn explains, they were implying, “There’s nothing wrong with me, but there is with you. Never mind the shared experiences with medicalization and marginalization.” (Figure 13) Quinn continues that they began to understand that their depression was connected with dysphoria, but could not be wholly explained by it.

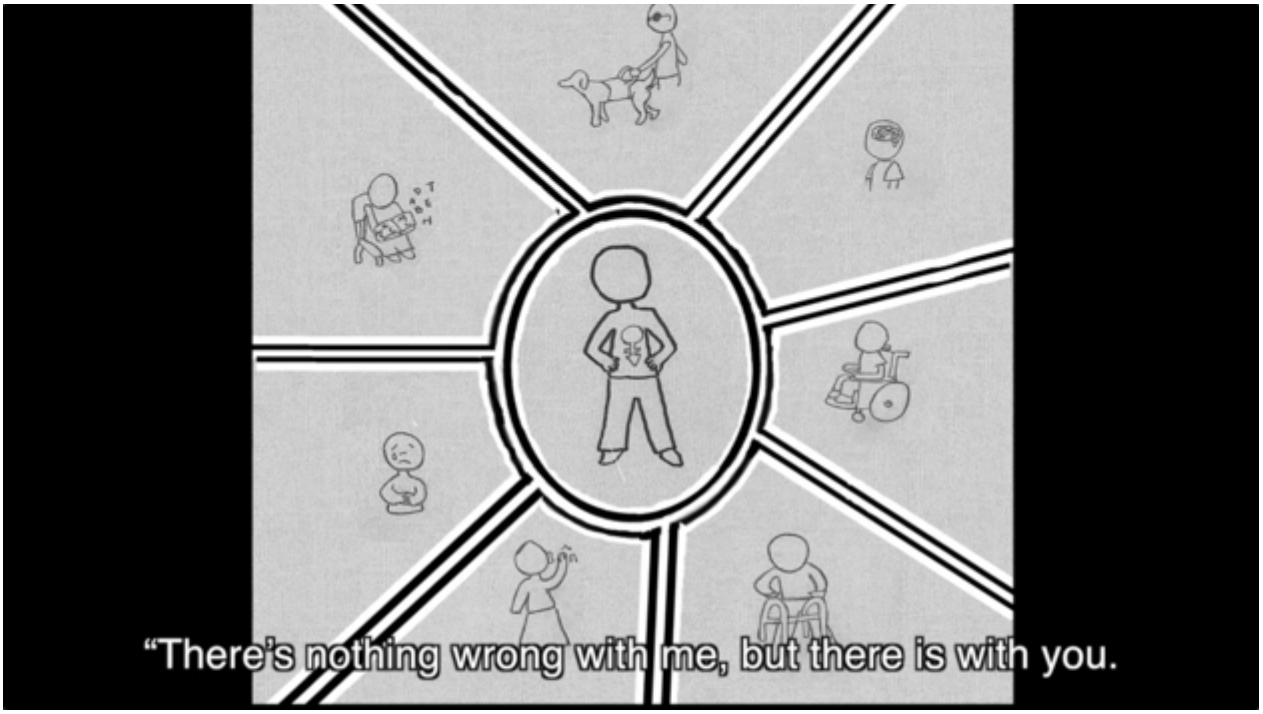
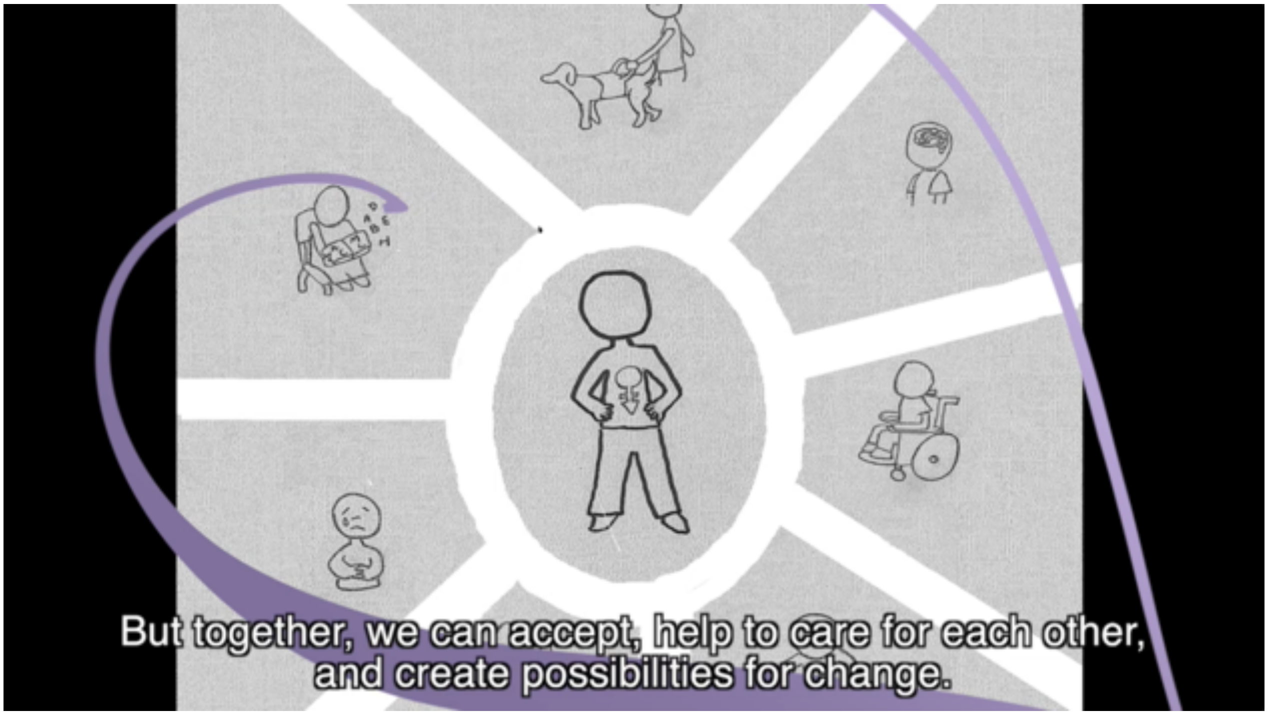


Figure 13: Illustrating the divisions between the trans and disability communities

Quinn concludes with a call to trans, genderqueer and gender non-conforming people to embrace disability and disability identity, and to consider the impacts of refusing to claim disability. The lines that had divided the figures vanish and a purple ribbon swoops across the image as Quinn says that although oppression impacts all trans and disabled people "... together, we can accept, help to care for each other and create possibilities for change" (Figure 14).



But together, we can accept, help to care for each other,
and create possibilities for change.

Figure 14: Erasing the barriers between trans and otherwise-disabled people

Ray

Ray was a white man in his early 30s. He described himself as male and transmasculine and used he/him pronouns. He was pansexual. He came from a working class family, but had been raised in a relatively wealthy suburban GTA town. He graduated from an Eastern Ontario university with a professional degree, and after a long search for permanent work found a well-paying job in his field and began to identify as middle class, although he was worried about the potential precarity of his job due to long-term trends within his industry as well as potential negative reactions to his transition in the workplace. At the time of our interview, he lived in a large GTA city with his partner.

Ray disclosed that his parents were physically and emotionally abusive, and he was bullied severely at school as a child and throughout his adolescence. His first contact with mental health care happened when he was in Grade 3, when he punched a bully who had been repeatedly physically assaulting him over an extended period of time.

Ray explained that as a child, he felt like he was not really a girl and would be frustrated when expected to conform to gendered norms. He came out as gay toward the end of his undergraduate studies, then in his late 20s with the support of his partner, he began to more deeply consider his relationship to gender. He realized that he was male, changed his name and started to use he/him pronouns. He had begun to take hormones prescribed on an informed consent basis, but he had experienced difficulties accessing his prescription as a result of transphobic interactions with pharmacy staff. Ray envisioned a world where all gender identities and expressions would be welcomed and protected.

Ray's Digital Story: Untitled

Ray's story explores his journey of growth and self-understanding as he critically evaluates the labels that have been applied to him.

Ray's story begins with a black screen, then an image of a sunset behind a tree and some houses comes up (Figure 15) as he begins to read aloud a poem that he wrote:

Figure 15: A sunset seen through a tree on a residential street

At dusk, the nightingales herald a splitting-off
An incantation of otherness spewing forth from the caverns of perpetuity
They are no longer me
Pay heed to the crows, for they tell of dawn’s hastened arrival
We must no longer anticipate miseries clasped in the wretched maws of those who seek
to cancel out our gains
From below the cliffs, the carrion screams, “I will unravel you.”

As Ray reads, images fade in and out on the screen. Red and white tealights on white boards, in front of some petals, leaves and twigs and a pentagram emblem. An old, broken window leaning against the siding of a house, large weeds and grasses growing around it. A sunrise against a pier, jutting into frozen water (Figure 16). A black and white image of a doctor’s examination table, blood pressure monitor and otoscope hanging on the wall (Figure 17). A weed grows against a concrete wall from a crack in the sidewalk.

Figure 16: The sun rises behind a pier

Figure 17: A doctor's examination room

We see the camera zoom out to reveal that the image is embedded in a comic book layout, then zoom into an image of the surface of a wooden table against a blue wall. Ray says, "You have bipolar disorder…" and an empty prescription pill bottle appears on the table. Stop motion photography shows the bottle opening, some yellow yarn filling the bottle, then the bottle's lid closing. "Borderline personality disorder and post-traumatic stress disorder…" he continues, as two more pill bottles appear, are filled with yellow yarn, and close back up. "So I'm putting you on strong medication to control what are essentially seizures you're experiencing." The image distorts and swims. "If you behave yourself, you won't need to come back and see me." More bottles appear and fill with yarn as Ray continues listing more diagnostic labels (Figure 18).

Figure 18: Ray's prescription pill containers, each containing a tangle of yellow yarn

He explains that the labels were what he heard from people who sought to "fix" him and from those from whom he sought help for his distress and depression. One by one, the prescription bottles open and the yarn tangles escape onto the table as Ray asks, "I wonder why I might be afraid of other people if they're constantly labelling me and refusing to listen to what I need?" Ray questions why some of the labels applied to him seem contradictory, wondering "Are any of them real?" (Figure 19). "Who the hell am I without all of these labels?"

Figure 19: The tangled yarns begin to unravel

We zoom out from the image, then into a video of a rough wall of red brick and rough stucco. Ray shares his realization "Wait, am I trans? Is that the actual label? Is that real?" We scan past a black button reading "IT'S OK" and a note scrawled in pen reading "Just shut up and listen to your instinct, FFS" as Ray explains that he felt like he wasn't living his life. He decided to start to take testosterone and to get top surgery, finding affirmative health care. He explains, "I lost many people from my life, but now I'm here and I'm actually starting to feel somewhat okay." We see the yellow tangles straightening and laying side by side strand as Ray concludes, "Sometimes things just need to unravel."

Reuben

Reuben was a white man in his early 20s who identified as cis, and was not publicly out to anyone about having transitioned in the past. He used he/him pronouns and was pansexual. He also identified as autistic and as a nerd. He was raised in a GTA town. Growing up, Reuben's family was initially middle class, but due to job loss and the onset of his mother's disability, they fell into poverty. At the time of our interview Reuben lived in a larger GTA city with a housemate in an apartment. He had earned two post-secondary degrees, and had a good job in the field of education and was working toward paying off his student loans.

After being misdiagnosed as having ADHD, and being put on a high dose of Ritalin as a child, Reuben's experiences in high school after he came out as male were also very difficult, with the school singling him out in regard to access to changing rooms and washrooms. He also faced several transphobic incidents when accessing general health care and was dealing with ongoing difficulties with government agencies failing to consistently use his correct gender marker and name. Reuben envisioned a society where trans people's privacy and individual choices would be respected, and where there would be multiple options to gain access to transition-related care and other health care.

Sandy

Sandy was a mixed race Indigenous trans woman in her mid 20s. She specifically identified as trans as a means of ensuring her visibility so she could not be disappeared or erased (either metaphorically or literally), to show that she was strong and could not be manipulated or placed into dangerous situations. She used she/her pronouns and identified as pansexual or bisexual. Her parents were of European and Algonquin ancestry, but she explained that her family did not have strong connections to their Algonquin culture. Although her family had moved often while she was growing up, Sandy had originally come from the Eastern Ontario city where she was attending university and sharing a home with her younger sister who was going to a local college. Sandy had previously attended a university in a Maritime province, but had to leave prior to graduating but was later able to return to her studies at the university in her hometown through a bridging program for Indigenous students.

Sandy first sought mental health care services while attending university in the maritime province as she was experiencing emotional struggles, but she did not find the services to be helpful, and felt misgendered and stereotyped by the clinicians' presumptions about her gender and sexuality. She eventually sought and received more helpful services through the Eastern Ontario university as well as a religious-based social services agency in the same city. She was given the option of taking medication to address her depression and anxiety, but declined, feeling that it was not the right choice for her.

She then started to see a gender therapist who helped her to address both her experiences around gender identity and her previous trauma. Sandy was then able to access hormone therapy through a referral from her family doctor to a local endocrinologist. She also found support and community through the bridging program, where she was hired as a mentor following her completion of the first year of the program. Although she was continuing to experience a difficult time with finding employment, Sandy envisioned her future self as powerful and successful, and dreamed of a world where all kinds of differences would be welcomed and accepted.

Sandy's Digital Story: Miigwetch, or "Completion Through Fire by the Wendigo Dreamcatcher Appropriator"

In her digital story, Sandy draws from her Algonquin heritage and identity. The first word in the title of the story, *Miigwetch*, means thank you in Anishinaabemowin. The title also refers to the wendigo, which is an Algonquian supernatural figure representing greed and weakness. Wendigos are often humans who have been transformed into cannibalistic monsters as a result of their greed (DeSanti, 2018)

The story opens with the title against a bright turquoise background, with black diagonal stripes across the top and bottom of the screen. We hear the opening of the song Mt. Washington by the American indie band, Local Natives. The story opens with a time-lapse video showing a burning white candle tied into a white dreamcatcher, resting on a blue circle against a blue background. Sandy begins, “I’ve spent a cumulative quarter of the past year contemplating how to light myself on fire next to the eternal flame located on Parliament Hill.” (Figure 20).

Figure 20: A white taper candle burns at the centre of a dreamcatcher

The flame flickers and the candle begins to melt as Sandy continues, “My desire was to protest the then-government’s success at having once again killed the transgender bill of rights before it could be ratified in the Senate.” We cut to a photograph of some paints and other art supplies in a studio space, then see some photographs from a sketchbook: A person’s face drawn in black marker and red pen; a drawing of a large, single cherry next to a young birch tree. We cut back to the burning and melting candle in the dreamcatcher as Sandy explains, “I thought that perhaps by doing so, I would shame the government, draw attention to transgender rights, and that I would no longer be a complete burden to friends, family and society.” We see more of Sandy’s sketches and paintings (Figure 21).

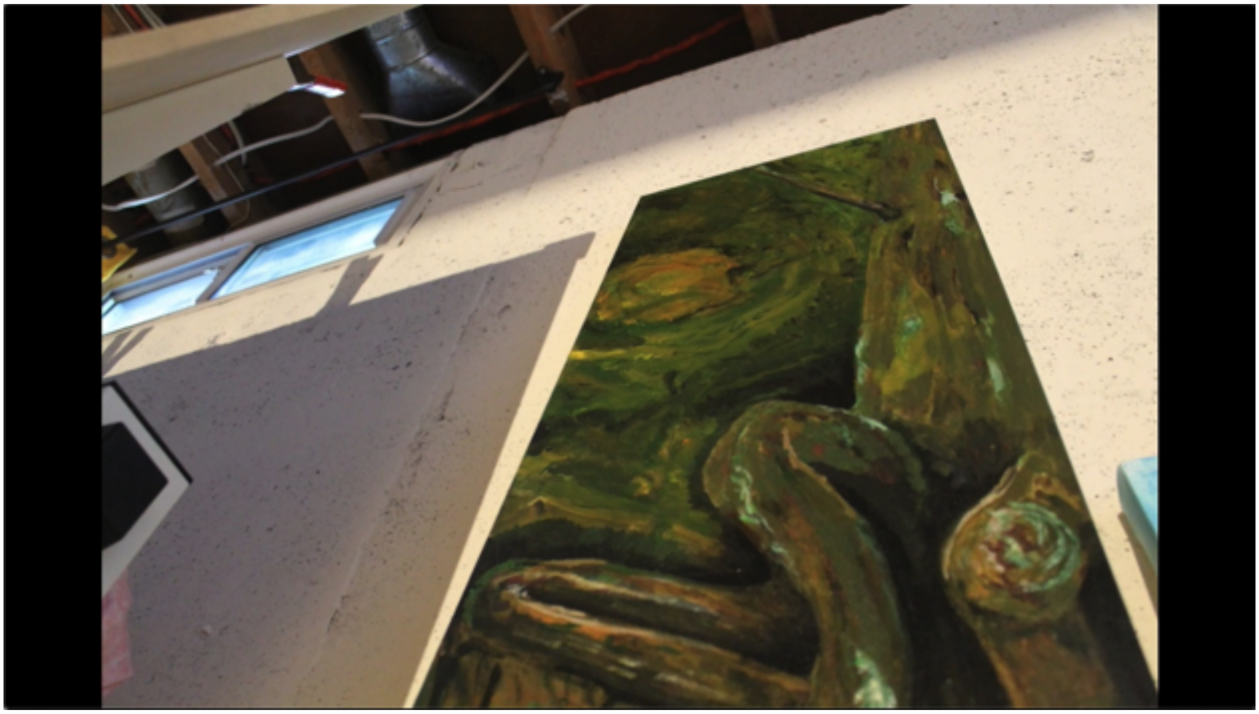


Figure 21: Sandy’s painting

Sandy explains that she has had a long struggle with depression and thoughts of ending her life. She describes her negative feelings and thoughts as an invisible form of self-harm. We see shots of Sandy's bedroom, a gift box that reveals a supply of new, sterile hypodermic syringes when opened, as well as cotton swabs and a sharps container. We cut back to the candle, which is melting into a puddle inside the dreamcatcher. Sandy says, "Adding to it the issues surrounding my identifying as a trans woman of Indigenous background, and you have further barriers and challenges to face." We see more of Sandy's art, including a drawing of a faceless feminine person (*Figure 22*) and the artificial sinew of the dreamcatcher starts to burn as the candle melts, as Sandy describes how her dysphoria and fears that no one will love her lead her to wish to do physical harm to herself to distract from her emotional pain.

Figure 22: Sandy's drawing, pinned to a bulletin board

She describes an urge to hide from friendships like she did before coming out, explaining that her reluctance to connect with people stems from her fear of being subjected to transphobic violence. Sandy explains that after she came out, family friends and co-workers were accepting and loving, and that she was able to access mental health resources and medication, which Sandy describes "ways of keeping me connected to others" that enable her to share her feelings. Sandy is silent as we watch the candle burn to its end as we hear the song continue: "I don't have to see you right now…" and we cut to more photos from Sandy's home. We return to the candle, the dreamcatcher and its paper base catching fire as Sandy says, "Yet sometimes the allure of ending it all is so strong. Like it's the only way I can achieve an ending that I have control over" (Figure 23).

Figure 23: The dreamcatcher burns up

Sandy describes how she feels bitter, robbed of all the time when she had hide herself, and explains that she sometimes wishes to hurt others by ending her life. The dreamcatcher burns itself out into a pool of liquid wax, melted sinew and ashes.

Chapter Ten: Social Determinants and Well-Being

Introduction

In this chapter, I review the experiences of participants through the lenses of the social determinants of health and the concept of well-being, synthesizing the perspectives to show how gender diverse people's lives are shaped by the kinds of broader social dynamics that cannot be effectively addressed through individually-focused interventions. Throughout, I apply the perspectives of intersectionality, feminist new materialism, critical disability studies, mad studies and disability justice, with my discussion taking place across these multiple registers.

I discussed well-being in detail alongside the related concepts of resilience and wellness in Chapter Three of this dissertation. As I have noted, well-being is centred in this project because its promotion was a stated objective of Ontario's mental health policy at the time that I conducted my interviews and digital storytelling workshop (Ontario Ministry of Health and Long-Term Care, 2011, p. 4). Additionally, as I explained in Chapter Three, in its more critical permutations, it can be both more holistic and context-sensitive than "mental health," which is often regarded primarily as rooted in individual pathology. For this reason, I think that it makes sense to talk about the social determinants in relation to well-being, rather than only in regard to health.

I provided an overview of the social determinants of mental health in Chapter Six of this dissertation. Below, I draw from the 16 determinants as identified as especially relevant within the Canadian context by Raphael (2016a, p. 11). Because health care experiences comprise the primary focus of this research, the determinant of health care services is addressed separately within the following chapter. In the original source, the 16 determinants appear in alphabetical order, but to facilitate discussion, I have grouped the remaining 15 into the following themes: Social Locations; Geography; Childhood and Education; Income and Employment; Shelter and Food; and Inclusion and Exclusion. In addition to the social determinants identified by Raphael, I have included dimensions of well-being that arose from the data collected for this project that were not included among the 16 determinants. In particular, while much of literature on gender as a social determinant of health does not consider the experiences of gender diverse people, gender diversity is the primary the focus of this research, so it is emphasized here. I also include a discussion of sexual identity as a social determinant, reflecting participants' experiences. In conversation with the determinant of social exclusion, I have added social inclusion and community as further determining factors of the well-being of participants.

Social Locations

As the concept of intersectionality reveals, all dimensions of life are shaped in relation to social locations or identities. For this reason, each social location has a significant impact on people's experiences in regard to the other social determinants of health and well-being. Because the social locations themselves are also intersectional, the construction of a list of discrete identity categories is problematic, but in what follows, I will attempt to highlight specific social location-based determinants while accounting for the ways they intersect with other identities.

Gender and Sexual Identity

As I outlined in Chapter Six, the omission of gender diversity from mainstream analyses of gender as a social determinant is deeply problematic given the degree to which trans and gender diverse community members are impacted by oppression and exclusion. Because the experiences of trans and gender diverse community members is the primary focus of this research, the many facets and impacts of gender and gender diversity as social determinants of health and well-being are addressed throughout this project, particularly in this and the following chapter. In this section, I begin with a discussion of sexual identity as a social determinant. I then discuss some themes relating to 2SLGBTQQIA+ identity that I identified from participants' interviews and digital stories.

Sexual Identity as a Social Determinant of Health and Well-Being

While sexual identity is not included on the list of Canadian social determinants, it has clear impacts in the lives of participants in this research—all of whom also identified as belonging under the queer umbrella—and for queer people generally. Due to pervasive heteronormativity and queermisia, queer people often face discrimination and social exclusion, which are damaging in themselves and also result in additional negative impacts. For example, a recent US-based study found that queer people were more likely than straight people to experience housing insecurity and instability and food insecurity, and queer women also faced higher rates of financial insecurity (Downing & Rosenthal, 2020). 2SLGBTQQIA+ people face a range of physical health disparities, including in regard to sexual health, some chronic conditions and cancers (Casey, 2019). A study comparing the health of bisexual, lesbian, gay, and straight people using UK data found that bisexual people reported the worst health and straight people the best overall health, accounting for physical and mental health measures (Booker et al., 2017). Research has consistently found that queer people are more likely than straight people to experience mental health difficulties, with bisexual people facing an even higher risk of being diagnosed with a mental health condition. 2SLGBTQQIA+ people also experience higher than average rates of problem substance use (Casey, 2019).

The minority stress model—which describes the long-term debilitating impacts of encountering stigma—suggests that exposure to queerphobic and biphobic attitudes and the consequences of discrimination are the underlying causes of these problems (Casey, 2019; Hatzenbuehler & Pachankis, 2016). The intersecting nature of identity means that racialized and Indigenous members of gender diverse and queer communities face interlocking impacts of oppression, with compounding stressors intensifying the burdens of stigma, discrimination and their debilitating consequences (Wesp et al., 2019).

Concealment and Visibility

2SLGBTQQIA+ people face a double bind around identity: Being identifiable by others as queer or trans is associated with a greater risk of encountering stigma and discrimination, but the "concealment behaviours" that may serve as a means of avoiding negative encounters have been linked with negative emotional impacts over the longer term, and are also thought to pose a barrier to accessing appropriate health care (Hatzenbuehler & Pachankis, 2016, p. 988). That noted, as I describe in the following chapter, the prevalence of transphobia in health care means that negative and harmful health care encounters are not uncommon occurrences for trans people, and I would suggest that the solution to addressing this problem is to address transphobia rather than to encourage people vulnerablized by transphobia to disclose their gender history within an often-hostile medical system.

Participants described how the pressure to hide their identities impacted them: Ray felt socially isolated before coming out as queer, not personally knowing any other queer people until his third year of university. Io had come out to their grandparents as queer but not as trans, fearing that they would reject them and they would lose access to the family supports they still needed. Francis thought that the once common transition health care practice of telling trans people to hide their past was harmful and potentially traumatic, erasing people's personal histories in the interest of upholding the illusion of a binary gender system:

> If you transitioned at 25, then zero to 24 doesn't exist anymore, and that's heartbreaking. Because you were still all of these things.

Mark had endured that experience, having been told that he would have to hide his gender history to protect his safety, linking concealment with survival:

> That survival drive is so high, right? And coping mechanisms that you develop in these past contexts are all about blending in. So, it's—it's an apology that comes after, you know. It's—it's a burden. It's—it's a caveat to my identity in some ways… It's the thing that you minimize so that you can get on with the rest of your life.

Reuben had not been told that he should hide his gender history, but he made a personal choice not to share that information with anyone. He explained that he did not find it particularly stressful to maintain his privacy around this aspect of his life, and he would find it more difficult to be perceived by others as anything other than a cisgender man. In contrast, knowing that she faced an increased risk of violence, Sandy felt safer disclosing to people that she was a trans woman. She felt that being out was her “shield,” reflecting her strength and signalling that her trans identity could not be used to manipulate or harm her:

> Being known sort of protects me from people who would try and disappear me, I guess. Like, you know, to try and kill me or something like that.

Intra-Actions with Clothing and Style

Many participants described clothing, makeup and hairstyles as important means through which they expressed and created their gender and identity. In discussing this theme, I follow Jackson and Mazzei’s (2012) Baradian reading of how a business suit intra-acts with the body of Sera, a first-generation, early career academic, to produce her as a confident and legitimate subject in the context of an academic conference:

> While the suit conveys a particular image, the wearer of the suit (in this case Sera) is produced in a mutual becoming with the suit. The suit molds Sera’s body, producing a different carriage and a sense, on the part of her and the others, that she is in her place, she belongs, and is no longer an impostor (p. 129).

Because style and appearance are so closely associated with gender norms, it is likely that most people’s choices around self-presentation are connected in some ways with their gender identity. Appearance is perhaps especially significant for trans people, whose gender identity is subject to so much questioning and scrutiny. As I described earlier, gendered appearance standards were a significant aspect of the medicalized diagnostic and treatment process for Gender Identity

Disorder, with some gatekeepers restricting access to transition care to those they perceived as most likely to “pass”—or even those they found most sexually attractive (Schilt, 2010, pp. 22–25). Until very recently, the required “real life experience” period required conformity to gendered appearance norms: The therapist Miriam was required to see before she could get a referral for hormone replacement told her to wear “female clothing” to her appointments, which took place in the middle of Miriam’s work day, suggesting that Miriam’s standard work uniform was not sufficiently “feminine.” Io had decided that even if formal appearance expectations were no longer in place, when seeking access to hormone therapy she would present herself in line with gendered norms:

> If I were to go to a place like that, I would just be so femme. I would just be, like, “I’m the most feminine person ever. Give me drugs.”

Io recognized the disruptive potential of wearing feminine clothing, noting that although they felt comfortable with it, some people might not feel confident and safe to do so until they had access to hormone replacement or other transition-related procedures. Quinn also commented on the intra-action of hormone replacement and style choices, explaining that they hoped not to develop facial hair while on testosterone because it did not reflect their self-image.

Some participants’ relationships with their family members were produced through intra-actions with clothing, hair styles, makeup or accessories. Often these intra-actions produced conflict. Io’s grandmother asked them not to wear a dress in public. Io explained that when they refused to agree, their grandmother replied, “Well then, please don’t make me walk down the street beside you if you’re wearing one.” Io’s grandmother’s transphobia and cissexism—the idea that she would be publicly embarrassed by the presence of her grandchild in feminine clothing—was activated through this imagined interaction. When Ray cut his hair short before he came out as trans, his mother interpreted this choice as a manifestation of his bipolar disorder diagnosis, rather than as evidence of his masculinity. Bryce's mother told them that she did not respect their masculine identity because they styled their eyebrows and sometimes wore makeup. Contrastingly, when Miriam came out as trans, her mother lovingly told her that she had anticipated this because she had noticed that Miriam had recently pierced her ears.

Participants were also produced in relation to the queer and trans communities through their intra-actions with the things they wore. Nina explained that one of her formative experiences as a trans woman happened when a drag queen friend of hers helped to dress her femininely, then she would dress "more and more frequent, until I go to work already like a girl, and like 24 hours." Reuben described his clothing as "effeminate," signifying his gay identity. Alesha described how her nail polish sent messages to those familiar with the queer practice of "flagging"—using colour-coded accessories to signify an interest in sexual practices:

> I'm also kinky, as a sub. That's the black. I am very, very out in my presentation… And the floral print means I'm into being wooed. This means, "I'm a dyke. I want you to woo me and then take me home and beat me."

Alexandra queered her classroom environment through her and her self-presentation choices' intra-actions with peers. She explained that on the first day of class, she wore men's clothing, then she came in wearing a dress and makeup, "the full nine yards," a few days later. When a fellow student asked her to tell him about her "style," she refused to comment or explain, disrupting expected narratives and opening space for her refusal of a coherent gender identity.

The intra-actions between fabric and bodies are discussed by Francis and Hermione, who both had experiences of managing their breasts using sports bras. Initially, Francis wore multiple sports bras to compress their breasts while exercising, but became interested in flattening their chest at all times. After they recognized that they were not cisgender, they were relieved to learn that the more convenient and effective option of a binder existed. After undergoing hormone replacement therapy, Hermione wore a sports bra to make their breasts blend in with their upper body fat, quipping, “Fat privilege is the ability to pass off as male easier.” Paired with one of their flannel “dyke shirts,” they were able to conceal their physical transition from family members to whom they had not yet come out.

ID and Identity

The many problems with navigating the medicalized dimensions of transition are described in the following chapter, but participants also talked about the barriers posed by the cumbersome and expensive legal transition and name change processes. Without access to identity documentation showing the correct name and gender marker, it is difficult to access any part of society where documentation is necessary, including employment, financial institutions, health care, and education. Lacking correctly gendered identity documentation can also make people even more vulnerable to transphobic discrimination (Kapusta, 2016). Using a trans person’s former name is often referred to as “deadnaming,” and is regarded as unacceptable in trans and gender diverse communities due to the emotional harm and safety risks it causes (Knutson et al., 2019). Being addressed by the correct name is extremely important. For instance, Sandy shared that she had put an enormous amount of thought into her name, choosing a name that felt powerful, memorable, and reflective of her Indigenous identity.

For most participants, the name and gender marker change processes were complicated or even inaccessible: Bryce could not afford the cost of changing his name and gender marker, so he had to ask people to use his preferred name, and people did not always comply. As someone who was born outside of Canada, Quinn's birth certificate was not on file with their province, so they were unsure how to begin the name change process. Alesha's birth certificate gender marker change had already been rejected twice, and they noted how problematic this is given that trans people often face family rejection:

> I have been working on this for months now, and it's like I can talk to my mom about this information and expect her to actually put in half of an effort to figure it out and get back to me. If that was not the case, it'd be, like, well, fuck.

After having spent a long time double checking her paperwork and gathering all the required documentation—including hard copies of support letters from her doctor—Hermione finally sought help from a lawyer after her name change application was rejected for a third time. Sandy's name change took more than a year, with five or six resubmissions. Shortly after Miriam completed her legal name change, she started the process of updating her health card, but before she could submit the paperwork she received a letter from the Ministry of Health threatening to terminate her OHIP coverage because of the discrepancy between the name information on her health card and birth certificate, making her concerned that this would interfere with her ongoing medical transition.

Miriam and Reuben shared that they were both impacted by Elections Canada's ongoing issues with maintaining accurate identity information for transgender voters (D'Amore, 2019). Despite having previously updated her information, Miriam later found that gender marker was incorrect, requiring her to change it at the poll. Reuben's name change had been completed before he was old enough to vote, and he had still received voting cards addressed to his deadname. People affected by this persistent issue have identified it as a barrier to democratic participation, as triggering, and even as a safety risk (D'Amore, 2019).

Other aspects of the name change processes have also disregarded the safety of transgender people. All provinces generally require name changes to be announced in the public record. Some no longer publish gender identity-related name changes and most make an exemption process available, but Mark did not have access to those options as a teenager so his legal name change was published digitally in his home province's gazette. The fact that his name is permanently linked to his deadname online has made him feel vulnerable to discrimination:

> The fact of the matter is that if someone does want to look me up, I could lose my house. I could lose my job. I could lose whatever, right? This whole issue of feeling safe and feeling trust is not a recurring theme in my life.

Homonormativity and Neoliberalism

The experiences of 2SLGBTQQIA+ people are not homogenous or unified. While general attitudes toward gender and sexual diversity have certainly shifted in ways that have benefitted many community members, these gains have not been evenly distributed. Much of the

2SLGBTQQIA+ anti-stigma and pro-acceptance work taking place in recent decades has adopted a rights-based model that emphasizes the interests and priorities of otherwise privileged LGB people. This has left unaddressed many of the interests of more marginalized community members—especially trans and Two Spirit people, racialized and Indigenous people, and lower income people. Awwad (2018) cites Duggan's (2002) concept of homonormativity and Puar's notion of homonationalism (2007) to describe how the dominance of conservative issues such as same-sex marriage have normalized and nationalized "the queer citizen-subject… recuperate[ing them] into dominant neoliberal state structures and institutions" (Kindle Location 631). Ray described what this means for trans community members:

> Okay, I can marry my partner. That's nice. But a lot of trans people are still having trouble with things like employment. Things like housing. Things like street harassment. Things like being fucking killed.

In the following sections, I describe some of the ways in which disability, race, immigrant status and indigeneity reveal the limitations and exclusions of the recuperative homonationalist project, as the interests of people produced as undesirable or as not belonging are ignored or negated in service of neoliberal objectives.

Disability

Disability is a critical social determinant of health: The exclusion of disabled people from employment and the inadequacy of disability income support programs in the neoliberal political context means that disabled people are more likely to live with a low income (Frier et al., 2018, pp. 540–542, Peter & Polgar, 2020). In turn, this means a higher likelihood of facing difficulties accessing adequate housing and food, which is especially problematic for people whose disabilities may be exacerbated by poor living conditions and inadequate nutrition.

Because mental health care experiences are at the centre of this project, all participants identified themselves as having lived with mental health difficulties or as having been labelled with mental health conditions, although as I will explain, not all participants would identify as having a mental health disability. As a result of the impacts of oppression, trans and gender diverse people are more likely than average to be identified as having mental health difficulties, but it is certainly not the case that all trans people share this experience, so the experiences of participants in this research should not be interpreted as representative of all trans and gender diverse people. Participants' experiences with mental health and mental health care (including care focusing on autism and substance use) are discussed in detail in the following chapter, and some specific issues related to disability appear elsewhere in this chapter: For example, participants' experiences with disability, work and income support are discussed in the Income and Employment section.

Disability Identity

Participants had different relationships to disability as an identity. Besides relating to mental health diagnoses or experiences with mental health difficulties, Hermione identified as having a physical difference and a related hearing impairment, and described how the normalizing surgical interventions she was subjected to had traumatized her as a child. She also identified as autistic. Reuben was also autistic. Some participants described how they questioned whether the label of disability would apply to their situations. Sandy did not want to be labelled with mental health diagnoses, fearing that she would face discrimination and judgment, especially from family members who had previously demonstrated negative attitudes toward people identified as experiencing mental health difficulties. Alesha considered their struggles with feelings of anxiety and depression to be tied to the stress they experienced in relation to their gender identity and transition, and exacerbated by particular circumstances:

> I'm definitely still in the phase where I'm not "disabled enough" to consider myself a person with disabilities, but I do live with occasional bouts of depression and anxiety, particularly in specific situations.

In many cases, the people in participants' lives tended to minimize the impacts of the mental health difficulties they faced. Francis described how because they were perceived as "high functioning," their problems went unrecognized and they were not always offered support, although they also recognized that this meant that they were less likely to be forced into contact with unhelpful services or programs. The people in Bryce and Io's life did notice their struggles, but they often ignored or downplayed them. Bryce's aunt even blamed him for the symptoms he experienced: After she learned that the seizures Bryce was having were considered psychogenic, she claimed that he was faking them to get attention.

Alexandra did identify as disabled due to the debilitating impacts of her anxiety and sleep problems, but she pointed out that people still tended to deny or minimize her experiences, likely because her impairments were not visible to them. She described the disclosure strategy she adopted to mitigate that:

> Besides the trans stuff, people don't really see me as disabled, and it's kind of hard when I'm, like, having a really God-awful day and they see me, and it's like, "How are you doing? And I'm like, [in a cheerful tone] "I feel pretty terrible! Feeling pretty God-awful! Wish I was dead!" and [they say], "Oh, but you look great!"… Having a psychiatric disability, often instead of other people learning how to deal with [your] problems, you kind of have to learn how to handle them for people.

Trans and Disability

The relationship between being trans and being disabled is contested. In Canada, gender identity and expression are specifically protected grounds in human rights legislation at the federal and provincial/territorial levels (Canadian Bar Association, 2021), but writing from a US perspective Wahlert and Gill (2017) argue that trans people should be classified as disabled for the purpose of promoting their legal protection via the Americans with Disabilities Act (ADA) and the Equal Employment Opportunities Commission, given the absence of anti-discrimination laws addressing the status of trans people.[58] They argue that because trans people must often face medicalization to access transition-related procedures and services only available through the medical system, and because community members face widespread discrimination, "they deserve protections that would help them achieve the pillars of *safety*, *access,* and *respectful care*" afforded by the ADA.

Withers (2013) points out that in Canada, trans people are often recognized as disabled within human rights law, but are generally not classified as disabled for the purpose of accessing income support programs (pp. 27–29) (although, of course, trans people who have other disability conditions may qualify for income support). Withers describes how trans people face stigma and pathologization in ways that are similar to other people labelled with DSM diagnoses, pointing out that removing trans categories from the DSM does nothing to challenge pathologization and relies on the rejection of disability and disabled people:

> When trans people and allies argue that only the trans sections of the DSM are social constructions or judgments, they reinforce the idea that other psychiatric and physical diagnoses are neutral biological realities. … According to the radical model of disability, disability is an identity that is imposed on people as a tool for social control. Of particular relevance to this principle are the arguments revolving around trans people not wanting the stigma of disability. This desire is irrelevant. Trans people are already constructed as disabled and already have that stigma… This argument also applies to those trans people who say that considering trans a disability is offensive… They are taking for granted that everyone knows that being disabled is bad, is negative and they negate all other possible experiences of disability (2013, p. 46).

In their digital story, *Trans as Disability,* Quinn described how they had not seen themselves reflected in the dominant portrayals of trans people as extremely distressed. Even though they had sometimes experienced unhappiness and depression, they thought of themselves as someone who "functioned well enough to not classify as someone with mental illness." To illustrate this point, Quinn's comic book-style avatar was shown holding a trophy, standing in a room filled with more awards and diplomas representing their accomplishments (Figure 24).

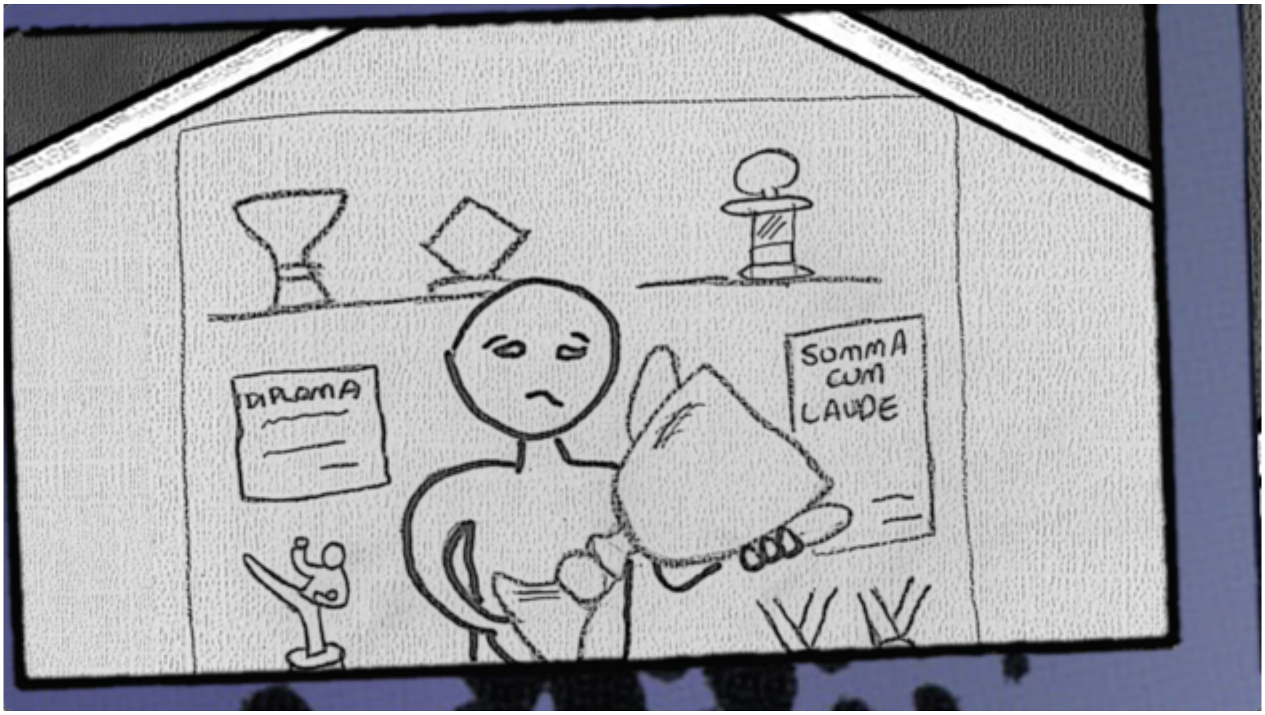


Figure 24: Quinn contemplates their accomplishments

Quinn cited the work of Withers (2013) as having changed their relationship to disability, quoting them as follows:

> Trans people are disabled… The distinction between trans people and disabled people is problematic because it implies that trans and disability are separate and distinct, erasing those people who are otherwise-disabled (p. 6).

Quinn recognized that because they were trans, they faced interconnected trajectories of medicalization and marginalization alongside other disabled people and explained that they recognized their experiences of depression as not wholly subsumed by their gender dysphoria. They called upon fellow trans people to embrace the identity of disability, and reject the co-constitutive oppressions of heteronormativity, cisnormativity, binarism and ableism, working to create a better world of acceptance and care (Figure 25).

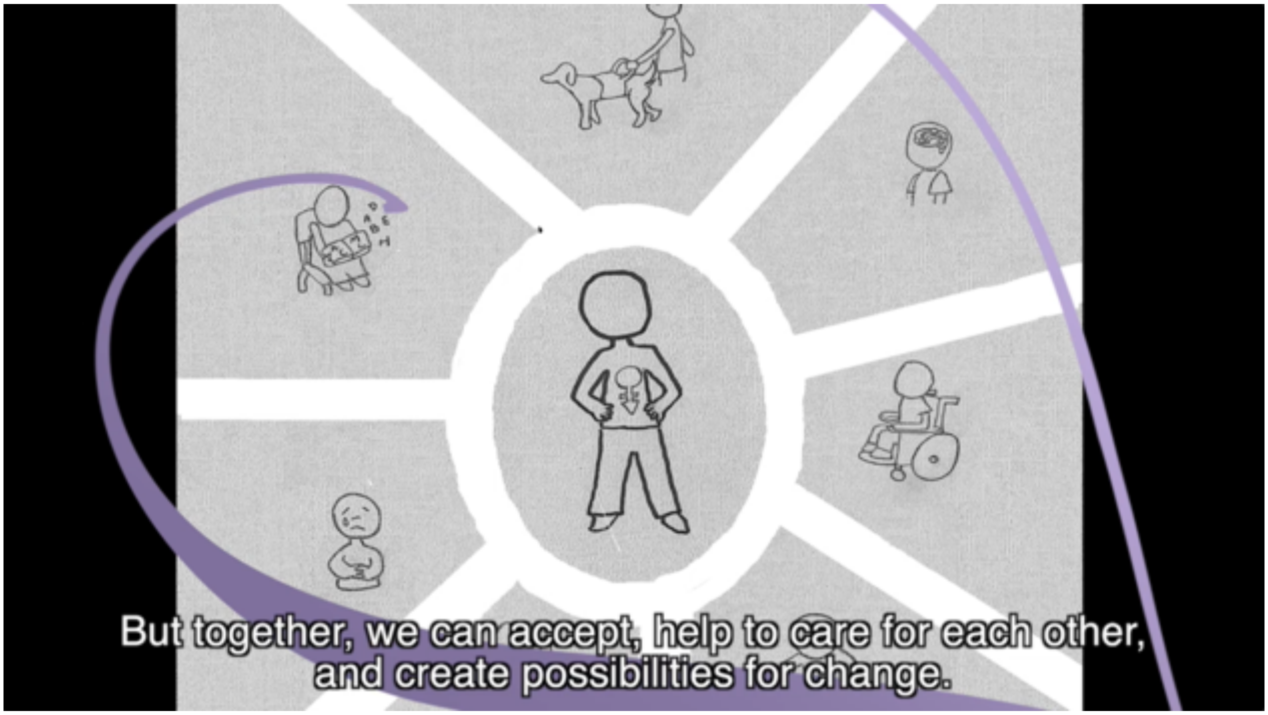


Figure 25: The transformative potential of trans as disability

Quinn's story highlights how their understanding of trans identity had been shaped by media representations and dynamics of medicalization that constructed trans people as inherently pathological. This contradicted their embodied self-knowledge and awareness of their own gender identity, and finding new ways of understanding what it means to be trans by engaging with critical discourses of trans and disability facilitated their growth and their material/discursive becoming outside of the limitations of dominant discourses.

Race

Race is an important social determinant of health because structural racism is interconnected with all other social determinants, shaping access to health care, employment, education, and housing. Racialized and Indigenous trans and gender diverse people face the intersecting impacts of racism, colonialism and transmisia.

White Privilege and White Supremacy

Most participants in this project identified themselves as white. Some noted that they were aware of the impacts of white privilege—"the multitude of ways in which people who are identified as 'white' enjoy countless, often unrecognized, advantages in their daily lives" (Gillborn, 2006, p. 319)—on their lives and as a social reality across the spheres of health care, work, and generally in Canadian society. Ray discussed the oppression of trans people of colour and described how his self-advocacy when encountering transphobic treatment in the health care system may have been successful due to his white privilege: "I get listened to because I'm white. Other people have probably been turned away and just totally shut down and not listened to." Alesha explained that a counselling program with an ostensibly "general" focus was really geared toward cisgender, straight white men, excluding everyone else.

Mark commented that his professional field was generally understood as "progressive" and was connected with the creative arts, so he had experienced it as relatively friendly toward queer and trans people: "It's a little easier in that regards to just naturally not feel any friction, right, in those types of circles." At the same time, he recognized that the field was heavily dominated by white people, and noted that racism was prevalent within it, even if it was often expressed in ways that he perceived as subtle.[59] Reuben mentioned that white privilege was often a topic of discussion during his volunteer work with a group of primarily racialized, newcomer young people through a youth mentoring program but he did not comment on any potential issues with his and the organization's choice to place a white man in a mentoring position with racialized youth (Gaddis, 2012).

Reflecting the construction of whiteness as "the unseen normative category against which differently racialized groups are ordered and valued" (Bonds & Inwood, 2016, p. 717), most white participants did not tend to describe their experiences in relation to race, although the absence of this recognition is significant in itself. In other instances, white participants positioned themselves as normative in opposition to racialized others, as in a story Bryce told about a negative interaction with their former co-workers:

> I didn't like working there… because I was the only Canadian person, and it's not because I'm racist. I don't care where they came from, what colour their skin is, but there's that language barrier… I literally can still see in my mind the two girls talking about me… I don't care if I can't understand your words.

Despite Bryce's insistence that their issue with their co-workers was based on a "language barrier" rather than racism, this is not an unproblematic assertion. The idea that colleagues who speak languages in the workplace other than the dominant one are suspect and a cause for concern others people who speak non-dominant languages. Promoting cohesion between co-workers is often cited as a justification for the imposition of dominant language-only policies in workplaces (Colón, 2002). When employers fail to support the use of multiple languages in a workplace, this limits employment opportunities for members of linguistic minority communities (Gonçalves & Schluter, 2017). The fact that the co-workers Bryce described were also racialized girls or women means that they also already encountered the impacts of systemic racism in regard to employment. Further, as Colón (2002) notes, because language, nationality and ethnicity are interconnected in complex ways, discrimination on the basis of language can be a covert means of discrimination on the basis of ethnicity (pp. 239, 247–248), so the framing of this interaction as unrelated to race may reflect a lack of understanding of the intersections of these dimensions of structural oppression.

Discussions of white privilege can tend to focus on individual experiences, and do not always reflect the systemic centring of the interests of white people and the hegemonic status of whiteness within a structurally racist society, culture and political system (Bonds & Inwood, 2016). The concept of white supremacy can more fully account for the "forces that saturate the everyday, mundane actions and policies that shape the world in the interests of white people" (Gillborn, 2006, p. 320). Ansley (1989) defines white supremacy as follows:

> A political, economic and cultural system in which whites overwhelmingly control power and material resources, conscious and unconscious ideas of white superiority and entitlement are widespread, and relations of white dominance and non-white subordination are daily reenacted across a broad array of institutions and social settings (p. 1024).

Bonds and Inwood (2016) explain that particularly within settler states such as the United States and Canada, an analysis of white supremacy must also account for the nature of settler colonialism, through which processes of colonization—including the subordination of Indigenous peoples—are ongoing. Io described how as a white privileged, low income trans person, she sought to resist co-optation through homonationalist and neoliberal ideologies and to work in solidarity with other oppressed people in opposition to racism, colonialism, environmental degradation, and capitalism.

Racialized and Indigenous Participants' Experiences with Racism[60]

While Quinn did not describe having encountered direct race-based housing discrimination, they recounted that they overheard their building's superintendent—a white woman—questioning a guest of another resident about what she was doing in the building, then indicating to someone over the phone that she had viewed the guest as suspicious because she was Black. Quinn inferred that the superintendent's bigoted views meant that she had the potential to react negatively to their transition.

Hermione discussed encountering the intersections of racism, ableism, transphobia and homophobia in employment, often being rejected in favour of less-marginalized candidates for jobs, despite the skills they had to offer. They contrasted their experience with that of white, cisgender, heterosexual, able-bodied men:

> Everything is designed to, like, try to stop me. And everything is designed to benefit them, and this is impacting my ability to procure employment and to do the things I want to do.

Hermione literalizes Crenshaw's (1989) metaphor of intersectionality in her digital story, *Roadkill Trans Woman*, which uses still photographs of modelling clay figures and children's toy cars to express her experiences at these intersections. In the opening shot of the story, Hermione's green manicure matches the colour of the figure named Beryl that serves as her avatar. The story of Beryl closely parallels that of Hermione, finding belonging and support in community to cope with the impacts of structural oppression and exclusion. When Beryl encounters barriers and rejection as voices shout the same aggressions Hermione described in her interview: “We don’t know how to deal with someone with your… difficulties,” and “You’re Chinese?! Ahh! But you look so white!” The insults continue as Beryl’s soft body is shown being run over repeatedly by toy vehicles, a stereotypical car crash sound effect playing loudly, over and over (Figure 26).

Figure 26: Beryl is run over by a toy truck

The figure is visibly damaged but gets up and keeps going, until a final assault results in her death. Hermione then invokes the cultural figure of the zombie in a revenge fantasy and “morbid critique of social structures” (Cady & Oates, 2016, p. 311). They explain that Beryl still “had dreams, and a little death wouldn’t stop her! She rose as a zombie. A fast, strong, high-stamina zombie.” Zombie Beryl attacks the clay figure men responsible for her death as they make excuses and scream slurs at her, but nothing can stop her from eating them. Next, Zombie Beryl continues her revenge spree, finding and biting the people who had harmed her. The bitten undergo a transformation, changing from hateful people into caring zombies who come together to build an egalitarian socialist utopia (Figure 27).

Figure 27: Caring zombies build an egalitarian socialist utopia

Hermione's positioning of a racialized trans woman zombie as a figure of personal resilience and resistance against systemic injustice resonates with trans theorists' considerations of transness and "monstrosity" (Nordmarken, 2014), especially Stryker's 1994 article "My Words to Victor Frankenstein above the Village of Chamounix," an adaptation of an earlier performance piece commenting on the charge that transgender people are "unnatural." Stryker embraces monstrosity as a force that opposes the tyranny of the normate. She also describes how being perceived as a "creature" poses a challenge to humanistic ideologies, writing, "I find no shame… in acknowledging my egalitarian relationship with non-human material Being; everything emerges from the same matrix of possibilities" (p. 240). Stryker concludes with a call to everyone to recognize themselves as “constructed,” asking the reader to “risk abjection and flourish, as well have I” (p. 241). In her new materialist analysis of Stryker’s text, Barad (2015) describes how Stryker

> … embraces the would-be epithet of monstrosity, harnessing its energy and power to transform despair and suffering into empowering rage, self-affirmation, theoretical inventiveness, political action, and the energizing vitality of materiality in its animating possibilities (p. 392).

Similarly, by giving the power of monstrosity to Beryl, Hermione constructs a world in which a disabled, racialized trans woman cannot be stopped by violence, and in fact has the power to end often unrecognized forms of violence while leading the way toward revolution and liberation.

Immigrant Status

In the following section, I describe some elements of participants’ experiences with immigration as a determinant of health.

Immigration and Social Exclusion

Hermione described the mental health impacts upon her mother and herself of the discrimination that her mother experienced as an immigrant from China to Canada. In China, her mother worked as an instructor at a university and was involved in the arts community. Although things were not perfect, she had a good support network. When she moved to Canada, her credentials and experience went unrecognized and like many immigrant women of colour, the only work she could find was low-status, precarious and poorly paid (Premji, 2018; Umaigba, 2017), like washing vegetables at a restaurant. Hermione recounted that her father did not contribute financially after her parents divorced, leaving her mother responsible for the family's needs, including for her own parents who had also moved to Canada. She eventually began working as a substitute teacher, but was unable to obtain a full-time teaching position:

> Partially due to racism, no support, no community. Shitty community. Exploitive community. And co-workers who harassed her. Students who harassed her. Just all this stuff piling up on her, and I know this because she used to vent to me about all the horrible things that she had to deal with.

Hermione's mother's mental health was affected by having faced the impacts of social exclusion for so long. As Hermione explained,

> She started to act out more against me. She started acting out against everyone else, and her controlling nature became more controlling. And then eventually she started hearing voices and her—her mental health deteriorated.

Hermione thought that the mental health care that her mother was receiving was medicalizing, and seemed not to be very effective or helpful. They thought that their mother could benefit from psychotherapy, but culturally safe services were not readily available in their Southern Ontario city. Hermione recognized that their mother's abusive behaviour was connected with her mental health difficulties, which arose in response to the racist and xenophobic exclusion she had experienced, and they understood their own problems as rooted in this intergenerational trauma.

Immigration and Homonationalism

Nina described her experiences in Canada as an undocumented immigrant and as a refugee claimant as having been very damaging to her mental health. She pointed out that she had to pass a psychological test to get her previous job as a florist on a cruise ship, and the difficulties she faced with depression and problem substance use had only begun after living in Canada, where she experienced homelessness, engaged in survival sex work, and was subjected to the threats of incarceration and deportation. Due to her immigration status, Nina had no access to health insurance coverage, so she was only able to access limited mental health support.

At the time of our interview, Nina was waiting for the results of her Pre-Removal Risk Assessment. If it did not succeed, she planned to apply to stay in Canada on humanitarian and compassionate grounds. She recognized that her applications were not likely to be successful but she remained hopeful about her situation:

> Even though they told me that there is, like, only one percent that I'd be approved, I'm still, like, very hopeful that, you know, I'll be approved. I'm just so thankful that I get approved for legal aid even though I don't have status.

Nina had endured debilitating circumstances during her time in Canada as a result of the intersections of transmisogyny, poverty, criminalization, and exclusionary and punitive immigration policies. As a refugee claimant who had faced criminalization and economic marginalization within Canada, Nina was aware that her immigration status was unlikely to be regularized, but she repeatedly expressed her gratitude and thankfulness for even the limited assistance she had received, including from programs operating under Sanctuary City principles, which allow undocumented immigrants to access city-run services without risking exposure to threats of detention or deportation (Aery & Cheff, 2018, pp. 1–5). She commented that even the police officer who arrested her after falsely assuming that she was the perpetrator and not the victim of a crime was "nice," and "just doing her job—they're people too, it's just their job." She continued that she still had faith in the Canadian system:

> I think the government is doing its best to, like, you know, provide people their status, and I am thankful for that.

The disjuncture between the painfulness of Nina's experiences in Canada and her positive comments about the help she received and her hope for a future in the country resonate with Ahmed's (2010) notion of the "happiness duty," which requires immigrants and refugees to Global North, colonizer states to feel and express gratitude:

> Migrants as would-be citizens are thus increasingly bound by the happiness duty not to speak about racism in the present, not to speak of the unhappiness of colonial histories, or of attachments that cannot be reconciled into the colorful diversity of the multicultural nation. The happiness duty for migrants means telling a certain story about your arrival as good, or the good of your arrival. The happiness duty is a positive duty to speak of what

> is good but can also be thought of as a negative duty not to speak of what is not good, not to speak from or out of unhappiness (p. 158).

As I discuss later, the reason Nina gave for why she did not want to leave Canada was that she would have to detransition to be able to find work in her home country, given the prevalence of anti-trans discrimination in workplaces there. Despite her negative experiences in Canada, she envisioned herself as having more possibilities for employment as a trans woman. As Murray (2015) writes, the "queer migration to liberation nation" discourse positions Canada as "a nation where sexual diversity is held aloft as a feature of a 'civilized' society, opposed to 'uncivilized' societies characterized by their rampant homophobia" (pp. 21–22). At the same time, the narrative obfuscates the realities of homophobia and transphobia that persist in this country, including in the area of employment, despite the existence of official policies prohibiting discrimination or ostensibly promoting inclusion. Murray (2015) explains that the homonationalistic refugee assessment process serves the purpose of strengthening the Canadian narrative of being "accepting" and "welcoming" while upholding highly selective, stringent criteria that still exclude refugees considered undesirable:

> The refugee apparatus is contributing to the production of a new permutation of homonationalism, a highly delimited and normative narrative of same-sex sexual citizenship and national belonging, which now includes some migrant bodies, but excludes many others who do not fit the narrative's acceptable performances, characteristics, and/or aesthetics (p. 5).

Indigenous Ancestry

Indigenous ancestry is a social determinant of health because colonialism is a social determinant of health (Czyzewski, 2011; Smylie & Firestone, 2016). The history and ongoing reality of colonialism profoundly shapes the experiences of Indigenous people and settlers, disprivileging Indigenous people, communities and Nations, while privileging the beneficiaries of colonization. As I describe in Chapter Six, this leads to significant disparities in regard to the social determinants of health and in health outcomes themselves between Indigenous and non-Indigenous people.

Sandy was the only Indigenous participant in this research, so my primary focus here is with her experiences. She described how she had always been aware of her Indigenous heritage and family connections to an Algonquin First Nation[61] in Eastern Ontario, but her grandparents and parents encouraged her to see herself as "Caucasian" and to relate primarily to the European parts of her ancestry. Sandy shared that her family members often shared and repeated racist and xenophobic comments and jokes, which could be understood as a means of shoring up a white identity (Pérez, 2017). She explained that she did not become connected with her Indigenous culture until she enrolled in an academic bridging program for Indigenous students at her university, which connected her with fellow Indigenous students and staff, as well as other resources:

> They have an Aboriginal student centre there as well now. So between the program providing support and the students and the centre there was a lot of community kind of stuff that I was able to access.

She shared that connecting with Indigenous community was an intense experience of self-discovery, describing it as a "balancing act between understanding and experiencing and figuring out who I am and who everybody—and, whoa." In her interview, Sandy did not often specifically discuss Indigeneity in relation to her experiences with health care or with respect to other social determinants of health apart from education. This may be because she did not encounter or perceive anti-Indigenous discrimination, it could follow from the way I framed the research questions, or it could be a reflection of a lack of safety in extensively discussing those Indigenous issues with a non-Indigenous researcher. There is strong evidence that for Indigenous people, having access to culture is itself a significant contributor to health and well-being (Currie et al., 2019; Oster et al., 2014). Sandy's digital story, *Miigwetch or "Completion through Fire by the Wendigo Dreamcatcher Appropriator"* more directly expresses her experience as a trans, Indigenous woman who lives with the impacts of colonial and transmisic trauma and exclusion.

The story opens with a time-lapse video showing a white taper candle that has been tied into the centre of a dreamcatcher. As the candle burns, Sandy describes how she thought about undertaking a political protest against the government's killing of the transgender bill of rights: She envisioned setting herself on fire next to the Centennial Flame on Parliament Hill (Figure 28), a fountain featuring an "eternal" natural gas flame in commemoration of the colonial milestone of the 100th anniversary of Canadian confederation, located on the unceded Algonquin territory illegally occupied by Canada's capital. Sandy explains that she hoped that her protest would shame the government and resolve her feelings of being a "burden to friends, family and society."

Figure 28: A burning candle is tied into the centre of a dreamcatcher

Sandy next intercuts photographs of her art studio space and sketchbooks, as well as health care supplies relating to her transition. As the candle burns down and the flame begins to melt the sinew binding it into the dreamcatcher, she explains that she faces difficulties as a person whose identity intersects being trans and being Indigenous. She describes the feelings of self-hatred and body dysphoria that she sometimes feels, along with the urges to self-harm that she believes might be a means of alleviating her pain. She lists some of the supports and resources that she has found since coming out and connecting with her Indigenous community, explaining how they allow space for her to share her thoughts and feelings with others.

But Sandy's story and her pain are not resolved. In the next shot, the fire has run away from the candle, burning all but the dreamcatcher's metal hoop to ashes as Sandy describes the impact of having to hide herself without connection for so long: "Parts of me are poisoned by bitterness from decades of hiding." She speaks hurriedly, concluding that she still thinks about ending her life because there is a part of her that wants someone else to have to live through the kinds of hopelessness and despair that she was forced to endure. The flames burn themselves out and smoke rises from the ashes and the melted wax (Figure 29).

Figure 29: The dreamcatcher burns

Throughout Sandy's story, Mt. Washington, a down-tempo, acoustic-guitar based song by the American indie rock band Local Natives plays quietly in the background. The band's name has been described as an instance of the kind of cultural appropriation Sandy points to in the title of her story (Brownstein, 2010). The song's title could refer to the colonial re-naming of Indigenous landscapes, and its lyrics make reference to "our whole empire" before its repeating refrain, "I don't have to see you right now." This could represent Sandy's having been positioned as invisible to those upholding the values of colonialism and transmisia during her years of hiding and isolation.

The figure of the wendigo that Sandy invokes in the title of her story is described by Ojibwe researcher DeSanti (2018) as follows:

> …One of innumerable Ojibwe manitous (spirit beings) residing within the cosmos. Ojibwe and other Algonquian-speaking communities generally understand the windigo to be a tall, rail-thin monster with a heart of ice and cursed with a taste for human flesh. The windigo's appetite for human flesh is believed to increase infinitely, assuring that it is never satisfied (p. 8).

The wendigo appears in the mental health literature in the name of a supposed "culture-bound disorder" described by colonial psy professionals in the 20th century. Called "windigo psychosis," the "disorder" was said to involve "an individual's belief that he or she was turning into the cannibal monster"—although the colonial professionals describing it had no evidence that anyone had ever engaged in cannibalism (Waldram, 2004, p. 192). As DeSanti (2018) explains, "Individuals who are lost or alone in the woods are susceptible to attacks by the windigo or even becoming one due to the stress and emotional trauma of being isolated" (p. 8). Sandy's decision to invoke the figure of the wendigo may reflect the lack of resolution of the exclusion and trauma that she had faced, as well as her complex relationship to forms of self-harm that might also have harmful impacts upon others.

Geography

Rural and Urban Issues

The relationship between geography, health and well-being is complex. Many studies have shown that people living in cities tend to have better health than those living in rural and remote areas. Some of the reasons for this pertain to other social determinants of health: People in rural and remote settings generally have lower income, greater food insecurity, reduced availability of social connections and supports, and more limited access to health care (Caxaj & Gill, 2017). For 2SLGBTQQIA+ people, problems accessing social connections and health care resources are often exacerbated (Ristock et al., 2019). In Ontario, the majority of trans and gender diverse community members live in urban areas (Blodgett et al., 2017). None of the participants in this project would be considered as living in a rural or remote area at the time of our interviews, although some participants had previously lived in smaller cities or towns. Francis explained that they experienced social isolation in their small GTA town. Miriam had previously lived in smaller cities in Eastern Ontario and reported that she was unable to access transition-related care while living there. As I discuss in greater detail in the following chapter, until 2015, clinics at the Centre for Addiction and Mental Health in Toronto were the gatekeeper for public insurance funded access to transition-related care in Canada. This meant that people seeking such care would have to travel long distances to get access, typically having to pay out of pocket to do so.

Several participants were living in lower socioeconomic status urban neighbourhoods and had experienced some of the issues identified in the literature in regard to accessing services and health care (McGibbon, 2016), often being required to travel relatively long distances to get to work, or to seek medical care—especially transition-related care, or gender diversity-friendly medical care, which was often unavailable in their neighbourhoods.

Navigating Travel and Public Spaces

Transportation policy in Canada has tended to prioritize private vehicles over other methods of travel. Those who are unable to afford a private vehicle—which includes many members of the trans community—must instead rely on public transit systems that are often inadequate and expensive to use due to underfunding (Legrain et al., 2016). Intercity transit options are relatively limited (Marshall, 2020), which is problematic for those needing to travel between cities to access services or care. Housing located near more convenient transit options such as subways and light rail systems tends to be more expensive, while lower income neighbourhoods are often underserved by less frequent and more unreliable bus services (Mpaka, 2016). Because trans people are more likely to live in lower income areas (Abramovich et al., 2020), they are less likely to have access to efficient transit, further increasing the burden of having to travel to access services or employment.

For gender diverse community members, commuting via transit can be particularly stressful because transit systems are often unsafe spaces (Lubitow et al., 2017). Nina described how she avoided transit when she could afford it because she felt scrutinized by fellow passengers:

> Before, I'd always take a cab, which costs a lot of money, but now since I don't have a job… I am forced to use the public transportation… It's like they don't see a lot of [trans

> people]. It’s like they don’t know that staring at people is being not nice at all… It’s disrespectful.

Miriam recounted being misgendered while purchasing an intercity rail ticket: “The person addressed me as sir, and I just looked behind me to see…” The ticket seller recognized their mistake and corrected themselves, but it was still an uncomfortable encounter. For Alexandra, bus trips to her psychiatrist’s office were stressful because fellow passengers would often subject her to microaggressions, which she described as “miserable” and difficult to cope with. Ray explained how he became a year-round cyclist to avoid transphobia in the transit system:

> When I ride my bicycle all winter long, it’s partly because I like riding my bicycle, but it’s also because I don’t want to have to deal with bullshit from people… I don’t like using the transit because 90 percent of the stuff that I get is on transit. Like, I’ll get elbowed when I’m walking out of a door, or I’ll get someone actually ask me, “What are you?”

Other public spaces could also be unsafe for participants. In addition to facing harassment on public transit, Ray frequently encountered aggression while walking on the street, including on his way to our interview:

> Even this afternoon when I was walking here, I had a guy spit on the street next to me when he looked at me. I just looked at him and I was like, “Fuck you.” Then I heard him

> yell something. I had headphones in, I just kept walking. I wouldn't have said anything if it was nighttime.

Bryce described how he also faced danger on the street as a trans person:

> I can't walk down the street without being afraid that someone's going to kill me. Like, that is a huge fear. And, like, it's a fear because it happens… I'm still terrified walking down the street. Like, I have to have my phone on me. I will not leave a building until my phone is at least a little bit charged because if I need to call 911 or something because someone is hurting me… I have really bad paranoia and it gets really, really bad. To the point that, that's half the reason I can't leave the house sometimes.

Alesha was also nervous in public places, but their concerns were with the possibility of having a negative interaction with police. Because trans women are sometimes targeted by police harassment and violence (Tobin et al., 2015), they felt that law enforcement would be more likely to further victimize them than to help them if they encountered a dangerous situation. Alexandra had faced street harassment and constantly evaluated her personal safety and her options for addressing potential violence while walking in public, asking herself "If a fight breaks out, could I kick this person's ass?"

The transmisogynous construction of transgender women as ostensibly posing a safety threat in public washrooms (Jones & Slater, 2020, Serano, 2021, Stone, 2019) caused anxiety for Sandy:

> [I] went into the washroom and it’s one of those things where you see a mother grab her child close. It’s that whole mentality of, like, “It’s a monster in the washroom, watch out,” kind of crap. I sort of feel like there’s people who reduce me to just a monster… like predators in the washroom kind of thing… There’s no way I could even… communicate to them. Somehow, I guess I want to portray that I’m just as scared, but that’s not the real issue. The real issue is seeing people as people and not as monstrosities.

Sandy expressed her hope that the transgender rights bill that had died in the Senate when the 2015 federal election was called would eventually be passed to protect trans women’s right to use women’s washrooms. This hope would later be realized in 2017 with the passage of Bill C-16, which gave federal recognition to gender identity and gender expression as protected grounds (Canadian AIDS Society, 2017).

Gendering Spaces

Some participants discussed how binary gender norms had been imposed upon them through spatial relations, especially during childhood. Participants described the realm of play and sport as especially fraught. Discussing changes that would need to happen to dismantle the gender binary, Sandy pointed out that toy retailers would have to reorganize their shelves. Ray explained that as a child, he faced pressure to adhere to feminine comportment norms (Young, 2005, pp. 33–45) and was discouraged from having a stereotypically “masculine” relationship to space.

> I was always really confused about why I was being told that I had to behave a certain way, because I thought that was just garbage. I didn't want to play with Barbies, I wanted to go out and play on a BMX and get covered in mud and, like, build forts and burn sticks and stuff…

Later, Ray became a talented swimmer, but he left the sport after he was denied permission to wear a t-shirt in the pool, which would have allowed him to continue to participate despite his gender dysphoria. While many people have a sense of discomfort with their bodies, it was clear that administrators had not considered the impact of the policy on trans and gender diverse youth, as well as others who face body stigma.

2SLGBTQQIA+ Spaces

For some participants, spaces specifically identified with the 2SLGBTQQIA+ community, such as queer neighbourhoods, community centres, social and support groups and entertainment and social venues were important to them. When he was coming out as queer during university, the one queer friend that Ray had made brought him to gay bars in their city, helping him to feel connected to the community. Bryce and Io went to queer and trans support groups and appreciated the opportunity to engage with people who understood their situations. As Io explained, "[It's] a good community. So it's kind of like you're not in this alone."

Alesha pointed out that some of the most trans-friendly health care organizations in the GTA were located in queer neighbourhoods, and that creating "a very queer space" within health care was part of the reason for their success. After encountering transphobia at his local pharmacy, Ray reported switching to a pharmacy in a queer neighbourhood because he felt that staff were less likely to question his transition-related prescriptions and more likely to treat him with respect. Nina had moved to her 2SLGBTQQIA+ neighbourhood in the GTA at the start of her transition and felt much more comfortable there than anywhere else:

> I already know a lot of people around. I think that's one reason why, like, I love [the city] and, I'm doing everything, what I'm doing right now, to stay here. I sometimes go outside [the neighbourhood] but it's a bit difficult. Like, there's some issues because some people outside downtown is not truly used to seeing trans women and it's—like, it really bothers us a lot if people are staring at us.

Mark explained that living in a large European city with a "critical mass" of 2SlGBTQQIA+ people helped him to finally feel more able to explore his identity: "It's just really getting lost in the crowd. That's the only thing that makes me feel safe or feel like I can kind of—kind of get out there." At the same time, he had not always found 2SLGBTQQIA+ spaces to be comfortable. After coming out as trans as a teenager, he had negative experiences in the gay clubs and 2SLGBTQQIA+ support groups in his hometown in a Western province:

> The community there really kind of chewed me up and spat me out, and so I stopped identifying entirely, and my main goal was basically to go back into the closet and reintegrate as fast as possible.

Reuben also found that some queer-focused spaces were unsafe, mentioning that he had been repeatedly sexually harassed and insulted at gay bars and pride events, so he had decided to stop going. Io critiqued corporate-focused pride events as inauthentic representations of queer and trans communities:

> Capitalism's pretty much made pride a pseudo straight pride parade because… Here are these corporations having all these floats. All these corporations run, primarily, by straight people and cis people… There's just a disconnect there.

As Walcott (2015) points out, in Canada, the locations celebrated as "queer spaces" are in reality colonized, homonormative spaces that "provid[e] space for elites within (nation) states to self-express while arguably alienating the poor, the black, and those who engage in taboos of all kinds" (Kindle Location 89). At the same time, the existence of these spaces legitimizes the state's (self-)image as tolerant, benevolent, and progressive while doing nothing to challenge its "violent inequalities" (Kindle Location 89).

Childhood and Education

Early Life

Children's experiences in regard to the social determinants of health and well-being have a significant impact on health during childhood itself and through adulthood (Gonçalves de Assis et al., 2012).

Income and Class

Participants came from a range of class and income backgrounds in childhood. Alexandra described her family of origin as being upper middle class. Alesha, Francis, Mark, Quinn and

Sandy described their families as middle class. Miriam and Nina implied that they came from middle class families, but did not specifically identify as such. Bryce, Io, Hermione, Ray and Reuben noted that their parents had disabilities, chronic illnesses or mental health difficulties, and all described their families as living on a low income at least some of the time, reflecting the financial impact of the exclusion of people with disabilities from the workforce as well as the inadequacy of disability income support in Ontario (Stapleton, 2013). Living on a low income during childhood is a source of stress, and can limit access to necessary resources required for health and development (Raphael, 2016b, p. 222–224).

Childhood Social and Family Environments

Childhood experiences also have an influence on health and well-being, with adverse experiences—such as suffering neglect, abuse or trauma—linked with negative outcomes (Finkelhor et al., 2015). Because trans and gender diverse children and young people so often face a lack of understanding and support within families of origin and among peers, the risk of facing social exclusion is substantial for members of this community (Hatzenbuehler & Pachankis, 2016).

Some participants discussed having positive experiences during childhood, with family members who were supportive and nurturing, as well as positive relationships with friends, and helpful community-based supports. For example, when she came out to her counsellor as queer, Hermione was referred to the newly-opened LGBT youth group in her city. She described this as, “Amazing timing… It was through that moment I was able to get into queer community and all the things that led up to me today.” At the same time, the presence of community-based supports did not guarantee inclusion. Mark was also referred to the LGBT youth group in his city after coming out as trans, but the group had a social focus and Mark did not feel like he could relate to the other members. He would have preferred a structured support group, but no alternatives were available.

Participants also experienced a lack of support in other ways. Sometimes this resulted from problems impacting family members. Francis and Reuben had family members who faced health problems or disabilities and lacked access to assistance, making it difficult for them to consistently provide a supportive environment for their children. For Alexandra, her mother's stigma-based view of mental health difficulties presented a barrier to receiving support:

> If I said to my mom, "I would like to speak to a psychiatrist," or something, she'd [say], "You're not crazy, there's nothing wrong with you." You know, very much that kind of defensive, "Obviously I couldn't possibly have a mentally ill child because we raised only healthy children in this house."

In some instances, participants lacked support in regard to gender diversity. Several participants dealt with the stress of having to hide their gender identity and expression from transphobic family members. Others had family members who were not understanding, or were upset or hostile upon learning that their children were transgender: Although she later became more supportive, when Mark first came out as trans to his mother she told him that she would never allow him to access hormone therapy or surgery while living at home.

Because childhood trauma is so closely linked with emotional distress and diagnosis with mental health difficulties in adulthood (Rossiter et al., 2015), it is unsurprising that many participants in this project focused on mental health care experiences encountered traumatic and abusive situations during childhood. Io’s mother died when she was eight years old, and she had to move from her home province in the Maritimes to live with her grandparents in Ontario. As I will describe in the following chapter, her grandparents seemed not to understand her grief and the limited mental health supports she was offered did not work well for her. Bryce’s mother experienced difficulties with substance use and with her mental health and was often verbally and physically abusive toward her children. Bryce also faced bullying at school and in their neighbourhood.

Francis’ father had problems with substance use and was abusive toward their mother, and their mother had mental health difficulties that contributed to their social isolation. Sandy’s father was verbally and physically abusive, and she also encountered severe social ostracization and bullying at school, including an incident in which students left fecal matter in her gym locker. Trying to avoid further victimization, Sandy withdrew socially: “I just decided to completely shut myself off from making friends and dealing with any of the drama.” She went through the next seven years of high school and university with no friendships. Hermione had experienced medical trauma as a young child and had been traumatized by a serious car accident. They were then impacted by their mother’s abusive behaviour and mental health struggles, as well as their father’s neglect. They also encountered queerphobic bullying at school. Ray’s father had difficulties with substance use and his parents were verbally and physically abusive. He was also bullied, including being repeatedly physically assaulted by older students when he was in elementary school.

Health Care and Social Service Responses to Childhood Difficulties

As I describe more fully in the next chapter, in response to the difficulties they faced in childhood and as teenagers, several participants were brought into contact with health care, family services organizations, and in one case, Children's Aid. In some instances, these encounters were helpful, providing participants with support. For example, Hermione understood the counselling they received as instrumental in helping them to cope with the abusive home environment they were in. Several other participants found encounters with professionals to be unsupportive or even damaging or traumatic in themselves. In some instances, service providers disregarded or downplayed the possible impacts of the social circumstances that were contributing to participants' problems, instead subjecting them to pathologization.

Messages about Gender and Sexual Diversity

Participants described the impacts of the messages they received about gender and sexual diversity as children. Participants in this project grew up between the 1970s and the 2000s, and for most, the messages they received about queerness and gender diversity as children were generally negative. Instances of queerphobic and transphobic bullying were among the earliest messages Sandy received about sexuality and gender. Throughout elementary and middle school, Sandy's classmates would make fun of her mannerisms and appearance by calling her gay: "I didn't really know about myself and my sexuality or my gender identity or anything. It was just very—all inner confusion."

Particularly in the 1980s and 1990s, media portrayals of 2SLGBTQQIA+ people were often stereotype-driven or sensationalized. Several participants mentioned noted daytime talk shows (such as *Maury* or *The Jerry Springer Show*) as among their earliest exposures to images of gender diversity. While their presence alerted participants to the existence of trans people, these programs typically portrayed gender diversity as a matter of curiosity, with jeering audiences expressing shock and disgust as guests were asked invasive questions about surgical procedures and intimate relationships (Gamson, 1998; McBride, 2020). Alexandra described how despite this, she would watch talk shows “religiously” in the hope of seeing transgender guests because they were only source of representations of transgender people that she could access.

> I mean, actually in one of the first ones that I saw was one that was done pretty well… They kind of brought on a woman, [said] tell us about yourself. “Oh, I’m going to college…” And then, “What else can you tell us?” “Oh, yeah, I used to be a boy.” And there was me there, little nine-year-old, like, “Wow!”… The entire time I’m thinking “That’s amazing. The idea that, like, a person could go from a boy like me, into that. I am so wowed. That is totally what I want.”

Mark explained how his problematic introduction to trans representation in the 1990s reflected his ongoing sense of needing to guard his privacy in relation to his gender history:

> My mentality has basically been still that 14-year-old in that bunker in the dark watching *Maury* with the speaker volume at one bar, ready to change the channel if anyone walks in, you know?

Later, representations became less sensationalistic as attitudes shifted. In the late 2000s, Reuben's initial introduction to trans identities also came via media representation, but it took place through a positive news article about a teenager's successful transition that fellow members of the Gay-Straight Alliance at his school were discussing during a meeting. Reuben recognized himself in the story immediately:

> I was like, "Wait a minute, what does, what?" And that was when I found out there are surgeries to do this, and this, and this, and hormone therapy, and people who identify as that can be this, and the assignment at birth might not be correct… And then I thought about it on and on, and I was like, "Oh! Maybe I should go talk to my doctor?"

Nina, Io, and Bryce explained that because cisnormative, binaristic and heteronormative assumptions suffused the messages they received about gender, sexuality and relationships at home and school, they had grown up with a limited understanding of 2SLGBTQQIA+ people, which impeded their self-understanding. Io argued that school curricula should be overhauled to be more inclusive, pointing out how she could have benefitted from learning about gender diversity in school:

> If I was 14 and heard the term genderfluid—because I'd never heard that word before—there's a possibility I would have been, like, "Yeah," and I would have had four more years of my life being more authentic.

Those who grew up after internet access had become widely available often used the internet to learn about sexual and gender diversity, but there were still limitations. Some worried that their parents' monitoring of their online activities might out them and were careful to take steps to mitigate that risk. Participants who were looking for information in the 1990s and early 2000s described being unable to find relevant and reliable information: For instance, Quinn explained that they learned that people could be trans in the early 2000s, from a website that mentioned the existence of the DSM category of Gender Identity Disorder by way of advancing the argument that "gay women wanted to be men." Mark described the irrelevance of the information he came across online in the late 1990s and early 2000s:

> Imagine, you know, searching for trans type of issues and stuff and getting maybe two or three sites for "male-to-female"? Or maybe one very shaky resource dump on a Yahoo mailing group type of thing, right? My experience with transness has basically started and stopped at my own personal experiences and, you know, the few outrageous Maury Povich things that were my only key into the fact that this was even possible.

In some cases, participants had been raised with conservative religious beliefs centring heterosexuality and gender normativity. Until they were a teenager, Quinn believed that being gay was a sin. Nina had attended a Catholic school, where her "values education" classes made no mention of the existence of 2SLGBTQQIA+ people and relationships.

Education

Access to education is an important determinant of health and well-being, with years of completed education linked with better health outcomes. Having more education is also connected with better employment outcomes and higher income, which facilitates access to other social determinants of health, including health care, housing, food security and social inclusion (Page-Reeves & Cardiel, 2016; Shankar et al., 2013). Education systems were not designed to promote equity, or even to mitigate the impacts of structural inequity upon students. Exposure to hostile curricula, with the presence of stereotypes and the absence of representation sends students the message that they are not safe and do not belong. For instance, Francis described how the existence of trans men was not acknowledged in any of the gender-focused courses they took during university. Students belonging to oppressed groups often encounter more direct forms of hostility in the education system, including bullying, exclusion, and excessive punishment (including criminalization, particularly among racialized and Indigenous students). These issues have their own impacts on health and well-being, and can serve as barriers to continuing in and completing education (Martino et al., 2019; Shankar et al., 2013).

Rigid Gender Roles and Transphobia in Education

Several participants described how their schools had policies that strictly upheld gender norms and divisions in ways that impacted them negatively. Miriam described how during elementary school, she always wanted to make friends with girls, and to participate in girls’ activities and sports but she was not allowed because she was seen as a boy. Despite having been identified as a gifted student, she quit school at age 10, because her depression had become too severe. She opted to be homeschooled instead, and later to return to an alternative school. When she was in

Grade 1, Sandy would sometimes use the girls' washroom. A teacher "caught" her and told her that she had to leave or she would be in trouble. At the time, Sandy was frightened and confused by the teacher's hostile reaction, and later realized that it could have been an opportunity for the teacher to show some understanding toward a student with a non-normative gender identity, but she was not surprised that this did not happen given the lack of awareness of gender diversity in the 1990s.

When he came out as trans during his final year of high school in the late 2000s, Reuben also faced difficulties with gendered washroom policies and other hostile and transphobic actions taken by school administrators and teachers at his GTA high school. He was given permission to use a single person staff washroom, but was not allowed to use the boys washrooms. He was also not allowed to use the boys changerooms. He was offered a single person changeroom, but it was located inside the girls changeroom, which invalidated his identity and meant that he could be questioned and outed every time he used it: "The new kids could tell if they'd seen me and they thought, 'He might be a guy... Oh wait, he's going behind the female door… What?'"

Although Reuben changed his name, the administrators and teachers declined to use his new name, choosing instead to call him by a "masculine" nickname derived from his deadname. Rather than using he/him pronouns as he had requested, Reuben's teachers avoided using any pronouns in reference to him after he came out, instead committing to constructing awkward, contorted sentences for an entire school year. Hermione encountered problems when she changed her name while attending graduate school, with some administrators and instructors continuing to use her deadname until another professor intervened on her behalf. Alesha faced similar difficulties: Although the university she was attending at the time of our interview did have a preferred name policy in place, Alesha explained that it was difficult to navigate and initially “just didn’t work,” requiring her to visit multiple offices across campus to attempt to rectify the situation. Ultimately the process took so long to navigate that she suspected that the university did not process her request until after her legal name had been changed.

Alesha faced other manifestations of transphobia and cissexism within their graduate program. When they informed a prospective supervisor that they planned to conduct research relating to gender, he discouraged them from pursuing their chosen topic, telling them that their work was “me-search” and therefore lacking in objectivity. They explained, “Basically what he was saying is only cis men can study gender objectively.”

Disability and Access to Education

Francis shared that despite missing some school when they were sent to inpatient eating disorder treatment, because teachers saw them as a “good student,” they were granted the credits they might otherwise have missed, which allowed them to graduate on time. Other participants reported facing difficulties accessing education for reasons relating to their mental health, a lack of access to accommodation, and the difficult social situations they encountered. As I mentioned, at age 10 Miriam stopped attending school as a result of depression and social exclusion, but she was able to continue her education through home school and alternative school. Due to the stresses he faced, Bryce also left school before graduating, in Grade 10. He tried to re-enroll the following year, but the school said he could no longer attend because he lived out of the catchment area, but he suspected that the real reason for his exclusion was related to the administrators’ ableist attitudes:

> I had already lived [outside of the catchment area] when I went there in the first place. They just transferred me on different buses. And they're just like, "Yeah, you can't come here." And I know it's because, like, I had these pseudo seizures. I had the grand mal seizures. I fell down the stairs and they didn't want to deal with it anymore.

At the time of our interview, Bryce was attending an alternative program and working toward finishing their Grade 11 credits. Io completed secondary school, but the effects of their anxiety and depression had made school more challenging for them. Having limited access to mental health care meant they were not able to access to a formal diagnosis and accommodations, so while some teachers were supportive, others thought their struggles were a result of "laziness." Io explained the impact of facing these barriers:

> [For] people with mental health issues, and even people without mental health issues, the education system's so strict and so harsh, it just makes it so difficult to get that education. And, like, it makes you feel so bad about yourself.

Post-secondary students also faced barriers relating to disability. As I describe in more detail in the next chapter, Alexandra's university tried to stop her from accessing her dorm room and attending classes after she experienced a mental health crisis. She eventually withdrew from her program, but would later re-enroll and complete her degree. Sandy tried to register for disability services at her university on the advice of a supportive professor, but she found the process intimidating and inaccessible, and was ultimately unable to complete her registration:

> Like in terms of how you get accepted into it, you need, say, like a psychoeducational assessment or some kind of assessment by a psychiatrist, and the money involved in that… Due to our own limited finances and stuff, to even get properly diagnosed by… That's just another barrier.

She described how the lack of formal accommodations impacted her progress through her degree program:

> I've had extensions a couple times. More than often I've thought of myself as not deserving of it or wanting it, so I've dropped a course instead. Or two or three at the same time.

Financial Accessibility

While some participants had adequate support from family members and scholarships, several had faced financial barriers to accessing education. Students with disabilities often encounter financial inaccessibility in post-secondary education (Harrison, 2015). As I described, Sandy's progress through her degree program was slowed because was unable to access disability services due to administrative and financial inaccessibility. This caused her to exceed the maximum number of semesters that student loans would cover. She was able continue in her program with family support, but she faced an increased financial burden going forward. Miriam had to leave her undergraduate program when she was denied access to student loans because her spouse's income was deemed too high to qualify. After her divorce, she was able to return, although her financial struggles continued. Io had to drop out of university after the first year of her program because she was unable to afford to continue.

Ray argued that the unaffordability of post-secondary education had a disproportionate impact on trans people, explaining that the barriers to employment would make student loans more difficult to repay, leading to further financial distress.

> You end up owing them money, and if you can't find work, how are you going to pay that back? And then your credit rating goes in the toilet and then you can't find housing and then it's just like this huge, giant snowball that you can't get out of. Tuition should be free.

Support and Growth Through Education

Participants also had supportive experiences in the education system. Alexandra reported that because she was a strong student most of her school experiences had been positive. All of her teachers had been supportive of her, and peers respected her, so she was comfortable in classroom environments. She explained that this afforded her the confidence to express her gender through fashion, where in other situations she may not have felt safe to do so.

Some participants credited experiences in the education system as having been personally transformative: Quinn was initially introduced to feminism and Marxism by a progressive politics and history teacher at their otherwise fairly conservative Catholic high school, introducing them to the political perspectives that would become core parts of their beliefs and identity. Io first learned about genderfluidity and pansexuality in a university course, which finally provided them with the concepts and vocabulary to describe those aspects of their identity. The same course also deepened Io’s awareness of intersecting structural oppression. Hermione credited their teacher’s supportive response to her trauma reaction in the classroom as having put them on a better path:

> She recognized the signs of abuse and, instead of sending me to the principal’s office to be punished for, like, assaulting people [with] water in the classroom she sent me to the guidance office instead and got me into the therapy place, which was what I would have needed. And it was through the therapy that I received, over a decade of having the right person at the right time, that I was able to grow into the person I am today.

In university, Hermione was encouraged to pursue her academic and creative interests, developing an analysis of orientalism and racism in gay dating culture through her work.

Having not completed her previous undergraduate program, Sandy was initially rejected when she applied to another university program, but staff from the university’s academic bridging programs reached out to her, and she was ultimately admitted through the bridging program for Indigenous students. Accessing the program also enabled her to connect with the Indigenous community at the university, allowing her to make friends, to learn about her Indigenous identity and culture and to take part in anti-colonial political activism:

> The year I was going was [when] the Idle No More [movement was] going on. So there was lots of learning experiences that were good and a few, in terms of negative stuff, like, just people clashing. But it’s kind of in a good way… where you understand that it’s not just one single story, either. You get to understand that different groups of people, even in

> something that is just, you know, usually flattened… Not everybody agrees. Everybody has different views. Which is good, open.

Sandy maintained her connection with the bridging program after she completed it, receiving ongoing support from program professors, and eventually becoming a program mentor herself. Other participants also participated in advocacy and activist work in education settings. Hermione undertook a needs assessment with 2SLGBTQQIA+ students in their school as part of a high school co-operative education course through their placement with a queer organization. They presented the completed report to the school board, speaking out in support of the board's proposed equity policy:

> Apparently it was my speech as a queer youth who was doing this research, which completely changed the vote from—like, there were Christian people also trying to organize against an equity policy… And so it was like a wishy-washy thing across the board, and I changed the entire vote to a unanimous yes minus two abstentions, who couldn't vote.

Miriam served on the Senate as a student representative and was involved in the gender and sexual diversity advocacy organization at her religious university. She was also writing a chapter on transgender and family for her professor's family and spirituality textbook: "Well, I asked the instructor is there going to be a discussion of trans stuff in the book? She said, 'No, do you want to write it?'"

Income and Employment

In this section, I discuss income and its distribution, employment and working conditions, unemployment and employment security and the social safety net. Because these determinants are so tightly interwoven I approach them holistically and intersectionally, informed by the relevant themes I have identified in participants' interviews and digital stories.

Impacts upon Health and Well-Being

As I discussed in Chapter Six, employment and income are closely tied to mental and physical health and well-being for a range of reasons. For individuals, having limited financial resources often means less access to adequate housing, food, health care and education, and a greater likelihood of experiencing social exclusion, as I describe in the other sections of this chapter. In the absence of a robust social safety net as is the case in neoliberal Ontario, income is largely dependent upon employment, so people who are unemployed or receiving payments from the inadequate income replacement programs in place in the province are likely to have a low income. In Ontario, trans people often encounter employment discrimination (Bauer et al., 2011) and are much more likely than average to live on a low income (Bauer et al., 2010), meaning that the impacts of low income are especially significant for trans community members.

Living without adequate income, especially in a situation of increasing inequality, is a cause of health-damaging stress (Auger & Alix, 2016). In Canada, the rise of neoliberal economic policies has caused income inequality to increase substantially since the 1980s and has also led to disinvestment in social services and infrastructure. This has left more people in a financially precarious situation even as the kinds of social safety net supports that might help to mitigate some of the impacts of inadequate income have been stripped away (Curry-Stevens, 2016).

Participants' Income, Employment and Income Assistance Status

Participants in this project had a range of income levels and employment statuses. Mark, Ray and Reuben had launched their professional careers and had relatively stable, adequately-paying jobs and so were not on a low income at the time of their interviews. Schilt (2010) points out that although trans men often face employment discrimination, white trans men working in "professional" jobs who are perceived by others as cisgender men sometimes have good employment outcomes, experiencing high levels of "recognition and respect" (pp. 3, 133–134).

Several participants were or had recently been receiving social assistance payments. Because Miriam was also a student but did not have any financial support, she was on OW when not receiving OSAP. Hermione had completed their graduate degree with scholarship funding, but had not been able to find a permanent job. She explained, "generally, employment has been a failure." She had been on OW until having recently found a seasonal job. Alexandra was unable to find work after completing her degree and was receiving ODSP. Bryce had not yet been able to finish his education, and was also on ODSP because his disability prevented him from working. Because social assistance rates in Ontario are so low (Stapleton, 2013), all participants receiving income support would be considered low income (Csiernik et al., 2017).

Two participants were on a low income and were not receiving social assistance. After having to drop out of her university program, Io was unemployed and not receiving any income support while living with her grandparents, who were themselves living on a low income. Nina was ineligible for income assistance as an undocumented immigrant. She was homeless, sometimes engaged in survival sex work and received some services from community health and food programs.

Transition Funding and Financial Stress

As I will discuss in greater detail in the following chapter, because so many transition-related procedures were (and are) not funded by OHIP or were only accessible through a restrictive gatekeeping process that was not accessible to everyone, several participants discussed the additional stresses of having to save for the costs of their health care. This could make even relatively stable financial situations difficult and pressure-filled. For example, Reuben was considering undergoing lower surgery, and anticipated that he would have to pay for it privately at a cost of at least $20,000. He was unsure about whether he would be able to afford this expense while also repaying his student loans and saving up to buy an apartment and a car. For participants on a low income, knowing that needed procedures were out of reach was a further stressor.

Working Conditions

Work that is high-status, secure and well-paid is beneficial to people’s health, whereas low-status, precarious and low-paid work is harmful (Jackson & Rao, 2016). Most participants in this research who had been employed worked in conditions that were precarious to some extent. Nina was in the most difficult situation. She had been a cruise ship florist and had initially found work in a flower shop when she arrived in Canada, but she no longer worked there after her transition. Lacking legal status and facing the impacts of racist, xenophobic and transphobic discrimination in employment gave Nina very few options for earning money, so she was doing survival sex work, which she described as difficult to tolerate, leading her to use substances to cope:

> And most of the time they—our clients are mature ones. And that's why it's like—you know—like, we don't want to do this and that's also one reason why—why we return to, like, the substances or something like that. Or, like, alcohol or something like that.

Transgender people who are homeless, who have experienced assault and who are sex workers are at greater risk of substance use (Lyons et al., 2017). Because trans people often face transphobia and misgendering in workplaces and may lack access to identification documents, sex work is sometimes a more viable option than mainstream employment, but at the same time, sex work can come with risks of criminalization, harassment and violence (Diamond & Kirby, 2014, p. 251). Nina expressed her relief that most clients treated her with respect, and that few clients had been disrespectful toward her. Because sex work remains criminalized in Ontario, workers are often unable to report violent or abusive encounters with clients. Nina's status as a racialized, unhoused, undocumented immigrant facing removal proceedings would have made seeking assistance or protection even more difficult, if not impossible due to the impacts of systemic discrimination in law enforcement (Lyons et al., 2017), as well as the fact that engaging in criminalized activity would further jeopardize her chances of winning her appeal to remain in the country.

Other participants faced lesser degrees of employment precarity. For some, the temporary or contract-based nature of their employment was related to their student status. Participants who were students often worked in the post-secondary sector, and tended to describe their working conditions as generally acceptable. Quinn reported that, as they expected, their supervisor was supportive when they came out to her. Similarly, Francis described how despite their concerns, their work as a teaching assistant was not significantly impacted by their transition:

> I was worried when I was teaching my first class as an MA student because I was basically presenting myself as a guy. But clearly everybody thought I was a butch lesbian. Which was fine. It worked out fine. Like, nothing bad happened. I was really nervous when I read my first student evaluations that they were going to say something mean, but, no, they were all very, very sweet.

Although Alesha found that living on a student budget “straddling the poverty line” was stressful, she understood herself as having the potential to be in the upper middle class after completing her graduate studies. For others, precarious, low-paying jobs were all they could find. Despite completing her graduate degree and gaining extensive volunteer experience, Hermione was unemployed and on OW until she finally found a temporary seasonal job at a factory. The job was low-waged, required a long commute via public transit and involved heavy exposure to irritant substances. Hermione found that the workplace culture was male-oriented and tolerant of misogyny and the factory’s ad hoc work group production model left her feeling socially excluded. Despite this, as a survival job she found it preferable to the alternative of engaging in sex work to supplement her income from OW:

> If it wasn't for this job, I would be doing sex work right now, which I really, really, really don't want to do. [It's] not for me because being sex trafficked, it's still playing a large part in my life.

Some participants had jobs that were relatively well-paid, but issues relating to the decline of employment quality meant that working conditions were not always ideal. Downsizing was common across Ray's industry. After half the full-time staff in his department were laid off, he was fearful of losing his job and was under even more productivity pressure:

> [I'm doing] four times the amount of work that I used to do. I'm constantly getting questioned about why are we not hitting this goal and it's like, "You lost two full-timers last quarter and you're wondering why people haven't been producing? Well, fill the full-time job. Don't just hire contractors where I have to retrain people every two to six months because then people don't get the experience they need and they don't get up to par… That's not a sustainable business model." So I just worry a lot about it all the time. Like, what does it mean if I lose my job?

Employment Discrimination

Participants had concerns about facing discrimination in employment. As a strategy for avoiding discrimination, several participants had a policy of not sharing their gender history or gender identity in the workplace. Reuben and Mark did not share information about their gender histories with others, and neither reported having faced difficulties with finding employment, or with having encountered direct discrimination in the workplace. Although Mark reported that his field was generally welcoming toward 2SLGBTQQIA+ people, problematic incidents sometimes occurred. Mark made a complaint about a transphobic and racist project codename that was in use in his workplace and was unsure whether the human resources worker who handled his complaint had guessed that he was trans, but the issue was resolved and there were no further incidents. Bryce had not begun the physical process of transition and although they had not yet legally changed it, they were no longer using their birth name. If they worried that an employer might discriminate against them, they would tell them that they disliked their birth name and preferred to be called something else. Francis explained that they did not discuss their gender identity in the classroom and were not concerned about how their gender was perceived by students, saying, “They’re going to see me as a female instructor. Whatever. I’m not going to argue because teaching’s not about me.”

Participants who were perceived by others as trans did face employment discrimination. Ray began his transition while working in the job he held at the time of our interview. His employer and co-workers had been largely supportive, but his manager seemed uncomfortable, and subsequently gave him an unexpectedly low performance review score. Ray described what happened when he asked the manager what he could do to improve, noting the impact of discrimination on his emotional and physical health:

> He looks at me and the first thing that comes out of his mouth is, “This isn’t anything to do with your personal life.” … For months and months after that, I was like, “Oh God, my boss is transphobic and is trying to mark me down so that I eventually leave.” I had a really terrible stomach that whole summer because I was just so angry. Every time I was at work I was just so angry.

After graduating from university, Alexandra applied to teach English in a country in Asia, through a national program for foreign teachers. Her application was not accepted, and on the rejection letter she received, someone had used correction fluid to change the salutation on the letter from “Miss” to “Mr.”

> I was like, “Oh, I have feeling that something was on their mind when they composed this particular document.” I guess I could have made a political stink if I’d brought it to somebody, but you don’t necessarily want to deal with the fact that you kind of got discriminated against. You don’t want to admit it to yourself that people could, like, so devalue you as a human being that they would dismiss you simply because of this one aspect of who you are.

Before coming to Canada, Nina had worked as a florist on a cruise ship. She faced the difficult social and emotional impacts of having to detransition if her appeal to stay in the country did not succeed:

> The fear that I have if I go home is that I have, in order for me to get a decent job there I—I have to go back being a man. I don’t know. If I want to go back to the ship, like, I cannot be a trans anymore because in the corporate world it’s still—it’s not acceptable.

Unemployment

Employment discrimination is a significant reason why gender diverse people have such a high rate of unemployment (Bauer et al., 2011; Davidson, 2016). Since she had moved to the Eastern Ontario city where she was attending school, Sandy had not been able to find a job. This was frustrating for her, especially because she had previously gotten every job she applied for. She was unsure whether her lack of success was due to a tough job market, if it reflected something about her own value as a worker, or whether the way people perceived her was playing a role: "Balancing between a norm that will get me employment and respecting myself enough to try and be myself… was really difficult. Everything else pales in comparison." As a non-binary, genderfluid person, Io had not been able to find employment and feared that if they did find work, potential employers might not respect their gender expression, name and pronouns, noting the irony of having to work in "a horrible environment" to survive and pay for the things they needed for self-care.

Hermione noted that despite their work as a volunteer with several queer and trans community organizations, when long-term employment opportunities came up less marginalized people would always be chosen over them, reflecting how they faced discrimination as a racialized, autistic trans person.[62] They also explained how the impacts of discrimination also meant that they lacked the kinds of connections and mentoring opportunities required to find long-term, stable employment:

> Like, there's no workshop on how to pretend that you're neurotypical so you can survive the system and get jobs. How do you harass privileged people to give you employment and to give you the right connections you need?

Because his employment was precarious, Ray feared having to navigate the job market while undergoing his physical transition:

> I do worry about losing my job. Especially when I'm still working on getting my top surgery and my body's still changing with hormones, right? Like, what does it mean to go in an interview looking totally ambiguous? How difficult will it be for me to find a job if I lose my job?

Income Assistance and the Social Safety Net

Participants who were eligible for ODSP had been found unable to work due to their mental health difficulties. Bryce would have preferred to work, but the strict attendance policies of the jobs he was qualified for were not be compatible with the unpredictability of his mental health condition. Rigid scheduling is often a problem for workers with episodic disabilities (Vick & Lightman, 2010). After graduating from university, Alexandra had tried to find work but was unsuccessful. She explained that apart from her experience with the English teaching program, "I didn't hear back from anyone, even. Like, I didn't even get the chance to be turned down for being trans." When she sought work through employment agencies, staff were not encouraging, commenting on how employers were likely to react negatively to her height and the tone of her voice and suggesting that she remove her degree from her resume, as she was overqualified for the kinds of minimum wage jobs she was likely to be able to get. Alexandra said, "That's actually pretty much when I got on ODSP. I was, like, I can't actually take this shit. Like, I can't do it."

At the time of our interview, the maximum monthly amount that ODSP would pay for a single person had just been raised to $1,110 (Income Security Advocacy Centre, 2015). This meant living on a very limited budget, but Alexandra reported that ODSP was adequate for meeting most of her basic needs at the time, at least allowing her to not worry about the immediate threat of homelessness. For Bryce, living on such a strict budget was difficult, so they often struggled to pay their bills and were unable to afford important expenses such as a legal name and gender marker change. Although the maximum monthly OW amount for a single person had also been recently raised, the new amount was only $681 (Income Security Advocacy Centre, 2015), which was not in line with the cost of living in Ontario at the time. As OW recipients, Hermione and Miriam both had to ask for help from friends and family to survive. Miriam described her experience: "[It] isn't enough to live on. Fortunately my housemate's been able to cover off the last bit of rent, and my mom helped out, but it's an ongoing challenge."

Hermione described how the process of accessing OW was painful as a trans person who had not yet been able to complete her legal name change: "OW means paperwork, forms, people misgendering me, having to use that horrible legal name that I still need to get done."

Shelter and Food

Housing

Income and Resources

Participants' experiences with housing were in large part connected with income. Predictably, those who had stable employment or access to family support were generally in more secure housing situations than those who had fewer material resources. Although she was previously employed in the information technology field, Miriam had only experienced financial precarity following her transition. As she explained, “I’ve had some good work experience, but I haven’t been above the poverty line since this started.” Miriam’s income sometimes came from OW and sometimes from OSAP, but was always inadequate. As a result, she experienced multiple dimensions of housing instability: Facing difficulties with abusive landlords, and having to move very frequently (including one year in which she moved five times), and having stressful encounters with housemates. As an ODSP recipient, Bryce faced similar difficulties with housemates. At the time of our interview, he was living with two housemates in a chaotic situation, and had just started to work with a housing specialist at a local resource centre for young people to find a place of his own even though he knew it would be difficult on his limited budget:

> I don’t care if I’m going to be broke all month. I’m going to get my own place. I’m getting a bachelor next month… Like, I am so fucking excited because, like, I’ve never had my own space, and I want to decorate the walls and just have my own space and not be worried…

Alexandra was also on ODSP and was sharing a basement apartment with her wife. While their situation was relatively stable, their limited budget meant that she had limited options for furnishing her space: “It is kind of like, after groceries I guess I can save up to buy some things from Value Village?” She explained that she had considered seeking subsidized housing but gave up after learning that the waiting list was several years long, which is a common occurrence across Ontario due to decades of government divestment from social housing (Kalman-Lamb, 2017; Walks & Clifford, 2015).

Io described how for young trans people like herself and many of her friends, losing family support could mean losing access to basic needs such as shelter and food. After having to drop out of university, Io moved back in with her grandparents, but they had begun to express discomfort with her gender expression and she worried that they might ask her to leave. She had not yet been able to find a job, and was concerned that her unstable housing situation might also require her to hide her gender identity and expression in the workplace:

> If you're in that situation, like, what are you going to do? You don't want to lose your job because you need it… So many people—and this is a real reality that could happen to me—just are forced to, out of survival, deal with that and just suffer through it.

Discrimination and Bias in Housing

Although gender identity and gender expression were not included as protected grounds in the Ontario Human Rights Code until 2012, they had been "read in" as dimensions of sex discrimination since the early 2000s (Ontario Human Rights Commission, 2000; Ontario Human Rights Commission, 2014). Despite this, members of the gender diverse community still encounter transphobic discrimination in housing in the province (Ontario Human Rights Commission, 2008). While racialized and Indigenous people are also disproportionately impacted by housing discrimination (Centre for Equality Rights in Accommodation, 2009; Knötsch & Kinnon, 2012), the racialized and Indigenous participants in this project did not mention any such instances, which could reflect that this was not a part of their experiences, but it is also possible that participants may have preferred not to discuss this topic with a white researcher. Some participants described facing housing discrimination related to transphobia. In some cases it was subtle and difficult to prove, but in other instances it was overt. For example, early in her transition, Miriam was living in a basement apartment that put her into close contact with her landlord. When he discovered that she was transgender, he asked her to leave, saying, “Think of the children, there are children in the neighbourhood.” Concerned for her safety and wary of the stresses of fighting the eviction, Miriam decided to move out immediately. The notion that transgender people—and particularly transgender women—are dangerous to children is a hate-driven myth based upon the same lies that previously positioned gays and lesbians as similarly sexually and morally threatening (Faye, 2018; Serano, 2021).[63]

Alexandra had encountered difficulty finding an apartment as a student and later as an ODSP recipient, even though her parents were financially stable and willing to co-sign a lease with her. While discrimination in housing on the basis of receipt of social assistance is illegal in Ontario, it is widespread (Ontario Human Rights Commission, 2008). Alexandra said that although she never experienced anything she would label as overt anti-trans discrimination, “I would still get turned down and never actually know the reason.”

While Alexandra’s family helped support her in finding housing, some participants’ family members were unsupportive or even discriminatory themselves. As a child and a teenager, Alesha had a difficult time while living at their parents’ house. At the time of our interview, they had been living in co-operative student housing for several months. They felt that the co-op was generally a welcoming, queer- and trans-positive space, but they were already contemplating moving out because the hectic environment was incompatible with their work schedule. Previously, Alesha’s sister had moved into an otherwise vacant house owned by a family member. Alesha had asked their sister if they could share the house, but their sister turned down the request on the grounds that she was uncomfortable with Alesha’s “weird friends”—a statement that Alesha recognized as rooted in queerphobia and transphobia. Their sister later allowed Alesha to house sit while she was out of the country, but found ways to let them know that they were still unwelcome:

> When I was gearing up to go there, one of the things she said to me in a harsh, judgey tone [was], "When you're there, don't go through my clothes and try them on." And it's, like, could you be more horribly transphobic and stereotypical ever? And that kind of sealed the deal. So, at that point I was like, "No. If I don't find a place by the time she gets back, I'll just couch surf until something happens." Because at that point in my life, I was completely ready to cut all ties with my bio family if they did not start treating me properly. And they've not quite been up to the standards, to be honest.

Prior to his transition, Ray and his partner were perceived as a same gender couple, and they had faced difficulties in finding an apartment due to homophobic discrimination. They ultimately found a unit in a duplex where the other unit was occupied by the landlords. After he inadvertently disclosed to his landlords that he was transitioning, he became concerned about their possible reactions:

> I've heard horror stories from so many people about landlords turning their water off, turning their heat off. In Toronto. Like people on Twitter who are trans writing about landlords turning hostile when they started transitioning and fucking trying to get them out. Evicting them without actually doing it.

Ray's landlords were ultimately supportive, but he worried about what would happen if he had to move in the future, especially during the time he was undergoing transition. Other participants were apprehensive about the possibility of discrimination even if they had not experienced it directly. For example, Quinn had lived in the same building since beginning their transition. They had not experienced any transphobic incidents and did not anticipate any serious problems, but they were still apprehensive about how their superintendent and their neighbours might react. As a non-binary person with a gender-neutral name, Francis decided to "pick their battles" and avoid confrontation by going along with their landlord or superintendent's perception of their gender rather than correcting them. Io discussed using queer- and trans-friendly social media groups to make their housing search safer, although they noted that this might not be an option for people seeking housing in smaller cities or rural areas. Because Mark had transitioned as a teenager and did not publicly identify as transgender, he reported that he had never encountered housing discrimination, but he was aware of the potential difficulties that he could face:

> That's part of the strategy, right? That's part of this, "I know that I'm not safe so I have to plan extra hard." That's basically the way the strategy goes, especially in Canada. That I always have to know my rights, you know? And the entire thing is, again it's different nowadays, but the entire initial idea is to integrate back in as fast as possible to avoid any of these problems.

Housing Instability and Homelessness

Many participants had faced some degree of housing instability in their lives. Several participants who had encountered difficult situations in their families of origin reported having faced housing instability during childhood. Io explained how their mother's disability impacted their housing situation:

> For the first few years of my life, I lived with my mother and my siblings, and she has—she had a chronic disability, and she couldn't work. So it was very difficult. We didn't really have a lot of money growing up. Because of that, we were forced to move a lot.

Abuse was another factor that contributed to participants' childhood experiences of housing instability (O'Campo et al., 2016; Slesnick et al., 2016). While he was growing up, Bryce was physically and verbally abused by their mother. They eventually began to report their mother's abuse to the Children's Aid Society, and they and their sister would often be temporarily placed with their aunt, who was a "treatment foster parent" who cared for several children at a time. Although she provided them with a relatively more stable environment, Bryce's aunt also put them on a weight loss diet and restricted their access to food, which they believed had contributed to the problems with eating they were still dealing with as an adult. Later, as a teenager, Bryce was placed in a group home, and would frequently stay with the families of their friends even when those situations were also unstable.

After leaving her abusive husband, Francis' mother disclosed to them that she feared becoming homeless. At the time, Francis was not aware that their mother's financial position was stable and this fear was not well-founded, so they were worried about this possibility although it did not come to pass. Francis’ mother experienced difficulties with her mental health, including with the excessive accumulation of items within the home, which contributed to Francis’ social isolation as they were growing up. Francis explained that this was one of the reasons why they were happy to move away from home to attend university.

For Alexandra and Hermione, their difficulties with housing instability began during their time at university. After being discharged from medical care following an attempt to end her life during her first year of university, Alexandra ran into an ableist policy barring her from access to her classes as well as her dorm room due to her having been identified as posing a safety risk. She fought the policy, but ultimately withdrew from school for medical reasons and had to move back in to her parents’ house. Hermione’s experience in university residence went relatively smoothly and the scholarship money they won enabled them to pay the fees, but they later experienced harassment in a shared living situation after experiencing a bedbug scare, eventually having to seek legal help and access emergency housing at their university. They next moved into a more stable living situation in an apartment with two housemates, where their mutually supportive relationship with their housemates helped them to make ends meet:

> I have to live off of OW… so I didn’t have to pay quite as much for food, and having side jobs under the table that paid in cash helped me survive. I couldn’t really, like, use my bank account very much. [So I was] getting roommates to pay for things and then paying them whenever I can in cash. Having a network of roommates, it was crucial to my survival in this instance.

Ray’s experience shows that housemate situations can be precarious: After university, his girlfriend’s best friend became his housemate, but when Ray and his girlfriend broke up, Ray’s housemate reacted angrily, stopped paying her share of the rent and started to verbally harass him.

Nina had experienced housing precarity since she arrived in Canada. At first, she used her savings from her previous job to pay for hotel stays, and she was also sometimes invited to stay with friends. At this time, she had limited access to employment opportunities, apart from occasional landscaping and painting jobs for her friends, but she then found steadier work in a flower shop, where she worked and paid for board in a room provided by her employer. When one of her friends found themselves unable to take care of their dog, Nina agreed to take care of it, but had trouble finding a pet-friendly place to stay. She was eventually able to find an apartment in a part of the city where she felt comfortable, renting from a landlord who did not ask her for documentation. Her partner moved in with her and was able to contribute toward housing costs, and Nina also did work around the building in exchange for reduced rent. When Nina’s partner threatened her and she called the police for help, the responding officers did not believe her account of what had happened and arrested her for assaulting her partner, which eventually led to the initiation of the removal proceedings she was facing at the time of our interview. Nina explained how this led to her becoming homeless:

> No, eventually, like, my landlord has to evict me because of all these issues. And since I don’t have a regular job, like, I was also working for my landlord. I was helping him clean and doing stuff like that, my rent’s lower. It wasn’t very nice. He just… Like, I was just evicted because of the issues with my ex. [Now] I’m staying with friends. Like last

> summer we stayed outside in a tent. It's hard, but I know, like, things will be better. As long as, like, I try my hardest, you know?

Nina described why she would stay outside with friends instead of in a shelter, and how she maintained hope by thinking about her future:

> I tried some shelter but I don't like the women's shelter because I don't—it's like, drugs so visible as well… I don't feel comfortable in there. Like, my—my worker would know that, like, winter time we were staying outside. I tell her, like, where I am. I stayed in the park. [I had a] sleeping bag, I set it somewhere. It was a bit scary but you know how humans, like, we get used to things. But the good thing is that—I always tell myself, "No, I'm not staying in this situation." It's like, again, I want to get this done soon so I could have more permanent and I started working.

Food Security

As is the case with housing, food security is also closely tied to income (McIntyre & Anderson, 2016). Participants with stable, well-paying jobs did not raise any concerns with respect to food security. Participants living on a lower income discussed a range of difficulties around accessing and paying for food. Although she did not describe herself as food insecure, Alesha explained how it was difficult to maintain "the façade of class" on a limited student budget, being expected to pay for living expenses and tuition fees while also meeting professional expectations around participating in social events involving going out to eat and drink. Because Alesha also had the additional expense of saving for the cost of transition procedures, these expectations were even more unrealistic for her. Io was also a university student, but she faced more severe food insecurity. She had strictly budgeted her meal plan funds while living on campus, but when a strike extended the school year, the funds ran out and she had to sell personal items to pay for food: "I dropped 20 pounds that month because I was, like, barely eating. I dropped down to 90 pounds."

Participants receiving social assistance had all faced food insecurity. Tarasuk et al. (2019) found that recipients of social assistance were more than five times more likely to experience severe food insecurity than those relying on employment income (p. 7). As an ODSP recipient, Alexandra described how after paying for food, she had little money left for other expenses. Bryce explained that even when he was able to work part time while on ODSP, if he was not careful with his money, he would have to use the food bank. Hermione engaged in several strategies to mitigate food insecurity as someone living on OW. She shared food expenses with her housemates and accessed other services to help reduce her cost of living, such as by getting food, transit fares and casual jobs through participating in community and campus groups. Miriam was also on OW and she explained that she felt fortunate that the food bank closest to her home was within easy walking distance, although she pointed out that accessing these resources would be more difficult for people with physical disabilities, as several of the food banks in her city were not inaccessible to people using mobility aids.

As an undocumented immigrant, Nina had no access to formal employment or income support, so she was also living with severe food insecurity. When her partner was unable to work after a surgery, Nina did escorting work to earn money for food. After she became homeless, she highlighted the importance of access to trans-friendly community-based services that helped her to access food banks and community meal programs in her neighbourhood and expressed her gratitude for the sanctuary model that enabled her to access these supports despite her immigration status.

Shelter, Food and Environmental Embeddedness

Participants' experiences with shelter and food reveal how political situations have impacts across every register. Because our we are embedded in our environments, our daily living conditions have an enormous impact our lives. Due to living on a low income during a period in which housing has become financialized and costs have been precipitously rising, many participants reported having lived in inadequate or substandard housing. Living in low-quality housing often means greater exposure to many environmental contaminants, which can include lead, asbestos, and toxic mold, each of which can cause health problems. Some participants had lived in basement apartments with low light levels, which is associated with vitamin D deficiency and may have impacts on mood and emotions (Parker et al., 2017).

The negative health impacts of homelessness cannot be overstated. Homeless people face increased risks of physical and sexual violence (Kushel et al., 2003). Navigating the shelter system is difficult in itself, and living in proximity to strangers who are dealing with their own difficulties is tough, as Nina explained. Exposure to the crowded conditions of shelters is also physically risky, as people living in congregate settings are highly vulnerable to outbreaks of contagious diseases (Moffa et al., 2018). Sleeping outdoors also poses many risks to health and safety, including those caused by a lack of access to sanitation and exposure to unsafe weather and temperatures (Every et al., 2019; Leibler et al., 2017). Most participants had experienced housing instability, the stress of which has its own negative health impacts. Living with housemates or renting spaces shared with a landlord can be a helpful way of making housing more affordable but it can also be a source of conflict, stress and risk, and feeling fear for one's safety is an additional health-damaging stressor.

Exclusion, Inclusion and Community

The multiple dimensions of social exclusion are discussed throughout this and the following chapter: As Galabuzi (2016) explains, social exclusion arises from the structural inequalities that prohibit oppressed peoples' full participation in all aspects of social, cultural, economic and political life. While inclusion is recognized by theorists of the social determinants of health as the converse of exclusion, it is not listed as a social determinant itself. This omission may be rooted in the critique of the promotion of social inclusion as normalizing and validating existing social relations (Labonté, 2016), which is a necessary caution. Looking at inclusion in accordance with the stories of participants in this research, I argue that it does not necessarily involve assimilation into or acceptance of oppressive social relations. For participants, inclusion often referred to supportive relationships and ties to communities, which were often a resource for opposing oppressive social norms. Participants also characterized these forms of inclusion as important contributors to their well-being. Greater social capital,[64] including through more robust social networks, is associated with subjective well-being (Helliwell & Putnam, 2004). I would posit that because trans and gender diverse people are more likely to face exclusion from (or within) some of the institutions that comprise significant elements of many people's social networks (such as workplaces, families of origin, religious communities, and even neighbourhoods), it is even more important to recognize the areas in which gender diverse community members are welcomed and included. In this section, I focus on participants' experiences of exclusion and inclusion in regard to relationships and communities.

Families

Specific dimensions of participants' experiences with family members are discussed elsewhere in this chapter and in the following chapter, so in this section I seek not to replicate that content but to consider family relationships through the lenses of inclusion and exclusion. Especially for trans and gender diverse youth, family support is recognized as making an important contribution to well-being and health (Hillier & Torg, 2019). Acceptance is by no means guaranteed, as research shows that many trans and gender diverse people face rejection and abuse by family members (Robinson, 2018).

Supportive

Some participants were accepted by their family members. Miriam was close with her mother, who was happy and congratulatory when Miriam came out to her as trans, and Miriam noted that her mother was a lesbian and part of the 2SLGBTQQIA+ community herself, so she was not surprised by her mother's positive reaction. Miriam's other immediate and extended family members were also generally supportive. As the youngest of six siblings, Nina also had a close relationship with her mother, and described how she would talk with her almost every day when she first arrived in Canada. She also had a good relationship with her sisters, but she explained that she had recently stopped being in frequent contact with family members because she felt bad about being unable to make financial contributions to support her parents at that time. Although she noted that trans people were not generally accepted in her home region, Nina's family was relatively accepting. She explained that her parents raised her and her siblings to be strong, independent people, so she felt that they respected her choices and would always support her.

Several participants described how after coming out, their family members took some time to process the information but eventually became supportive. Quinn’s brother and father were almost immediately supportive, but their mother was less understanding at first, invoking negative and problematic stereotypes of the possible “causes” of gender diversity by repeatedly asking whether she had done something wrong as a parent, or whether Quinn had been sexually assaulted. She eventually gained a better understanding of non-binary identity and became much more supportive, even helping Quinn to strategize around informing other family members. Similarly, because of the dominance of discourses of risk and danger in relation to trans women, Alexandra’s parents were initially upset and worried when she came out to them, but they changed their perspective after learning more. Alexandra also had a large extended family and she described them as “awesome people” who were “very, very supportive.”

After her initially negative reaction to Mark’s coming out, his mother later changed her perspective completely and had to be reminded that she had ever opposed Mark’s transition. Mark also had to intervene with his mother to have her stop outing him to extended family and friends, although he reported that their reactions were positive overall. After having faced difficult experiences together as children, Mark and his sister reconnected through family therapy as adults. Their relationship had become closer and more supportive than any Mark had previously experienced:

> Now I’ve got like a buddy in crime again, which is awesome. It’s—it’s so surreal to feel like you’ve got someone in your corner that’s not going to leave, you know?

Sandy described her relationship with younger sister as consistently positive, explaining that she appreciated having the opportunity to be a parental figure in her life. Sandy also had good relationships with most of her other family members, although her father's abusive and bullying behaviour was ongoing: He continued to joke about her gender identity, but also claimed that because he accepted her as a woman, she should conform to his sexist expectations for women's behaviour. Because some other family members were very conservative and had also previously mocked and joked about trans people, she wondered whether they were sincere in their support of her, but was relieved by their relatively positive reaction when she came out:

> I came into this whole thing, you know, armed and ready for battle. That's what I expected all my life. And to have everybody not only just be accepting but just be, you know, appreciative and keep me and not throw me out, that was really surprising.

Some Support

Some participants' family members were only somewhat accepting. Bryce appreciated that their grandparents consistently used their new name and correct pronouns after they came out, but their mother and aunt lacked an understanding of trans identities and were often disrespectful. Their sister was unsupportive: She persistently deadnamed them, used the wrong pronouns, and refused to tell her children that Bryce was non-binary. Bryce had decided to limit contact with their sister, and considered themselves lucky that most family members were tolerant, explaining, "I go through a shitty time with being trans but, like, I didn't get disowned." Bryce's low expectations were a reflection of the fact that trans and gender diverse people have often faced rejection by family members (Robinson, 2018). Most of Alesha's family members were transphobic, so they had chosen to limit their contact with them, explaining that they were not a source of support for them apart from the occasional time they might offer a small amount of financial assistance. In contrast, Alesha described their aunt as a “magic person,” because she immediately saw them for who they were when they came out:

> These people just fundamentally get it. Like, they take your identity as you state it at face value. Your gender is what you say to them and that’s that. They are magic.

Lack of Support

Several participants reported that their families were unsupportive and unwelcoming. In the section on Early Life, I described some of the experiences of abuse that participants had encountered. Unsurprisingly, these dynamics persisted into adulthood for some participants. Hermione had come out to their father, but he continued to use their deadname and incorrect pronouns. They had not yet told their mother and grandmother that they were a transfeminine person, concerned that their reactions might be negative. Describing how they responded to their mother’s ongoing abuse and violence and the “toxic” relationships between their family members, Hermione explained, “I deal with them as little as I can.”

Ray’s mother’s abusive behaviour had also continued, and at the time of our interview, Ray had not been in contact with her for three years. Ray’s family was unsupportive of him generally as well as in relation to his gender identity specifically: When he came out, some relatives unfoundedly warned that transitioning would be physically harmful to him and hurtfully predicted that his partner would leave him. While some family members would superficially express support, they would then behave in contradictory ways that revealed their true attitudes.

For instance, a family member would publicly invite him to an event then later privately rescind the invitation. He described how he adjusted his expectations:

> I can’t control other people, the only thing I can really do is control how I react to it. I’m just so used to it now that it’s, like, I expect nothing more of them. Disappointment implies expectations not being met, right? And they can just consistently meet my expectations.

Francis explained that their mother tended to interpret Francis’ experiences as signs of immaturity or manifestations of depression, making it very challenging for them to discuss their gender identity and sexual orientation with her. She continued to use Francis’ deadname and incorrect pronouns, even with people who had only ever known Francis’ new name. This was a source of distress for them:

> I’m used to, basically, people taking her word over mine. And so I try to keep those worlds separate as much as I don’t want to because I—I’m perpetually worried that as soon as something is said about the old life that I’ll be looked at as a fraud.

Io had not come out to her grandparents. Although she had never heard them saying anything transphobic, they were not knowledgeable about non-binary identities and she imagined that they would not understand: “They would talk to me as if I was, like, coming from the moon.” Because their relationship was generally strained and they tended to be unsupportive of most of her choices, she thought they were likely to reject her.

Partners

Support

Romantic partners were a source of support for several participants. Io and her partner provided mental health support for each other, encouraging each other to seek care. Alexandra described how meeting her wife brought her social isolation to an end:

> I had one or two friends who I'd see now and then. I didn't really feel close to anyone. I didn't feel like I had a community. I didn't feel like other people were around who understood me who I could talk to, or I could understand every aspect of, myself. And then I kind of met [Alexandra's wife], and finally I had this person who—[on] our first date we just talked for six hours straight.

Some described how romantic partners played a role in their coming out process. Alesha described how a pronoun mix-up made by one of their partners had been revelatory for them:

> I spent a while identifying as non-binary, mostly because it was a process of working through internalized transphobia. And my girlfriend at the time, when I was a wee baby queer, she got it wrong and was using "she" pronouns for me. And I really liked it. So I was like, I think that may say something. So, bless her heart for seeing me even when I didn't.

Whereas their previous partner had encouraged Francis to adopt their "black and white" view of gender, Francis' then-current partner was the first person with whom they discussed their realization that they were non-binary and had since become an ongoing source of support, especially for topics that Francis understood as “too heavy” to raise with friends. Ray gave his partner credit for being supportive throughout his journey of exploring his gender, and helping him to understand his experiences with psychiatrization: “[Ray’s partner] totally turned my life around and changed how, like, a lot of people were treating me, or how I was looking at that.”

Lack of Support

Partners were not always supportive or understanding. Transphobia played a role in some participants’ breakups: When Miriam came out, her wife immediately ended their relationship. Although she reported that the other people she had dated were all supportive, when she was first coming out as trans, Alesha’s then-partner broke up with her because she did not want to date a trans woman. When Bryce told his girlfriend that he was trans, she responded that he was just “trying to follow the trend,” and their relationship subsequently ended.

Participants also experienced other difficulties in their romantic relationships, including serious problems such as violence and abuse. Hermione mentioned that she had been sex trafficked by someone with whom she had been in a relationship, and she was still working on finding resources to process that trauma. Although Nina and her ex-partner had been sources of support for each other during their relationship, with both contributing toward expenses and Nina looking after him while he recovered from surgery, their relationship had ended following the violent incident that led to her being arrested. Because Nina had been spending most of her time with her partner, she had few friends at the time of the incident, which made the situation even more challenging.

No Partner

Some participants were not partnered at the time of our interview. For some, this was a choice or a temporary matter of circumstance, but for others it represented a larger problem. Hermione felt left out of the dating scene, explaining that it was hard to find the right person. Their feelings of exclusion are supported by research: In a recent Canadian survey of dating and social approval, 87.5% of participants stated that they would not date a trans person, reflecting a high level of transphobia (Blair & Hoskin, 2019). As I describe in greater detail elsewhere, Mark had been told at a young age that relationships were too risky for him as a trans person, which later made it difficult for him to date.

Alesha described how because their transphobic family was unsupportive of them, and the kinds of issues they faced were too difficult and intimate to discuss with most friends, their primary source of social support were romantic and queerplatonic[65] partners. They felt that they were the only ones they could share their experiences with, especially around transition, health care and embodiment. They did not have a long-term partner, which made their support network unstable and put them in an emotionally vulnerable situation. They described what happened after a recent breakup:

> We couldn't even be friends because, like, we just didn't actually have anything in common other than our lives were shitty. And I think that's an instance of, like, when you're not getting enough social support, you will—you will try and find it, even in relationships that are otherwise not any good for you. And you'll fuck people, because that's what goes along with getting people to care about you.

Alesha pointed out that there are few or no professional resources available for people dealing with personal crises that would not likely be understood by health care providers as rising to the level of requiring clinical support. She hoped that she would be able to find a partner who would make a serious commitment to being there for her in the specific ways she needed, including supporting her in interactions with her family of origin.

Friendships and Communities

Participants described themselves as having friend groups and connections across a very wide range of communities. In this section, I focus on some of the main themes that I identified in participants' interviews concerning friendship and community. I begin with a discussion of friendships, especially in relation to transition and mental health support, then turn to a discussion of participation in cultural and ethnic communities, 2SLGBTQQIA+ communities, and some participants' experiences with online and "nerd" culture communities, as well as creative and religious communities. Friendship and community are particularly important for 2SLGBTQQIA+ people, serving to counter some of the impacts of social exclusion facing community members (Galupo et al., 2014).

Friendships and Transition

Several participants discussed how their friendships were impacted when they came out. Bryce had a large friend network across some of the schools they attended, and they felt that their family's familiarity with a close friend of theirs who was out as trans had made it somewhat easier for them to understand their experience. Hermione explained that she had been out as queer since age 16, and because her friend group was primarily queer people, they were all supportive when she came out as trans. Quinn's friends were also consistently supportive:

> I haven't had any friends who've been like, "I can't be your friend anymore," or anything like that. I think if I had suspected that I wouldn't have become friends with them to begin with.

Although Sandy had gone periods of time without friendships and sometimes felt that she struggled to connect socially, she explained that the friends she had validated her experience and identity when she came out:

> I came out to all my friends, like, early on, before a lot of even my family knew, and that was really helpful. Everybody was really encouraging.

Making and maintaining friendships is often complicated, but the prevalence of transphobia can make it especially challenging for gender diverse people. Some talked about the process of choosing which friends to trust. Early in her transition, Miriam had decided to come out to a small group of her friends, selecting people who she knew would be supportive. Although Ray had lost some friendships, he explained that he felt "lucky and privileged" to have found a genuinely supportive community. He had decided that he would not maintain a friendship with anyone who was unsupportive:

> I’ve had some friends who have been—well they’re not my friends anymore because they’ve said stuff like, “I think trans people have mental disorders,” and I’ve been like, “Fuck you.” I refuse. I will not subject myself to bullshit like that from other people. I feel like it’s hard enough to be a trans person. I don’t really need to have people who are supposed to be my friends telling me that.

Alesha had a similar experience, noting that their transphobic friends “just sort of fade[d] out of my life,” leaving them with a better friend group.

Reuben and Mark did not disclose their gender history to their friends. Reuben had made many good friends during his time at university and in the workforce, but he had not disclosed his gender history to any of them. For Mark, the small group of trustworthy friends he had since childhood were the only ones who were aware of his having transitioned:

> I picked that group well, and we’re still close… That was all just this—this pre-strategy of having to get rid of people who I don’t think are going to be safe for me to be around.

According to Rood et al. (2017), for many trans people, choosing not to disclose can be a source of stress, but it can also be a strategy to avoid bias and for some, it can also serve as a means of “affirm[ing] their gender” (p. 710).

Friends and Mental Health

Some participants described how friendships played a role in dealing with the mental health difficulties they experienced. Io described how most of their friends at university were dealing with similar problems to the ones they faced, which allowed them to understand each other. At the same time, they pointed out that while they valued the opportunity for commiseration, the situation reflected the fact that no one in the group had access to the kinds of professional mental health care assistance that they thought would be truly helpful.

As a strategy to avoid having further encounters with the eating disorder treatment program (discussed in the following chapter), Francis and their friend would go out to buffet restaurants together as a fun way to encourage them to eat. Other friends were less understanding of the difficulties that Francis had faced, examining their behaviour for evidence of "symptoms" and often making inappropriate, policing comments. When Francis later switched to a gender-neutral name on social media, they lost their connection with many of their old friends, which allowed them some distance from the pathologization they had experienced. Having been subjected to surveillance by friends was an experience that stayed with Francis, making them concerned that if they were to disclose their mental health history they might "be branded again."

Ethnic and Cultural Communities

Indigenous and racialized participants described how their connections to ethnic and cultural communities were important sources of support for them. Sandy became part of the Indigenous community at her university, enabling her to access culture and support. Nina had connected with fellow Filipinas and Filipinos after coming to Canada, finding work and new friendships through community connections, and maintaining relationships with childhood friends who also lived in her city. Quinn described the importance of their ties with the Mexican community:

> I do have like cultural rapport with other Mexicans, like there's things that we can talk about… The language that we use is very similar. So that's definitely an important part of my identity.

2SLGBTQQIA+ Communities

Many participants described themselves as belonging to 2SLGBTQQIA+ communities. Bryce and Hermione had identified with the community since they were teenagers and had actively participated in many queer community organizations and events. In high school, Hermione had even helped co-found the first queer youth group in their Southern Ontario city. But not all participants felt entirely comfortable in the queer and trans communities, and especially in 2SLGBTQQIA+ organizations and events. As I described in the earlier section on queer and trans spaces, after being tokenized and mistreated in the LGB organizations in his hometown, Mark did not consider himself part of the 2SLGBTQQIA+ community at all. Several participants had found organized queer and trans groups to be cliquish and unwelcoming. Quinn and Miriam pointed out that issues with misogyny and the overvaluation of masculinity often went unaddressed, and Miriam and Alexandra noted that trans groups tended to be focused on promoting respectability, often rejecting sex workers and gatekeeping those who they considered as "not really transgender" because they did not conform to dominant, medicalized narratives of trans identity (I discuss dominant understandings of trans identity in detail in the following chapter). Ray made a similar observation:

> There's a lot of queer community that's really hostile towards trans folks and there's a lot of trans community that's hostile to some trans folks, like "Oh, you're not trans enough."

He noted that he felt that he could not claim the label of queer for himself because he did not often participate in events like the pride festival, and when he did attend he often felt that he did not fit in. Io also felt that they did not belong at pride, but argued that this likely reflected its status as a corporate-dominated event that did not reflect most community members' experiences or interests.

Alesha described how dynamics of exclusion transcended the bounds of widely-recognized events and organizations: She was embedded in the community through her one-on-one relationships, but as a gray ace,[66] pansexual trans woman, she recognized herself as being "at the bottom of the chain in, like, basically every area," with regard to sexual and gender identity, facing the impacts of compulsory sexuality as well as policing within the asexual community, in addition to biphobia and transmisogyny.

Outside of many of the officially-sanctioned manifestations of "queer community," Nina explained that many of her friends were from the trans community centred in the queer neighbourhood where she lived. She was friendly with everyone, but especially closely connected with fellow Asian trans women. Nina was also friends with several straight, cisgender women from her hometown who she had known since childhood and had also moved to the same GTA city. Nina felt that her childhood friends could not understand the hardships she faced as a trans woman:

> Their life here is, like, just work, house, stuff like that… If they would hear some of [trans people's] stories, they would think, like, "Oh, really? This sounds unbelievable,"

> something like that. But it's—it's a really hard life, which I choose, and I choose it because I'm happy with it.

Online Communities

Some participants described how online 2SLGBTQQIA+-focused communities were sources of support for them. This is often the case for queer and trans people, especially when few other resources or opportunities to connect in person are available (Green et al., 2015). As a teenager, Io connected with queer people through their Tumblr blog. Initially, they were out as queer online but not in their daily life, so they kept their online activity hidden from their school friends, but their "internet and real life kind of merged" later on as they came out and made more queer and trans friends in person. As a young teenager in the late 1990s, Mark could express his sexual and gender identities in chat rooms prior to coming out in real life, although the amount of time he spent online was viewed as problematic by his mother. Quinn and Alesha saw themselves reflected in the photos and videos that trans people would post on social media to document their transition. Reading the discussions taking place in the comments helped Quinn to understand that they did not need to fit the dominant transition narrative of having known from childhood that they were "trapped in someone's body," validating their experience. Sandy also gravitated toward LGBT videos on social media, especially during the time when she had no friendships. She explained that they served as an escape from the difficult social situation she was in, but she was concerned that she might become overly reliant on this coping strategy and eventually decided to re-engage socially instead of staying in her online "bubble."

2SLGBTQQIA+ online groups helped provide other resources for participants. Quinn belonged to a Facebook group for transmasculine people involved in physical fitness, and found it to be an important source of information and support. Io discussed how the Facebook groups "Jobs for Queers" and "Homes for Queers" helped community members to navigate employment and housing in the context of widespread discrimination.

Queer-focused online spaces were not always relevant or safe for participants. Miriam had accessed online support groups for trans women, but did not find them to be particularly helpful. Although Francis often re-posted trans- and queer-positive content on their blog, they did not feel safe to directly disclose their gender identity or sexual orientation, worrying about being unfairly judged as inauthentic:

> It's always the, "Are you trans enough? Are you queer enough?" narrative that crops up when you follow these circles…

Alexandra had a website where she had shared her thoughts and experiences concerning gender identity. Someone posted a link to her site on a forum, and she was subjected to intense harassment by forum participants, who subjected her to a torrent of abuse about her gender identity and sexual orientation, haranguing her with questions like "What are you attracted to?" and, "Which are you?" After the hate messages subsided, Alexandra thought about what it meant that her identity was incoherent to most people:

> I don't have enough of a social life that it really matters what I identify as. I can just pretty much be that weirdo in the back of the room and, you know, it's actually—it's actually more fun being confusing.

Online communities with other focuses were also places where participants found community. Hermione connected with queer people through online gaming communities. She and Francis were both involved in several fan and fan fiction communities, and both made strong friendships and even romantic relationships with fellow queer and trans people through them. Francis explained that they had participated intensely in a fan community surrounding a band for a long time, then took a years-long break. When they returned, they discovered that many of their friends from the community had also come out as trans.

Nerd Communities and Activities

Some participants identified other kinds of "nerdy" interests as a presenting opportunities to build community. Through their interest in anime, Quinn and Hermione discovered queer media and made friends. Alesha developed friendships through a gaming club that she started, and found that having a common interest in the game kept them together whereas some of her other friends seemed overly focused on her transition: "Dude's like, 'Nah, I don't care…' Like, we're still going to play our games." Reuben was also involved with gaming, including live action and tabletop roleplaying, and many other trans people belonged to his gaming groups. Although he did not disclose his personal experiences to them, he was happy to point newly-out trans friends to health care and community resources.

Creative Communities and Pursuits

Several participants described how participating in creative communities and activities enriched their lives. Francis and Hermione were both part of the fan and fanfic communities, and they were also writers. Alexandra was a writer, a visual artist and a videogame designer. Io was a writer and poet, engaging with political issues through her work and participating in spoken word competitions.

Religious Communities

I describe the ways in which religious organizations provided mental health support in the next chapter, but for Miriam, her involvement in faith communities was an extremely important part of her life more generally. She attended a religious university, where she worked to promote the inclusion of 2SLGBTQQIA+ students. She had converted to Judaism, intending to begin the process of becoming a rabbi. She explained that like many religious communities, the Jewish community in her city was generally relatively conservative, making it difficult for her to participate as a queer, trans person. As a result, most of her connections were in the United States, where she often travelled to attended conferences and educational programs. She was also playing a leadership role in developing a stronger community for a progressive faith movement in her city, explaining, "I've sort of found community that works for me."

Conclusion

The experiences of participants in this research show that the social determinants of mental health, from social locations, to geography, childhood experiences and education, to employment income, shelter and food, to social exclusion and inclusion each have a strong impact on the well-being of trans and gender diverse people. Participants described the supports and the stressors they encountered in regard to each of the determinants, and revealed not only the resourcefulness and resilience of gender diverse people, but also the substantial work that remains to be done to move toward inclusion for members of the community. Some of the social determinants may not be directly within the purview of social policy—for instance, issues such as housing and food insecurity or employment discrimination can and should be directly addressed by governments, whereas relationships with family members and friends are obviously not subject to the impacts of policy decisions in quite the same way. At the same time, though, inclusive education policies and curricula can play a role in encouraging greater understanding and acceptance of gender diversity. In the following chapter, I focus on the social determinant of health care services to illustrate how experiences with mental health care affect participants' well-being.

Chapter Eleven: Mental Health Care System Experiences

Introduction

In this chapter, participants discuss their experiences with mental health care, defined broadly as any support received for emotional issues or distress. In the interview question focusing on this topic, I listed a wide range of institutions, practitioners, and support providers (including doctors, psychiatrists, other health care practitioners, psychologists, counsellors or therapists, teachers, and community organizations) with the intention of encouraging participants to share the full scope of their experiences across decentralized systems. In addition, I asked participants whether their contact with mental health care resulted from requirements relating to access to transition or whether it had come about due to difficulties they were experiencing. I also asked them to describe any informal assistance for emotional issues or distress (i.e., friends, support groups, online, etc.) they had received. Participants discussed many encounters with the listed professionals and institutions, with other health care workers such as nurses, pharmacists, reception and administrative staff, and experiences with informal supports. Some of the encounters described may not be strictly related to what might be defined as "mental health care" in a more limited sense, but as participants' stories show, all health care experiences can have an impact on mental health and well-being. For those who sought medical interventions in support of transition, the impact is particularly clear. Further, participants described other encounters that I had not foreseen due to the limitations of my own perspective. For example, as I discuss toward the end of the chapter, several participants reported that clergy and religious organizations were important sources of emotional and even material support for them.

The themes that I identified from the interview and digital story data are as follows: Barriers to access; medicalization of distress; gatekeeping; medical coercion, harm and misconduct; subversive care; supportive experiences; spirituality, religion and pastoral care; and informed consent-based care.

Barriers to Access

It is not surprising that many participants discussed encountering numerous barriers to accessing mental health care and other related health care. Health care funding in Ontario has tended to deprioritize the provision of mental health care (Ashcroft et al., 2016; Bayoumi et al., 2020). This has led to a situation where mental health care is minimally funded in comparison with other parts of the system (Di Pierdomenico, 2016). As a result, it has often been the case that publicly funded services are unavailable or difficult to access, with long waiting lists and significant limitations as to the choice of therapeutic methodology and provider (Children's Mental Health Ontario, 2020; Cohen & Peachey, 2014; Loebach & Ayoubzadeh, 2017). For those without access to OHIP (or Interim Federal Health Program insurance), the options are even fewer. Because transgender people are less likely than the general population to be employed and are more likely to live with low income (Bauer et al., 2010; Adams & Liang, 2020), privately funded services have often been far out of reach for members of this community. These problems are complicated further for gender diverse people due to the unavailability of transition-related care specifically, as well as the lack of availability of culturally competent/culturally safe providers in the health care system generally, as participants' stories show. In addition to these issues, for participants who were in contact with the mental health care system due to the gatekeeping of access to gender confirming procedures, many described bureaucratic issues as a further barrier to access to care for them, reflecting the ongoing impact of the bottleneck caused by restricting approval for gender confirming procedures to the CAMH gender clinics. As I will discuss, although this policy changed during the time that these interviews were conducted, participants pointed out that the excessive waiting times for certain procedures would likely persist and even intensify due to an ongoing lack of approved providers.

Unavailability of Services

Across Ontario, OHIP-funded mental health care services are often difficult to access, with an inadequate number of providers and programs relative to demand (Rush & Saini, 2016, p. 16) and a limited range of services available (Cohen & Peachey, 2014). As participant experiences illustrate, this is true outside of major population centres where health care access is generally more limited (Canadian Mental Health Association, 2009; Reaume-Zimmer et al., 2019) but is also a problem in the province's largest cities. Although successive governments have touted their plans to undertake reforms ostensibly aimed at improving access to care in communities across the province (Di Pierdomenico, 2016, pp. 21–43), the goal has clearly not been achieved and the problem of the inaccessibility of mental health care has remained.

Having limited access to ongoing mental health care often results in increased use of relatively more expensive and resource-intensive emergency services (Cohen & Peachey, 2014, p. 127). This is most problematic for the people seeking emergency care, because they are in many instances experiencing crises that may have otherwise been averted. Io experienced the impacts of the limited availability of services when she sought emergency mental health care while attending university in the GTA. She had managed to go more than a year and a half without engaging in problematic substance use when she relapsed and took an overdose of Tylenol 3s during an especially bad night and had to go to an overcrowded emergency room:

> It took six hours before a doctor could see me. So when I finally saw a doctor, my overdose was completely cleared out of my body… He took some tests and was like, “Well it did no lasting harm to your body. You’re really lucky. Your liver is fine.”… During the time I was sitting there I could have permanently destroyed my liver, but I’m just sitting here, which is super.

She later faced similar problems accessing publicly funded mental health services after she returned to live with her grandparents in a city in Southern Ontario, where the cognitive behavioural therapy programs that had been recommended to her were only available to those with the means to pay privately. Unable to afford private treatment, Io’s access to mental health care was limited to brief OHIP-funded medication management appointments.

Facing ongoing emotional struggles with limited access to care, Io told me how although she had managed to find some support for her distress in online communities, she strongly believed that this could not substitute for the professional care that was unavailable to her:

> There are people who will send me positive affirmations but… it’s not really going to do much for me in the long term. This is a serious disability that I’m dealing with and the best that this world can offer me is… some people saying some nice things to me. It’s not medical care and it’s not a long-term solution.

Describing a four-year struggle to get to the point where her mental health would allow her to access health care, Io explained how the lack of access to care compounded her emotional struggles, and represented a further barrier to any possible future attempts to access support:

> It's so contradictory in terms of… I've gotten to a point where I feel so hopeless about the future of care because of what I've received already, and that makes me feel even worse, and it makes me feel like these are the people that are meant to help me and I can't even be helped.

Even if gender diverse people are fortunate enough to live in an area of Ontario where some services might be available—such as the GTA, where there are a number of programs that specifically aim to serve the mental health care needs of queer and gender diverse communities—they may not be appropriate or helpful for everyone. In his experience as a young adult in the GTA, Mark described mental health services for the 2SLGBTQQIA+ community as being of limited usefulness to him due to issues such as the staff of the community health clinic where he received services being "burnt out [and] overworked," as well as poor moderation of support groups he attended. Mark's experience demonstrates the importance of having a range of supports available to address a wide variety of individual needs and situations. The mere existence of an organization or group does not guarantee that they have the capacity to provide meaningful health care to help everyone who needs it.

Some participants described how they had been unable to access transition-related care. In Bryce's case, he had not yet gotten access to hormone replacement therapy, and he expressed his frustration about not having been able to access puberty blocking therapy, because he was unaware of its existence until it was too late. He explained that he would have taken hormone blockers before puberty, but “there’s no point in me going on them now because I already have all this shit and the only thing it would do is stop my period.”

Bryce’s situation was a common one until fairly recently. While the medications used to suppress puberty have been available since the 1980s, their use as a treatment for adolescents experiencing gender dysphoria has only become more widespread in recent years (de Vries et al., 2011; Hembree, 2017, p. 3880). Even as recently as 2019, there were fewer than a dozen clinics specializing in providing gender-affirming medical care to children and youth in Canada (Pullen Sansfaçon et al., 2019, p. 372), which means that depending on their location and the level of support available from their parents or guardians, many trans youth would still have limited access to this type of intervention.[67] Access to puberty suppression has been shown to be strongly beneficial to the mental health and well-being of trans youth (Ashley, 2019c; Giovanardi et al., 2019) which highlights the importance of making this aspect of care more widely available.

Another instance of a lack of access to transition-related care was described by Mark, who explained that while living in Canada, his access to the testosterone he had been prescribed was frequently impacted by shortages for as much as six months at a time. He also noted that the price of testosterone continually increased each time it became available again: “Over the past 10 years that I took it in Canada, the price went from eight dollars to $15 to $38 to $84,” pointing out that although this was within reach for him, the constant price increases would be a financial barrier for many.[68] Mark was able to create a small stockpile for himself to ensure ongoing access, an option that would not be available to everyone given its increased price and status as a controlled substance. Other trans people who have had to go without access to hormone therapy due to shortages have reported experiencing heightened dysphoria, emotional distress, and even suicidality (Donato, 2020). Drug shortages—including testosterone shortages specifically (Toth, 2012)—have become a persistent problem for health care access in Canada as domestic production has been reduced and consolidation has taken place within the industry, leading to increased reliance on a few manufacturers outside the country (Basky, 2020; Donelle et al., 2018). Mark described how when he moved to a country in Western Europe, he was surprised and frustrated to discover that having limited options for hormone therapy was not a universal experience:

> I've been just getting this one type of testosterone, and that's the stuff that I got when I was 14 and I've just been trucking down the road because that's what Canada gives you, right? … I went to an endocrinologist in [the Western European city]… I'm like, "Yeah, can I have more?" He's like, "What type is it?... Is it synthetic? Is it natural? Do you want pills or—I mean we can do what you're doing now, which is every two weeks, or you can come into the doctor once every four months, and there's a different type of testosterone for that. Or, you know, sometimes it's like, there's an oil. Gives a little bit of a rash or allergic reaction, so we change that. Or you can do the patch or…" I was just, like, "… Can I—can I just have what I've always had?" He's like, "But what is it? Like, is it synthetic or natural?" … I'm like, "I don't fuckin' know. I've only had one option!"

The importance of access to this dimension of transition-related care was noted by several participants. For instance, both Ray and Miriam described how they felt that having access to hormone therapy had been beneficial for their mental health and well-being. Miriam explained that as soon as she started taking hormones, her mood improved substantially, describing it as having "lifted the 27 years of depression." Miriam cited scientific research that confirmed her experience by referencing a study showing that giving trans people access to hormone therapy "can eliminate or reduce [the effective dosage level of their psychiatric medication] by 50 percent… Anywhere from 50 percent to completely gone in the level of dosage." Although I was unable to locate the specific research to which Miriam had referred, many studies have confirmed that accessing hormone therapy is associated with improvements in mental health for transgender people, especially with respect to alleviating depression (Achille et al., 2020; Aldridge et al., 2020; Tucker et al., 2018; White Hughto & Reisner, 2015).

Failures of Cultural Competency and Cultural Safety

Cultural competency and cultural safety are two approaches to addressing the need to "provide culturally congruent care" in a context in which contact across cultures is increasing (Garneau & Pepin, 2015). Cultural competency is defined by Whaley and Davis (2007) as

> A set of problem-solving skills that includes (a) the ability to recognize and understand the dynamic interplay between the heritage and adaptation dimensions of culture in shaping human behavior; (b) the ability to use the knowledge acquired about an individual's heritage and adaptational challenges to maximize the effectiveness of assessment, diagnosis, and treatment; and (c) internalization… of this process of

> recognition, acquisition, and use of cultural dynamics so that it can be routinely applied to diverse groups.

Brannigan (2012) argues that while cultural competency does involve demonstrating an understanding of the cultural context of patients, engaging with patients in ways that take their perspectives into account, patients ultimately evaluate cultural competency on the basis of "health professionals' genuine, interpersonal, face-to-face encounter, that is, their presence with patients. Authentic rapport and caring on the part of physicians in particular play a major role [in patient satisfaction], the key to which is imbedded in communication and presence" (p. 59).

The cultural safety (kawa whakaruruhau) approach was developed by Maori nurse scholar Ramsden in Aotearoa, and was intended to improve care access and outcomes for Maori (Ramsden, 2000). Since then, the approach has been applied across many contexts, including in Canada (Anderson et al., 2003; Garneau & Pepin, 2015, p. 11). Drawing from the work of Wood and Schwass (1993), Anderson et al. (2003) point out that it might be easier to define cultural safety in relation to "culturally unsafe practices," which are those that "diminish, demean or disempower the cultural identity and well-being of an individual." In contrast, culturally safe practices "recognize and respect the cultural identity of others and take into consideration their needs and rights" (p. 198). Cultural safety necessitates that practitioners take a reflexive, partnership-based approach to their care interactions with clients. It also positions clients the ones who decide whether safety has been achieved (Garneau & Pepin, 2015, p. 11).

Garneau and Pepin (2015) explain that cultural competency has been criticized as upholding racist, essentialist views of culture in ways that obscure political, socioeconomic realities while also centring Western dominant cultural norms (p. 10). Responding to these problematic omissions by bringing the concept of cultural safety into conversation with cultural competency to create “constructivist definition” of cultural competency, defined as:

> A complex know-act grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care (p. 12).

Much more work must be done across the health care system to establish cultural competency/cultural safety for gender diverse clients (Burkey et al., 2021; Carlile, 2020; Kcomt, 2019; Lawlis et al., 2019), and particularly for gender diverse people who are also located at other intersections of marginalization, including racialized trans people, whose access to care is even more limited by the impacts of racism within health care (Lena, 2019). This is especially necessary in relation to mental health care, given the high prevalence of stressors that may contribute to distress among gender diverse people (Goldhammer et al., 2019) as well as the pervasiveness of provider misconceptions about gender diversity and mental health (Snelgrove et al., 2012). Even beyond the issue of staff knowledge and attitudes, many other aspects of the health care system are not designed to accommodate gender diversity (Snelgrove et al., 2012, pp. 7-9). Although as I will discuss, the health care experiences of participants in this project were by no means uniformly negative, it is the case that many participants came into contact with providers who did not demonstrate a capacity to understand and work with gender diverse clients in knowledgeable and respectful ways. Most participants reported having encounters with ignorant, misinformed or even antagonistic practitioners. This was stressful and often led to a reluctance to seek care, knowing that engaging with the system would mean that they might be subjected to harm or that they might be required to undertake arduous educational labour.

Educating Providers

There is often an expectation that trans and gender diverse clients should assist with the training and education of their health care providers when it comes to dealing with gender and transition issues (Rotondi et al., 2013, p. 1833; Rowe et al., 2017; Smith et al., 2018, p. 127; Snelgrove et al., 2012, pp. 5-6). This is a reflection of the fact that many clinicians have little or no formal education or training about gender diversity and the health care needs of gender diverse clients (Carlile, 2020; Snelgrove et al., 2012, p. 5). Although Sandy thought that a therapist she saw who was unaccustomed to working with gender diverse clients could have benefitted from her expertise and knowledge, being put in an educator position made her uncomfortable and contributed to her concerns around exploring gender identity in a mental health care context. Sandy ultimately stopped seeing the therapist after a few sessions, explaining, "[it] wasn't enough and also I was terrified of going through that."

Ray described a stressful experience where a nurse at the medical clinic where he had been prescribed hormone replacement therapy insisted that putting an injection in his thigh would be risky, telling him that she could only put the injection in his gluteal muscle. Ray explained that the doctor had told him that it would be safe to inject in the thigh muscle, then felt forced to disclose his trauma history to the nurse to convince her to check with the doctor about administering the injection. After Ray's doctor gave her confirmation, Ray finally received the injection in his thigh. On his next visit, his doctor decided to use the opportunity to teach both of the clinic nurses how to do an intramuscular injection in the thigh. To Ray, this indicated that despite their extensive work with trans clients, the nursing staff were still not adequately trained in some of the most basic procedures involved in transgender medical care.

Miriam discussed how she had negative encounters with a family doctor who was unprepared to work with trans clients. After having experienced thoughts about suicide which she thought may have been caused by a change in her hormone therapy regimen, Miriam's endocrinologist told her to see her family doctor for a check-up:

> She opens my file on the computer, and she sees the bloodwork, and the first words out of her mouth are, "How are your periods?" And I said, "I don't have periods." [She said,] "Why not?" And I just said, "I don't have a uterus." At which point she frantically scrolls through… And then she didn't want to deal with it and said, "Contact your endocrinologist. Here's the bloodwork."

Preparing for her next medical appointment, Miriam worked to get herself into a frame of mind that would allow her to cope, and subsequently had to follow up by educating the clinic director about how to create a safer environment for gender diverse clients. She shared how her activism was ultimately successful:

> When I went for my physical, the doctor was brutal. If I hadn't mentally prepared myself, I could have been a puddle on the floor. I was asked about last period, Pap test by the nurse. And prep stuff for the physical. And then was treated like a slab of meat when she was doing it, and her language—which sucked, and I recorded it. Insensitive, no bedside, like, you name it… So I filed a complaint on the online form at the [health centre]. I had

> an hour-long meeting with one of the directors and I explained what had happened and this director asked if I wanted a different GP, and I said, “I’m not sure. Let me think about it.” So I outlined other stuff that I noticed and things that were wrong. You know, issues around preferred name, all this stuff, and I made concrete suggestions on how to fix it. And then I said, “Yes, I’d like a new GP.” It wasn’t really much, it was just, “These are the things you need to look at.” And they have implemented some of them. And the new GP has been great.

Problematic Encounters

The lack of access to trans and gender diverse-aware medical practitioners resulted in participants having many problematic interactions with providers. Because many providers do not follow best practices in regard to the use of preferred names, pronouns and honorifics, misgendering has been a persistent problem in health care (Carlile, 2020; Freeman & Stewart, 2018; Knutson et al., 2019). Misgendering refers to “the misclassification of gender identity” and has a significant impact on the well-being of gender diverse people. The more frequently someone experiences misgendering, the more likely they are to have negative feelings about their gender identity and about themselves generally (McLemore, 2018, pp. 53–54). Deadnaming is considered universally unacceptable by members of gender diverse communities, but it remains a common occurrence when engaging with institutions or services where such information is kept on file (Knutson et al., 2019). Ray described how what should have been a straightforward trip to the pharmacy became a hurtful incident when his pharmacist repeatedly deadnamed and misgendered him:

> I went to the pharmacist, gave him the prescription and he goes, "Excuse me, Miss [my last name]" And I said, "I don't use that pronoun." And he just totally ignored me and just continued misgendering me and calling me "Miss" and just, like, [Ray's former name] and just totally ignoring the fact that it said [Ray] in brackets next to my name. Like, just completely ignoring it and I told him repeatedly, "I don't use—I use Mr. and not Miss," and he just kept saying, "Miss," like, just totally disrespectful.

Similarly, Bryce noted how surprised they were after their psychiatrist and their family doctor started to use their new name and pronouns without prompting after they were updated in their patient records, pointing out that misgendering, disrespect and dismissiveness were much more common in their experience: "I've only had two good experiences in 20 years. Like, every other one has called me the wrong name or told me that my mental health is fine, and that I just need to get better on my own."

Throughout our interview, Bryce mentioned several times that he had repeatedly been told by health care providers that he did not truly need access to care, despite his intense distress. His experience with misgendering reflects its connection with other microaggressions within health care. Freeman and Stewart (2018) argue that when physicians position themselves as epistemically privileged over patients, this often results in microaggressions, which cause epistemic harm (a moral injury to a patient as a knowing subject) and often also result in practical harm (a lack of access to needed care, whether because it is denied or because patients stop seeking access to avoid further harmful interactions). They point out that microaggressions are often rooted in provider-held biases including racism, sexism, classism, homophobia, ageism and ableism alongside transmisia (pp. 417–418).

Beyond misgendering, practitioners' lack of awareness and sensitivity around terminology pose further problems for trans clients. Problematic ways of referring to trans people within health care have included the use of outdated terms, the use of language implying that trans people's identities are not valid or real, and stigmatizing or pathologizing language characterizing trans people as "disordered" (Bouman et al., 2017). Ray explained how he would challenge health care providers who referred to testosterone as his "medicine." As he put it, "That's not medicine, there's nothing wrong with me." He did not perceive the testosterone he was taking as a medication, but as something enhancing a substance that was already endogenous to his body.

Francis discussed how they spent three months in a structurally non-inclusive and non-affirmative (Goldhammer et al., 2019; LeFrançois, 2013) inpatient eating disorder treatment program in a GTA hospital in the early 2000s. Demonstrating a lack of awareness of gender diversity, the program assumed without question that all patients were cisgender girls and women, which contributed to the difficulty of Francis' experience in the program. Strongly gendered messaging was the norm: During a cognitive-behavioural therapy session, Francis described their desire to have a flat chest as being misinterpreted by clinicians as a desire to be thin. Francis was counselled to replace their wish for a flat chest with the message, "You're a beautiful woman." As Francis explained, "It was, like, no, no, no, I literally just wanted a flat chest because I'm not a woman."

Francis described how the treatment they were subjected to required them to acknowledge an illness that they didn't really have, while their deeper feelings went entirely unrecognized. They explained that in order to complete the inpatient eating disorder program they had to internalize the narrative that "[they] had an eating disorder" and "[they] beat it". Francis noted how reading Foucault's critique of the medical institution during university led them to realize that they did not have an eating disorder, but had experienced unacknowledged body dysmorphia and gender dysphoria. They explained,

> I knew something was wrong and I knew I never had an eating disorder. But I basically had to confess it so—so much of mental health is about confessing. So, like, it always made me feel like a criminal, and I always relate to the criminals on, like, *Law and Order* who are being cornered in an interrogation room for, like, nine hours and they confess to something they never did. And, like, that's just me watching too much *Law and Order* or it's actually like I feel like I was forced to confess something I never did.

Francis also recognized that their relationship to criminal interrogation and imprisonment as a metaphor was informed by their white privilege, noting the distinction between the ways they were pathologized and the ways that criminalization is often brought to bear upon racialized people (Chan & Chunn, 2014, p. 47) whose behaviour—however innocent and benign—is perceived by white supremacist observers as problematic (Morris, 2016). They acknowledged that although their experience with involuntary hospitalization was unfair and painful, it was not the same as the situation facing people brought into the criminal justice system.

Rejection by Practitioners

Gender diverse people have often faced rejection as clients by health care practitioners, for reasons including bias, discomfort and a lack of familiarity or knowledge about gender diverse people and their medical needs (Bauer et al., 2013; Giblon & Bauer, 2017; Goldhammer et al., 2019, p. 320; Smith et al., 2018, p. 127). If rejected care seekers are unable to find alternative providers, the results can be devastating.[69] Referrals to other practitioners could be an appropriate course of action (for example, several participants reported having been comfortable with being referred to endocrinologists by family doctors who were not trained in managing hormone therapy), but participants also recounted situations in which practitioners offered an inappropriate referral or even no referral after refusing to provide care. Participants reported problematic encounters even with practitioners who they thought would have some familiarity with transgender patients. After realizing that they might not be comfortable with taking estrogen-based treatments for menstrual irregularity, Francis decided to ask their endocrinologist for information about hormonal transition, only to be dismissed when the practitioner described the possibility of prescribing testosterone as being "against [their] standard of ethics," and failed to provide Francis with any further information, referral or resources.

Rotondi et al. (2013) explain that Francis' experience was likely not unusual:

> Although Canadian protocols exist for the provision of hormonal care by family doctors and specialists, physicians in Ontario are unlikely to be aware of the existence of these protocols. This may contribute to a perception that hormonal treatment of trans individuals is extremely complex, requiring specialist training and beyond the scope of their practice. In fact, virtually no physicians have received training in the administration and monitoring of transition-related hormonal regimens, even in specialties such as endocrinology, where it falls clearly within their purview (p. 1833).

For a long time, Sandy had trouble feeling comfortable working with therapists due to feeling overwhelmed by discussing her experiences and difficulties, which made her reluctant to ask for

assistance. During university, she finally felt ready to discuss her feelings about her gender identity, so she reached out to an LGBT support service, believing that the staff would have the capacity to assist her. However, Sandy had a "horrible" experience because the counsellor she saw did not listen to her, made inaccurate assumptions about her gender and sexuality, then immediately referred her to another provider based on those assumptions. This made Sandy feel like she was "pawned off to someone else," which led to feelings of self-doubt and rejection.
In Alesha's case, several practitioners agreed to take them on as a client, but each claimed a lack of familiarity and made it clear that gender issues would not be the primary focus of their work together. When they sought treatment at her GTA university's counselling service, the counsellor's refusal to address gender issues rendered the proposed treatment essentially useless for them. Alesha described the service as being geared towards "cis het[70] white dudes… [which is] in itself very exclusionary," causing them to stop attempting to access care through the counselling service.

Io described how their psychiatrist's efforts to engage with her around gender and sexuality were misguided and counterproductive, but they felt unable to challenge them for fear of being rejected as a client. Due to having such limited access to mental health care, Io did not feel comfortable mentioning to their psychiatrist that they had been misgendering them and making erroneous assumptions about their sexual orientation. Similarly, they worried that if they brought up their complex experiences with gender identity, dysphoria and distress with the psychiatrist, they might be left with no support at all:

> I can’t afford to—like, it took me so long to even get this person. I don’t know if I would even be able, mentally, to find a new psychiatrist. He’s what I got right now. I’m thankful that I have him just because it’s something. So I don’t want to risk him being like, “I think you need specialized care, I don’t know if I’m in a position to help you.”… So it’s difficult because on one hand, him not knowing is affecting my care, [and] in a perfect world he would be able to use that information to help me more effectively. But the way it is now, him not knowing that information is kind of in a way keeping me safe and it’s not risking this fragile thing that I have.

Avoiding Care

Knowing that knowledgeable providers are not available and the kinds of difficult encounters described above are likely, gender diverse people sometimes avoid seeking health care (Bauer et al., 2013; Cruz, 2014; Ding et al., 2020; Giblon & Bauer, 2017), which leads to negative outcomes. Miriam described how despite recognizing that she needed to raise the issue of gender with her therapist, she felt unsafe to do so while living in a relatively conservative town in Eastern Ontario in the mid-2000s. Despite the fact that Miriam’s family doctor referred her to a social worker in addition to prescribing medication, Miriam did not feel safe to discuss gender issues with this social worker, especially in an unwelcoming community. This meant that she had to continue without support, delaying her access to transition and ensuring that one of the factors contributing to her feelings of depression would persist unaddressed. Ultimately Miriam ended up moving because the environment “just was not healthy.”

Unavailability of Non-Transition Focused Mental Health Care for Trans People

Participants mentioned their frustration with the way that mental health services for trans people have seemed to focus quite narrowly on the transition process itself. Alesha described how as a young adult, they were unable to find support while they were discovering and exploring their gender identity, which left them to figure things out on their own:

> At the time, what I really needed was someone who I could sit down and talk with and explore ideas about gender, and that was very specific. And in practice, that just ended up happening all on my own… There was a lot of, like, sitting and processing and sorting through feelings and just the time it takes with, like, breaking down internalized transphobia. And, yeah, reading and talking with supportive friends. And I think coming to the conclusion fairly early on that I wanted to physically transition helped because that gave me a more concrete thing to focus on and progress through that helped ground the thought. But, yeah, basically, the short of it is, for that phase of my transition when I needed mental health support to explore, it just didn't happen.

Francis argued that mental health services for gender diverse people need to go beyond addressing transition. They explained that they would not automatically trust even a supposedly knowledgeable therapist or counsellor to understand their interest in therapy as someone who would not be seeking access to transition services. Francis described therapy as being a "goal oriented" process that was not helpful in their situation because they only wanted "to talk about stuff… Like, I'm not gearing up for surgery, at least in this point in time."

Mark contrasted his experience with the knowledgeable therapist who took a holistic approach in helping him to address the trauma he had experienced due to queerphobia and transphobia with typical transition-focused mental health care services:

> I think what's different is, is when I think about my time with [my therapist] versus, you know, like, you go to a therapist and you say you're trans, they want to refer you to someone who can help you with your transition, right? But, once that's been taken care of, the community is oddly silent in how to help you. That, that no one can really put together… [apart from my therapist], no one has been able to link any of these residual issues of ongoing depression and self-hate and all these types of things in a meaningful way back to, you know, the history plus, plus this queer identity plus all these other things, right? No one's actually been able to look at it that way.

Participant Perspectives on the Importance of Cultural Competency/Safety

A practitioners' lack of familiarity with gender diversity does not always preclude the development of a positive relationship (Sallans, 2016). For instance, Bryce's previous counsellor was initially unfamiliar with trans clients, but they ended up seeing her for four years and found her supportive. At the same time, Bryce recognized the importance of cultural competency in enabling gender diverse people to access medical care, explaining how interactions with professionals who misunderstood and minimized their experiences had negatively impacted them:

> All of these professionals, all of these doctors and counsellors and everything, they need to be educated on people that are queer, people that are trans… You can't help people if you don't know anything about it… And, like, I've had psychiatrists and psychologists that, like, literally have no clue what they're doing. They just tell me that they think I'm fine and [should] go for a walk.

Mark thought that improved standards for education for people working in the mental health care field might help address issues like the ones he had encountered, suggesting that many practitioners' understandings of the practice of trans health care were as outdated and irrelevant to current needs as the long-since discredited and discontinued historical medical treatment of bloodletting:

> It requires a higher standard across the board, and maybe, and particularly these incredibly vulnerable rural areas, right? Because you have all those other pressures outside, and you don't have those communities to pick up some of the slack. The professionals should really be doing it. You, you wouldn't let a doctor, you know, because he learned bloodletting in the 1800s still practice it today because he learned it back then, right? And I'm sure there's training and seminars and coaching and stuff like this, but that, that's what I think about. Like, what if I'd been in a smaller town?

Alesha argued that health care should be designed and led by trans people. Recognizing the limitations of her own perspective as a white binary trans woman, she explained why it is particularly important for trans people who are outside the gender binary and who are not beneficiaries of white privilege to be in decision making roles:

> To walk into a health care institution and expect to not be actively harmed by it would be nice. It would be really nice. So it would be nice if it wasn't transphobic… But can we, can we get some trans folks up in here designing this shit? At least consult with some, preferably some that aren't privileged, privileged white ones of the binary variety.

When health care is led and/or delivered by 2SLGBTQQIA+ and gender diverse community members, it is often more accessible and welcoming (Boudjikanian, 2019; Ding et al., 2020). It is impossible to overstate the importance of the representation of members of marginalized communities among care providers and within positions of leadership within health care. The impacts of structural oppression persist throughout health care, but the presence of marginalized people within the system helps to mitigate these enduring problems. For example, in the United States, Black infant mortality rates are significantly higher than average. This is partially due to the health impacts of systemic racism—often referred to as "weathering" (Simons, 2018), but discrimination within the health care system also plays a significant role. For instance, in a study looking at birth outcomes in Florida hospitals between 1992 and 2015, Greenwood et al. (2020) found that Black newborns were more likely to survive if they received care from Black doctors.

Funding of Services

Some of the issues limiting access to publicly funded mental health care even for people with OHIP coverage were raised in the previous section, and that discussion will continue throughout this chapter, but another significant factor affecting access to care for many participants concerned the inaccessibility of services not covered by public health insurance. OHIP will cover psychotherapy if it is provided by a family doctor, psychologist, psychotherapist or social worker at a hospital or as part of a family health team or community mental health service (Bieman, 2019). Outside of those contexts, some family doctors and psychiatrists offer OHIP-covered psychotherapy (Cohen & Peachey, 2014), but waiting lists are often very long (Bieman, 2019) or closed (Strauss, 2019). (And it may be the case that people who would be uncomfortable working with a practitioner whose training is likely to be primarily based in the biomedical model of mental health would be unlikely to pursue this option.) While some people have access to private insurance provided by an employer, due to discrimination this is less likely for gender diverse people (Bauer et al., 2011). Even for those who do have private insurance coverage that might provide some benefits relating to mental health services, psychotherapy itself is often not covered, and many plans provide only minimal coverage for psychology services (Cohen & Peachey, 2014). Although some private psychologists, psychotherapists and counsellors offer sliding scale rates, these can also be out of reach for many. As Miriam put it, “$90 an hour low-end sliding scale. Enough said.”

Financial Barriers to Transition-Related Services and Procedures

Another issue that participants raised repeatedly in this project is that besides the kinds of services typically identified as being directly related to mental health, there are also many limitations as to what kinds of transition/gender confirmation-related services and procedures are covered by public insurance. Although not all trans and gender diverse people choose to access gender confirming services and procedures, their availability is important for the mental health and well-being of those who wish to access them (Owen-Smith et al., 2019; Tucker et al., 2018), a fact further confirmed by many of the participants in this research. Although in response to intense activist efforts (Rotondi et al., 2013, p. 1835) gender confirmation procedures were reinstated for OHIP coverage in 2008 (Ross et al., 2016), it has remained the case that only a limited range of procedures are covered, leaving people to pay privately if they require anything that is not listed. A few examples of common non-insured procedures include chest contouring, hair removal, tracheal shave, vocal surgery and facial surgery (Trans Health Expansion Partnership, n.d.). It is also important to note that some of the participants in this research considered or underwent gender confirming procedures prior to the reinstatement of funding, and many have considered or accessed procedures that have never been covered by OHIP. As is the case with funding non-OHIP mental health care, due to persistent discrimination in the labour market, gender diverse people are both less likely than average to be able to afford to pay for care out of pocket and less likely to have access to employer-based insurance coverage that might help defray transition-related expenses, but although some insurance companies now offer products including gender confirmation coverage beyond hormone replacement, most employers still do not include this in their employee benefit packages (Rolfe, 2019; Williamson-Hopp, 2020).

Limitations of Publicly Funded Gender Confirming Procedure Options

Even for the transition-related procedures that are covered by public insurance, few options are available, which means that people cannot choose the kind of procedures that would work best for their body and that they might have to settle for less than optimal outcomes because the cost of paying privately for a more appropriate procedure is out of reach. Alesha explained how this impacted their sexuality and relationships:

> Specifically the fact that it's only this one surgeon is really frustrating because, like, there are just hands down better surgeries out there. Like, there are methods where vaginal depth is not impacted by the configuration of your genitals and, like, being able to get wet while sexually aroused is guaranteed as opposed to just a happy accident, and hell yeah I want that, I fucking love fluid play. But now that is just not an option to me because I don't have enough class privilege for that, so it's just kind of like, okay, well, I'm going to go in there and—and hope that my girlfriends can still enjoy how wet I get, which is really sad, oh my God.

Mark pointed out that publicly funded gender confirming surgeries tended to be less advanced and of lower quality than those designed to "correct" the gendered characteristics of the bodies of cisgender people: "The fact that gynecomastia patients can have better surgeries than, than what trans people have and stuff like that is just ridiculous, right?" As Garner (2017) notes, cisgender men gynecomastia patients also have the privilege of being regarded as having "natural" and legitimate concerns about their excess breast tissue, while transmasculine people's desire to undertake the same procedure is positioned as evidence of a mental disorder, necessitating a gatekeeping response (pp. 285, 289). Bryce and Reuben reported that they had the impression that publicly funded top surgery results were not generally very good. With help from an inheritance from his grandparents, Reuben decided to go to a private surgeon instead of accepting a referral to CAMH to seek approval for OHIP-covered top surgery:

> I hate it, but I will pay out of pocket because I'm going to live with this for the rest of my life. I'd like it to look a little better than it does now! So I'm not going through the hassle and the debacle of CAMH again to be just as unhappy later.

The Non-Universality of Canadian Health Care

Although Canada has "universal" health care, coverage is not extended to everyone, and accessibility issues are even more substantial for those who lack access to government-funded health insurance. All participants in this project had access to provincial insurance, except Nina. As an undocumented immigrant, Nina was not covered by OHIP so she lacked access to most kinds of medical care, including ongoing/preventative care, most types of mental health care, as well as transition-related care. By the time of our interview, Nina had made her refugee claim, but because this happened after refugee claimants were categorized by the Conservative federal government as ineligible for the full benefits of the Interim Federal Health Program (IFHP) (a decision that was only reversed in April of 2016) (Chen et al., 2018) she still had no health insurance and generally avoided seeking medical care unless it was absolutely necessary. She explained that she once received care at a hospital emergency department after she broke her finger in a bicycle accident, but later received a bill for $800 which she was unable to pay. Nina was able to use her knowledge of social services to reach out to an agency that works with homeless women and they were able to provide assistance with the bill, but it is unclear how this situation would have been resolved if she was not able to access this resource.

Lack of Access to OHIP Means Lack of Access to Care

As I have mentioned, Nina was the only participant in this research who did not have access to OHIP or federal health insurance. She expressed a wish to attend an inpatient substance abuse treatment program at CAMH, but explained that she could not because she did not have insurance coverage. Nina told me that her court mental health worker had said that it would help to clear the charge she was facing, but she also thought it would allow her to regain control of her life: “I’m doing this, like, for myself. Because it’s—it’s that thing that really, like, made me lose everything.”

Because Nina was both uninsured and was living with very little income, like many gender diverse people who find themselves without access to medically supervised hormone therapy (Rotondi et al., 2013), she sourced her hormone blockers and replacement treatment from fellow trans community members. She was aware of the potential risks of self-managing her hormone therapy without access to medical assistance and made decisions to try to mitigate them. She worried, “I might get heart attack, or just not woke up anymore,” and chose to stop taking hormones and just take blockers going forward.

Funding Private Services

As I discussed in the previous section, publicly funded mental health care in Ontario is often unavailable, and can be especially inaccessible for trans and gender diverse people. In addition, the kinds of transition-related procedures and services that are vital for some people’s well-being are also unavailable except to those who can pay privately. Participants described situations where paying for services or procedures represented a hardship or meant that they could not access them at all. Miriam explained that to get access to hormone replacement therapy, she had to pay a total of $1500 out of pocket for biweekly therapy sessions. She said, “That was the only way to get what I needed,” and took on the expense despite being unable to afford it. Miriam’s marriage ended when she came out as a trans woman, and she describes what happened how having to pay for so many therapy sessions made her already precarious financial and emotional situation even worse:

> I… got a referral to a psychologist in [an Eastern Ontario city], and they had a sliding scale, but their idea of low-end on a sliding scale is 90 dollars an hour… There was only one gender therapist in [the city] at the time. So, you’re kind of screwed if you want to get any sort of referrals. And I had this person pegged in the first appointment and I knew that odds were good I wouldn’t be able to work with them on stuff… So I had to see them for a number of things before I could even get a referral for hormones, and then I get told, “Oh, you have to show up in female clothing.” So then I concede even though these appointments are in the middle of the day, and I was doing IT work as an independent contractor. I wasn’t doing well because I couldn’t function, and I had a company shirt and dress code. And then I hit a nadir in the summer of 2009… I ran out of—I didn’t have money. I made 300 dollars in July 2009, total. And I had bills, a car, my phone was cut off because I couldn’t pay the phone because I was paying the psychologist. I run out of the antidepressant, can’t buy new ones…

Later on, the same therapist insensitively suggested that Miriam should fund her own gender confirming surgery instead of seeking OHIP-funded care, demonstrating her failure to comprehend Miriam's financial situation. Miriam explained, "I really felt like telling her to fuck off."

Alesha described the stress of having to prepare financially to potentially pay out of pocket for expensive medical care even while on a limited graduate student budget if her request to have surgery was blocked by the CAMH gatekeepers, explaining, "The incessant waiting and knowing how arbitrary the system is…" and her fear that, "you could just be dropped…" had a negative impact on her well-being. In order to save the $20,000 to $30,000 needed to pay privately for her transition Alesha was forced to set a minimal budget to live on: "It forces your life into this hypervigilance and it very much feels like it's kind of on hold in a lot of ways."

Participants also discussed being unable to access services because they could not afford to pay. Several participants mentioned that because there was no room in their budgets to save up for the procedures they needed, they knew they would not be able to access them unless health care policy were to change. Io described how along with most transition-related care, the gender confirming procedures she wanted were not covered by OHIP, making the "entire transition process super inaccessible" for her.

Miriam explained that she was interested in pursuing additional exploration of her psychological makeup to improve her self-understanding and help her mental health but she knew that she would have difficulty accessing the resources needed to pursue this, saying, "But trying to access that without money? No, they'd much rather have you attempt suicide and have to spend a fortune putting you in a hospital." Although Hermione had been able to access helpful services as a teenager and a young adult, they reported that significant gaps remained, especially with respect to services for trans victims/survivors of sex trafficking and for autistic adults (Lunsky, 2009). They explained why they had not accessed services to address these aspects of their life:

> I need somewhere to process what it means to be, like, sexually assaulted and exploited and used and abused in horrible, horrible ways. Specifically, preferably by someone who, like, gets trans things.

> There aren't services for adults with autism that are, like, covered by anyone. And since I got an adult diagnosis, I've not been… I don't have access to any services related to autism, beyond informal support groups. One of the things I wished for would be, like, being able to develop the skills to pretend to be normal. Because I'm tired of the harassment.

Some participants described having help from parents and insurance to access procedures and services that were not covered by OHIP and that they could not afford otherwise. Alexandra described how prior to the reinstatement of OHIP funding for certain gender confirmation procedures, the gatekeeping was just as intense but there was no path forward for those who did receive approval but who could not afford to pay. She commented on the impacts of this unfair system on her mental health: "The system is, like, awful. It's just abysmal… Part of why I was so depressed in this period of my life was the amount of horseshit that they made me go through." She had chosen to have a gender confirming procedure that had never been covered by the province, so the reinstatement of OHIP funding did not help her. She made it clear that she would not have been able to afford the surgery if her parents had been unwilling or unable to assist her financially: “I would have had to, like, somehow finagle $2000 together. For me, going to college, never having had a real job, you know…”

Io was able to get their medications as a student on their grandparents’ insurance plan despite not technically being enrolled at the time, but had concerns about what they would do when their access to their grandparents insurance ended: “I feel like I’ll probably just be forced to stop taking medication because I won’t have any other alternatives.”

In contrast to most participants, Quinn had a unionized job that afforded them access to private insurance with a reasonable amount of coverage for mental health services. This enabled them to access four sessions of therapy, which Quinn estimated would have cost about $1000. If Quinn did not have coverage, financial constraints would have forced them to reduce the number of sessions.

Bureaucracy

Participants discussed how bureaucratic difficulties played a large role in complicating or limiting their access to the supports they sought. One of the most significant barriers to access resulted from the long waiting list for assessment at CAMH, as well as serious organizational and scheduling problems that several participants reported in relation to CAMH’s Gender Identity Clinic. As I have noted, the requirement that all people seeking access to hormone replacement therapy and/or OHIP-funded gender confirming surgical procedures be evaluated by the Gender Identity Disorder Service/Child Youth and Family Gender Identity Clinic (for children) or the Gender Identity Clinic (for adults) was in the process of being eliminated when these interviews were undertaken, but as participants astutely forecasted, the waiting lists and bottlenecks would not be entirely eliminated even after the CAMH monopoly ended (Donato, 2020).

Alesha described the immediate barriers they faced when they first realized they might be trans, prior to the decentralization of transition-related health care:

> I run over to CAMH and be, like, "So, hey, can I get an appointment to talk about whether or not I'm trans?" They're like, "That's not really a thing. We'll see you in, like, a bajillion and a half years." And I'm like, "Okay, I'll go somewhere else." And I tried to find somewhere else, but I couldn't. And then, basically by the time that I got to someone who would even talk about it, I was, I'd already made up my mind, so it was just, like, "Fuck it. Just give me hormones."

Alesha explained how as soon as she had made the decision to transition, she submitted her information and got on the waiting list at CAMH, knowing that the process would take a long time. She described how she felt when she learned that they had lost her information and she thought that all the time she had spent waiting might have been wasted. She resisted the unfair system, undertaking self-advocacy and enlisting assistance from community resources:

> And then a few months ago… I contacted them to make sure they had all the right information and they're like, "Yeah, so you're not on our database." [I replied] "Well, the—the fax went in and I got a package. I sent the package back." Their awful, awful package. And then they're like, "Oh, did you keep a copy of your package?" I'm like,

> "I'm not keeping your transphobic shit in my life!" When that conversation was happening on the phone, like, at that point I was starting to cry and the guy on the line was like, "Oh, I'm sorry. It's always so hard to give people bad news." Yeah, okay, I'm going to spend the rest of the afternoon crying, but let's talk about how it's upsetting for you to give people bad news that is fucking over their lives. It's so hard, you're right. Let's take a moment for your feelings. Bye. And then just go cry. It was like, literally one of the most painful experiences of my life. It was a very real possibility that I would be back at the end of the wait list.
>
> [After that] we chased around, I consulted with people, but I got advice from the [staff at a 2SLGBTQQIA+-focused clinic]. We contacted them, we pled our case, we kept asking, and eventually I got put in my rightful spot. [It was] some sort of clerical error somewhere along the lines. The only guess I would have is I maybe didn't send the package fast enough, but, also I feel like if you got the package and it was outside of the catchment time because whatever happened, you'd just be like, "Okay, so we got your package and we can't accept it because bullshit reasons. Can you do it again?" So that theory is the best one that I have, but it's—even if that is true, it just reeks of compassionless negligence.

Beyond the CAMH clinic, participants experienced bureaucratic problems elsewhere in the mental health care system and with other institutions with which they interacted. Io experienced several instances where administrative errors hindered their access to services. They explained how they felt that they could not rely on having continued access to the anxiety medication they used after they missed an appointment due to a scheduling mix-up and a receptionist berated Io for “insulting” them and “wasting [their] time,” then threatened them with being dismissed as a patient if they missed any further appointments.

Eliminating the Trans Health Care Bottleneck in Ontario

Several participants argued that access to the kinds of services needed to promote their well-being and the well-being of gender diverse people across Ontario would be vastly improved if the CAMH bottleneck were eliminated. A few months prior to the announcement that alternatives to CAMH would soon be permitted, Reuben asked, “Can we fund more places than CAMH please? … Can we train regular therapists to at least talk about this, or something or whatever? Come on!”

Mark was equally emphatic:

> Shut it down. Shut it down. That relationship is between me and my doctor, and the doctor should be trained … to make that recommendation. I mean, they should be ashamed of the history of that place, and it needs to go away, you know, for a lot of reasons. I doubt that the work that [clinicians are] putting out is of any value. It’s probably not good science, you know? I don’t even know if it’s adding intelligently to the debate that the community’s having anymore… So, I mean, yeah, it’s self-evident. The model’s broken from a lot of different perspectives, and financially it doesn’t make sense for anybody. … You wouldn’t save a lot of money from closing down that department,

> but you’d distribute the load, which would reduce your wait times and that would reduce hospital admissions due to mental health, right?

Similarly, Miriam identified the requirement that people from across Ontario and other provinces receive approval for gender confirming care from CAMH, and that there was only one site for performing genital surgery as a major barrier and recommended changes to improve access:

> [We need] accessible mental and physical health care. Both financially and, you know, more assessment centres in Ontario. Actually have a surgery clinic in Ontario. They’ve got one for all of Canada.

Until 2019, the only publicly funded lower surgery provider in Canada was located in Montreal. As of 2020, there is a provider in Toronto (Bresge, 2019) and another in Vancouver (Vancouver Coastal Health, 2020), but demand for these procedures still outstrips availability, resulting in ongoing long wait times (Gibson, 2017), which have been further lengthened by the COVID-19 pandemic (Donato, 2020; Women’s College Hospital, 2020).

A short while prior to the implementation of the reforms that would end the CAMH monopoly, Io described how she remained apprehensive about whether the changes would have a significant impact in the short term, saying “It’s very, very shaky. There’s no certainty about it and there’s no timeline about it. There’s no reality to it whatsoever yet, like, not at all, which scares me.” She noted that the process of opening additional sites for service would not be simple, and pointed out the dangers posed by the ongoing reality of long waiting lists and restrictive criteria, citing results from a study that showed significant reductions in suicidal thoughts after transition:

> Recognizing the fact of people wanting to live authentically and not have dysphoria and stuff is 100 percent valid, but also making us wait is literally killing us. Like, as a health care problem, if I have access to easy transition I have a better chance and, statistically, a more likely chance of survival.[71]

One of the many problems with having only one site with the power to grant access to transition-related services was that people feared that if they questioned or critiqued that service, their access to care might be cut off entirely. Alesha discussed how potentially being unable to access care curtailed their ability to critique the problems with the services provided at CAMH, noting that they perceived them as especially resistant to feedback in comparison with other health care institutions/services:

> I would say the structural aspects of CAMH have definitely had a negative impact. Even aside from just, like, the way the entire system works, just like the way it was run in the past, my early interactions with them were very negative. And, like, how it's just such an untouchable institution. Like, that it is super negative, and I can literally say nothing about that. I have to bite my tongue and smile, because if I said something negative, well, I'm not getting access to care, which is like one of the biggest predictors of suicide in trans women.

Medicalization of Distress

According to Mulder (2008), the “medicalization of distress” refers to the way that negative feelings (sadness, tiredness, anger, anxiety) have been increasingly viewed as rooted in individual pathology, even when there is no evidence that this is generally the case. He argues that the notion that emotional difficulties are medical problems has been supported by ever more expansive DSM diagnostic criteria as well as the interest of the medical and pharmaceutical establishment in creating a broader base of potential patients/clients (pp. 241–243). When distress is treated as a medical issue, it is often the case that the problems in people’s lives that could be causing or contributing to their emotional difficulties are not addressed.

As Shapira and Granek (2019) explain in their discussion of how discourses of cisgenderism and ableism impact trans autistic people, many dimensions of life are subject to medicalization:

> The medical-psychiatric pathologization of gender variance happens in the context of the enormous significance of medical-psychiatric paradigms in modernity. A wide range of human behaviors and conditions are medicalized, individualized and decontextualized within the all-encompassing authority of the medical discourse (p. 497).

In the context of a discussion centred around trans and gender diverse health care, it is crucially important to mention that there is a significant difference between the kinds of unhelpful or unwanted medicalization and pathologization that gender diverse people often encounter, and the valid desire to access beneficial treatments or interventions that are only available through the medical system. In his digital story, Ray makes this contrast clear. He questions his relationship to the many psychiatric diagnoses that had been applied to him. To do this, he gives creative purpose to his prescription medication bottles. Instead of holding drugs, he shows them as being full of tangled, yellow yarn. As he narrates the process of engaging with his identity beyond the labels, the balled-up pieces of yarn emerge from the now empty row of bottles.

Figure 30: Strands of yellow yarn lie in front of pill bottles

The pieces are smoothed and laid side by side as Ray describes how embracing his gender identity and accessing the gender confirming care he desired improved his life. He concludes, "I'm here, and I'm actually starting to feel somewhat okay. Sometimes things just need to unravel" (Figure 30).

As part of the current backlash to advancements in trans rights, some writers and researchers who oppose medical transition have begun to argue that seeking access to gender confirming medical care represents an attempt to avoid emotional distress. For instance, in a 2020 article, a UK-based psychologist claims that people who transition are trying to escape into an ultimately futile fantasy that falsely promises that undergoing bodily changes can substitute for directly addressing the kinds of psychosexual trauma that he presumes to be the cause of transgender people's identification with a gender other than that to which they were assigned at birth. He argues that rather than being supported to access gender confirming treatment, trans people should undergo psychotherapy with the objective of resolving said trauma. This would enable them to align themselves with their gender assigned at birth (albeit in potentially "creative" ways, so long as these do not involve bodily change), allowing them to avoid becoming what he characterizes as "sterile, drug-dependent, life-long medical patients" (Withers, 2020). Of course, it is not the case that all transition-related procedures reduce or eliminate fertility, and it is possible to mitigate many such effects. Further, the psychologist assumes unfairly that it is inherently undesirable to choose to undergo a potentially fertility-reducing procedure. Similarly, his assertion that taking medication and engaging with medical care on a long-term basis is something that people should avoid appears to be rooted in cisnormative, ableist and healthist assumptions that ostensibly "natural" bodies always function well, and that it is preferable to live in one's "natural" body even if it is painful and damaging to do so. He also claims that his proposed course of action does not represent conversion therapy, and offers no explanation as to why the many cisgender people who have also suffered psychosexual trauma are uninterested in pursuing transition.

As I explained in my earlier discussion of feminist new materialism, the notion that gender diverse people should be able to deconstruct themselves out of any negative feelings they have toward their embodiment, extricating themselves from the web of meaning surrounding gender elides the fact that the overwhelming dominance of the binary system of gender persists, and that it has ideational and material effects that cannot be wished away by individuals. If work is to be done to expand the gender system and resignify the meaning of bodily characteristics currently considered as gendered, it is profoundly unfair to make this primarily the responsibility of those who are already most heavily burdened by the rules and expectations of the system. Because it is counterfactual, it is not possible to know what would happen if the gender binary were eliminated, but I am not convinced that people would no longer wish to change their bodies—or, indeed, that pursuing physical changes through surgical means is inherently politically problematic (Morgan, 1991). I have previously explained why I will not engage in a consideration of why people are trans, but I will assert that the belief that trans people who choose to undergo gender confirming procedures are being duped is based in invalid cisnormative assumptions that gender diverse people cannot validly know themselves and are therefore undeserving of—or even incapable of—autonomy and choice, as I will explain further in my discussion of informed consent and medical ethics later in this chapter.

Medicalization of Difficult Circumstances

To return to my discussion of the medicalization of distress, Miriam's story shows how stressful circumstances can cause emotional difficulties. She explained that she was denied access to provincial student loans after marrying someone who had a full-time job, so she had to stop pursuing her goal of earning her bachelor's degree and return to her IT job, where business was slow. At the same time, she was also dealing with the impacts of suppressing her gender identity. She asked her doctor for a referral to an OHIP-covered psychiatrist, explaining that she could not afford to pay privately. Miriam eventually had one appointment with the psychiatrist: "In the one meeting it was like, ‘Oh, you have depression,’ like a very surface… And I knew there was more that I needed to work on.” She was given no further support and her concerns about gender identity were left unaddressed.

Medicalization of Abuse and Trauma

Several participants reported having experienced abuse and violence, especially as children. The negative impacts of adverse childhood experiences on physical and mental health and well-being have been thoroughly documented. In the cases of Ray and Bryce, the mental health care system did not address the abuse they had suffered in childhood, leaving them vulnerable to pathologization. For Ray, mental health care was operationalized by his parents as a means to obfuscate their mistreatment of him. He explained that after he began to “act out” at school, his mother required him to see a school counsellor to address what was labelled as his “problematic behaviour.” Although Ray attended these sessions for an extended period of time, the fact that he had been facing abuse by his parents went unaddressed throughout:

> I saw that person for four years, and it was really interesting because it was supposed to be behavioural mental health support, but we never—and, like, this counsellor knew that I’d been, like, hit by my father and stuff like that—I didn’t even really realize, like, what my mom had done, in terms of the physical abuse that my mom had done when I was a child and I think that part of that was, like, survival tactics… Um, it was interesting because the entire time that I saw this person, there was only one session where we talked about my dad the entire four years… Why I started seeing her was my behaviour was so

> problematic, quote-unquote, “at school.” Like, so I was already being pathologized from a very young age.

As I mentioned in the previous chapter, and as I will discuss in further detail later, Ray was diagnosed with multiple DSM labels following an incident in which his brother tried to choke him and he physically resisted. He described how although he was an adult in his 20s, the psychiatrist spoke to him in an infantilizing way, as though he were disciplining an “unruly” child:

> Then I was diagnosed by this guy at CAMH with—and they were going based on the fact that I’d had multiple depressions and they labelled me hitting my brother as a “manic episode”—I was diagnosed with bipolar disorder, borderline personality disorder, and post-traumatic stress disorder based on the previous abuse from when I had grown up. I was told [by the psychiatrist], “If you behave yourself, you won’t have to come back here and see me, but if you don’t behave yourself, we’re going to have to think about what to do.”

Whereas Ray came to perceive these encounters as evidence that he was being unfairly pathologized as a means of dismissing the abuse he faced, Bryce had internalized the notion that the difficulties he faced were rooted in his faulty brain chemistry rather than relating to the trauma he had survived. His mother experienced her own struggles with mental health, and his father left the family. Bryce experienced bullying (including being repeatedly beaten and chased by boys from his neighbourhood) and abuse, and had witnessed several violent and traumatic events from a young age. He also experienced significant housing instability. He started to see a counsellor when he was in Grade 3, and starting at age 9 he had been prescribed an array of psychiatric medications. When he was 11, Bryce witnessed his older sister's suicide attempt. At 13, he began to engage in self-harm, and then began to make attempts to end his life. He was labelled as having borderline personality disorder (BPD). He accepted the diagnosis, saying that it reflected his experiences:

> You probably know what borderline personality disorder is, and, yes, this controls my life. And the impulsiveness and dissociating is fucking horrible. I have attempted to kill myself more times than I have the years I've been alive.

Bryce described how they came to understand their diagnosis when a psychiatry resident explained it to them some time after they had been given the label:

> Up until a little while ago, nobody actually explained BPD to me. I think like a year and a half, two years ago someone just told me… [the psychiatry resident] was just like, "Okay, I think you, like what you're describing, I think you have BPD."… It was like, "Okay. Now what do I do with this?" And it's like, "Okay, well, you can't do anything about BPD. You just have to get used to it and, like, learn how to deal with it." I've had so many doctors tell me that I just have to learn how to cope with it on my own. … He explains everything. He explains that it's really normal for people with BPD not to be able to have a stable relationship, having really difficult times keeping relationships, and it's like, what the fuck? Why did I—I thought it was me. This whole time I thought it was

> me. And this whole time it's been this imbalance in my brain. And like I was so happy when he told me that, and it's like because it's like, like a lift off my shoulders that it's not me that's doing this stuff. Like, I'm not purposely trying to fuck shit up. It's like I don't want to push people away… Literally, it's literally like that's how my brain is.

Goldhammer et al. (2019) argue that practitioners often misdiagnose trans community members as having BPD because they wrongly perceive gender diversity as evidence of the "instability" or "identity diffusion" that characterizes the BPD diagnosis (p. 320) and may also misinterpret gender diverse people's emotional difficulties as rooted in individual pathology rather than as symptoms of minority stress that arise in response to persistent discrimination, abuse and stigma (pp. 319–320). In their analysis showing that even when controlling for clinical presentation, lesbian, gay and bisexual people were more likely than straight people to be diagnosed as having BPD, Rodriguez-Seijas et al. (2020) note that clinicians may also misinterpret behaviour considered "culturally normative" within 2SLGBTQQIA+ communities as pathological due to their lack of cultural understanding (p. 2).

Shaw and Proctor (2005) point out that BPD is a gendered diagnosis, with women comprising 75% of people to whom the label is applied (p. 484), of whom most have suffered trauma, with 88% having experienced abuse and 70% having been sexually abused (p. 486). As they recounted, Bryce and Ray were both labelled as having BPD and although Bryce was a non-binary masculine person and Ray was a man, they had both been assigned female at birth and their diagnoses took place prior to their coming out as trans. Both had experienced childhood abuse. Ray had been sexually assaulted as a young adult, and Bryce reported having been sexually harassed by one of his mother's boyfriends and worried that he might have "blocked out" other incidents. Shaw and Proctor explain that the ways of being and interacting that are characterized through the BPD label as evidence of a disordered personality in fact typically represent "a complex attempt to maintain personal survival and integrity in the face of past and current trauma" (p. 486) and argue that the diagnosis represents a further instance of the long-established tendency within the psy professions to "deny the extent and impact of sexual abuse" (p. 486). They explain how the BPD diagnosis serves as a means of medicalizing abuse:

> BPD—which is defined with no reference to trauma—effectively decontextualizes the experience of distress from its social causes, paying occasional lip service to the prevalence of histories of abuse among the diagnosed population before going on to locate distress and difficulty firmly within the individual (p. 487).

Experiences with Psychiatric Medications

Critical research on psychiatric medication has revealed several issues: The "chemical imbalance" theory of mental health upon which the use of these medications rests remains unproven; These kinds of medication are often not as effective as claimed (in some cases, no more effective than placebo); They may also themselves cause or exacerbate emotional difficulties and are often difficult to withdraw from; They also pose risks to physical health (Harrington, 2019; Healy et al., 2020). Usage rates of psychiatric medications have increased substantially in recent decades, which has been enormously profitable for the companies that produce them (Healy et al., 2020; Whitaker, 2010). With the exception of those who receive coverage with social assistance benefits, age-related benefits, or who qualify for means-tested programs such as the Trillium Drug Program in Ontario, in Canada, medication is not covered by public insurance for most adults (Health Canada, 2019). This has perhaps contributed to the popularity of medication-based mental health care. Because private insurance and out-of-pocket payments typically fund this intervention, it may (at least in the short term) represent a savings for a public system that can externalize this cost instead of being required to provide funded services.

Given the inaccessibility of accessible alternatives to drug treatment, it is understandable that people who are experiencing difficulties will choose to access the options that are more readily available to them. Most participants discussed their experiences with psychiatric medication,[72] and a broad range of experiences with and perspectives on medications were represented. My critique of psychiatric medication is not intended to invalidate the viewpoints and experiences of participants. As the feminist new materialist perspective demonstrates, people's bodyminds and the cultural, social, built and natural environments with which they intra-act are enormously complex. Although research findings might suggest that a medication may be of limited efficacy for most people, or that it might not function in the ways that the company marketing it promises, it is entirely conceivable that the same medication might provide a benefit or a desirable effect for a specific person.

Medication Benefits and Problems

Some participants shared that they had found medications helpful, particularly in regard to assisting them to cope with acute anxiety and to help promote sleep. Io explained how she used Seroquel for these purposes: "It's like lying in bed, having a panic attack, and it's horrible. So having the reassurance of, 'I have taken this pill. I can relax for a bit and in an hour I will be asleep.' That's been, like, super positive." Participants recounted experiencing side effects from medication ranging from the mild to the severe. Individuals often reported that their experiences with medication tended to vary. For example, Mark noted that he did not experience any issues when he took Effexor as a teenager, but experienced stronger side effects while taking antidepressants as an adult.

While Alexandra mentioned that her then-current doctor took what she regarded as a helpful, consultative approach to prescribing medication for her, several other participants reported difficult interactions with doctors concerning medication. As I mentioned earlier, Io felt that her appointments with her psychiatrist were limited to addressing medication issues, leaving no room for her to raise other topics. In the hospital-based treatment program for people with eating disorders that Francis was forced to attend, they were prescribed Zyprexa and Prozac. They explained that although the medication itself did not seem to cause problems for them, they were disturbed by the cavalier attitude of their psychiatrist, who insensitively joked to Francis that one of the side effects of Prozac was weight gain, saying, “But hey, that should work in your favour.”

Io had been given Prozac, benzodiazepines, Seroquel and Abilify, but found most of them unhelpful. Her psychiatrist dismissed her concerns about the medications she was taking, telling her that because she had stopped self-harming and no longer had suicidal thoughts, this was evidence that they were working. Io feared that if she questioned him, she would lose access to treatment:

> I don’t want to lose my psychiatrist by getting in an argument… He feels like it’s the correct prescription, and he doesn’t want to waver on that in terms of, like, “Well, this is

> what I think you need. I don't want to recognize that you have your own thoughts on the matter, because I know best because I'm a doctor."

Hermione experienced emotional numbness, fatigue and somnolence after being prescribed mood stabilizers and decided to stop taking the medication on their own. Ray had a similar experience when he was given psychiatric medications following his diagnosis with bipolar disorder. While he found the antidepressant medication helpful, he had serious problems with the other drug he was taking. His concerns about whether he could maintain employment while dealing with the severe fatigue caused by the medication were not adequately addressed by his doctor and he decided to stop taking it without tapering, which resulted in a frightening and risky withdrawal experience where he experienced seizures.

Reuben described how he was given a "really, really heavy dose of Ritalin" without adequate follow-up after being diagnosed with ADHD at age 6. This resulted in serious health issues, including being underweight, insomnia and permanent growth stunting. Reuben eventually found out that the doctor who prescribed the medication to him was later convicted of malpractice.

Limitations of Medication-Based Treatment

Unlike most participants, Sandy had not taken psychiatric medication, concerned that it might shape her consciousness in ways outside of her control, explaining that she did not want to be forced "to think a certain way." Because medication-based treatment has recently been the main type of available help for mental health difficulties, and other potentially beneficial options are out of reach to those who cannot afford them, the potential benefits of the other options are often inaccessible. Alexandra discussed her wish that she could access other approaches and learn new ways of coping:

> It would be nice to have access to things … like this is a course on, “So you’re having a panic attack. Here’s ways to deal with it besides maybe just taking a benzo and kind of lolling out on the couch.”

Gatekeeping

The theme of gatekeeping was raised repeatedly by participants, who described multiple ways in which they were subjected to restrictions that limited their access to the resources they needed. I begin this section with a discussion of gatekeeping taking place on the basis of the perceived “severity” of their situation. In some cases, participants were told that their problems were not serious enough to necessitate help, or were told that their distress was not valid or even real. I then review the gatekeeping of access to gender confirming care, which is the cause of many gender diverse people’s coming into contact with mental health care in the first place. As participants reveal, gatekeeping has many negative impacts on their well-being.

Gatekeeping “Severity”

Io described an instance where she and her boyfriend received inadequate care at a hospital emergency room in the GTA while seeking help for suicidal ideation. After waiting eight hours to be seen, the doctors dismissed their distress, saying, “You’re not going to hurt yourself.” They refused to provide assistance beyond recommending that they consider learning about CBT and relaxation techniques.

Bryce described how after going through a difficult breakup while stuck in a precarious living situation with his ex-partner as a young teenager, they decided to try to end their life by taking an overdose of the medication they had been prescribed for anxiety and insomnia. When they ended up in in the emergency room, they reported that medical professionals did not take them seriously, telling them, "If you were going to kill yourself you wouldn't have overdosed."

In another incident, Bryce described how while experiencing dissociation following another breakup, he tried to end his life by running out into traffic, where he was hit by a truck. Although he was initially admitted to a psychiatric ward for a brief time, he was ultimately discharged and told that he would have to get better on his own:

> They checked out my spine and my neck and everything and cleared my head, and they're just like, "Okay, you're okay. Like, you're physically okay." And I'm, like, I didn't know my leg hurt so bad. I didn't know my leg hurt bad because I was in shock... I was in the psych ward. I was, like, locked down, I think that one was nine days. And then, I think a week—like, they discharged me, telling me that I need to go home and get better on my own. And, yeah, no, this is a reoccurring thing. They always tell me that.

Research has shown that in comparison to patients labelled with other DSM conditions, those who are identified as having BPD are more likely to be rejected and viewed negatively by clinicians. Clinicians report feeling higher rates of "frustration, indifference and disdain" toward those labelled with BPD, while also seeing them as "more dangerous" than patients diagnosed with conditions such as schizophrenia or depression (Liebman & Burnette, 2013, p. 116). In their 2016 study, Lam et al. discovered that the BPD label itself inappropriately colours clinical judgments, limiting labelled patients' access to other avenues for care (p. 263–265). They note that because of the negative impact of the BPD label and the supposed permanent nature of the diagnosis, "a diagnosis of personality disorder could … be viewed as a 'life sentence'" (p. 265). Reflecting Bryce's experience, Liebman and Burnette (2013) found that compared with other clinicians, psychiatrists were especially likely to report a negative disposition toward those diagnosed with BPD (p. 122).

Reuben explained how as a child he was put into therapy to address his diagnosis of ADHD as well as to help him cope with some serious problems his family was experiencing, but once his school performance improved this support was removed despite his ongoing difficulties:

> I finally got out in Grade 7 when they thought, "Oh, you've grown out of the ADHD now."… Like, they thought something was there, but they're like, "Well it's not ADHD, so we're just going to drop it. Your grades are fine now."

Hermione discussed how she discovered that she had several characteristics associated with autism and sought a diagnosis from the psychologist to whom she was referred by the accessibility service at the GTA university she attended. She was subjected to misgendering as well as ableist and racist microaggressions, then ultimately rebuffed entirely, leaving her without access to accommodations or support. The psychologist described Hermione as "neurotypical" and told her, "There is nothing wrong with you, you're going to do amazing things in the future." Hermione interpreted the dismissive attitude of the psychologist as "erasing [the] barriers" she faced, leaving her in a position of trying to "navigate the world as someone who experiences these issues related to being understood as someone on the autism spectrum, without actually having a diagnosis."

Gatekeeping Gender

As I describe in Chapter Two, the psychiatric gatekeeping of access to transition-related medical care has been a significant reason why gender diverse people come into contact with mental health care services, so many of the encounters that participants described took place as a result of this requirement. The gatekeeping model pathologizes trans and gender diverse people, and is based on notions of gender that often do not reflect the experiences of community members (Schulz, 2018). Engaging with gender-related gatekeeping represented a major source of stress and worry for participants, who were forced to navigate arduous and complicated systems that required them to expend unreasonable amounts of time, energy and money.

Jumping Through Hoops

As some of the stories already mentioned in previous sections reveal, the requirement that trans people undergo multiple counselling sessions and psychological evaluations (even when they are not covered by public insurance) to gain access to gender confirming care has been emotionally and financially burdensome. The current WPATH Standards of Care still recommends that a referral letter from a "qualified mental health professional" (Schulz, 2018) be sought in support of access to hormone therapy (Ashley, 2019a), but in Ontario, referral letters are no longer generally required for this purpose (Lena, 2019). That noted, in accordance with WPATH recommendations, a letter is still compulsory in the province for most gender confirming procedures and two letters are needed for genital surgeries, which continues to limit access to care to those who have the social and cultural capital and resources to successfully navigate the health care system (Lena, 2019; Schulz, 2018). This also means that the “thing-power” (Bennett, 2010) of the referral letter remains intact, functioning both a barrier to and facilitator of access. Pimenoff and Pfäfflin’s (2011) research on “noncompliance” among trans patients seeking access to gender confirming care showed that referral letters are of dubious value, as patients who falsified or misrepresented their story to facilitate access to care, or who directly accessed care without first getting a referral letter received treatment more quickly and had treatment outcomes that were just as positive as those who complied with all the gatekeeping requirements (p. 43).

As Alexandra’s story shows, without access to an informed consent-based option, even following the required procedure in no way guaranteed a positive outcome. Initially unable to access other options, Alexandra continued to see an abusive psychiatrist for a long period of time before finally realizing that he would never provide the letter of support that would enable her to get the gender confirming procedure she sought. (Alexandra’s encounters with this psychiatrist are discussed in further detail in the next section of this chapter.) She then saw several more practitioners in this her search for a letter of support. The next psychiatrist subjected her to more invasive and offensive questioning:

> We had, like, an hour-long session in which, basically, he goes down this list—this questionnaire kind of thing which was completely bizarre. It’s all stuff like, “So, are you attracted to children? Do you hear voices? Do you, do you sometimes, when you are masturbating, do you, like, asphyxiate yourself, you know, do you choke yourself?” And I’m like, “No.” He’s like, “Oh, yes, because we have research suggesting that

> asphyxiation in trans—transvestites are actually very linked with paraphilias."[73] … Of course there was, like, the more standard stuff. "How long have you identified as a trans person? How young were you?" Blah, blah, blah, blah. Looking for that kind of, "Oh, I was three years old," story that we're all supposed to tell.

In the end, Alexandra was not given the letter in support of the procedure she sought, and shared her suspicions that the intrusive questioning to which she had been subjected might have been used in the doctor's research. Alexandra's parents then funded multiple sessions with another social worker who ultimately decided that Alexandra was "unstable" and "too depressed" to undergo surgery, followed by yet another doctor who subjected her to more problematic questions about her sexuality and gender identity ("Do you have transvestite stuff in there somewhere?"), then also refused to provide a letter. Alexandra described the impact on her mental health of encountering barrier after barrier:

> A lot of my depression early on was kind of based around, like, you know, I was so frustrated with the whole trying to get the surgery letter kind of thing, a lot of my suicide ideation was, like, okay, I could perform the surgery myself, see, and I could just—as soon as I'm done getting those testicles thrown off the balcony or whatever, I could call the hospital, they could save my life, and then I wouldn't have any balls anymore. I wouldn't have to deal with psychiatrists, and then it won't be like a suicide attempt because I could die, but on the other hand if I survive I won't have any more testicles and won't have to worry about that anymore. It's, like, suicide logic, right?

> But then again if I fail and I don't manage to get them out of my body, chances are that they'll never, ever give me whatever surgery because I'm too "unstable." You know, that was the word they always used. And I was much less suicidal after I got the surgery and literally you could say that most of my experiences with the system made my problems worse in that respect. I remember, like, leaving the office of—like homicidal after that argument about whether she was going to give me the letter, and I was so angry, like, I decked that pole with all the rusty nails in it until my hand was a big, bloody mess. I was so… So, yeah, pretty much just kind of brings on the misery and woe.

If Alexandra had ultimately resorted to undertaking surgery on herself, she would not have been the first person to do so: Several instances of self-performed genital surgery have been reported among individuals lacking access to the gender confirming surgical procedures they needed, including several among trans people in Ontario who were impacted by the delisting of gender confirmation procedures (Rotondi et al., 2013, p. 1835).

Several participants noted that the intake questionnaire required by CAMH prior to accessing gender clinic services was invasive in similar ways to the questioning to which Alexandra had been repeatedly subjected. Miriam recalled her reaction to the intrusive questions and her strategy for avoiding it. She hypothesized that the scrutiny that the Child Youth and Family Gender Identity Clinic at CAMH had been under (as I will discuss later in this chapter) may have played a role in facilitating her access to care:

> It was like, "What the fuck are you asking me all this stuff for? You don't need to know this." They wanted to know if you were—had any drug use problems. All of this, the list is quite extensive… I was like, that's just way too F-ing intrusive. So I dragged my ass on it for quite a while, and so I didn't send it in… I just didn't deal with it, because it was just too intrusive. So, I called them up much later and I played dumb and said, you know, "I haven't heard anything back, and what happened to my questionnaire?" I don't put up with bullshit. And they said, "Oh, we need to get a new referral." So, this was after the review [of the CAMH Child Youth and Family Gender Identity Clinic]… and so my endocrinologist sent the referral.

Pressure to Fit the "Transnormative" Narrative

Participants recounted facing intense pressure to fit the dominant trans narrative—sometimes called the "transnormative" narrative (Riggs et al., 2019) to increase their chances of being granted access to the gender confirming care they sought. The dominant narrative is the story of having been "born in the wrong body," feeling from a young age that one's gender identity did not align with one's gender as assigned at birth. For people assigned female at birth, this meant having consistently exhibited behaviours stereotypically associated with boys, having male friends, and dressing like a "tomboy"; for people assigned male at birth, this meant having consistently exhibited behaviours stereotypically associated with girls, having female friends, and showing interest in feminine clothing. As I discussed in Chapter Two, being perceived by psychiatric gatekeepers as conforming to this narrative—and even to doctors' expectations around gendered physical appearance—was in many cases the only way to get access to transition until relatively recently (Schilt, 2010, pp. 23–25). Additionally, the dominant trans image was whitewashed and inherently white supremacist (Gill-Peterson, 2018, p. 27), with the practitioners who developed and enforced it demonstrating hostility toward racialized trans people (Lena, 2019, p. 28). Alexandra explained how medical practitioners' interactions with her were strongly influenced by these outdated but still dominant stereotypical narratives, and that the powerful status of that same narrative also initially shaped how she thought about her own gender:

> Early in my transition—so many of these doctors were just like, "Classical transsexual." … Because I was like tall, model height, I was skinnier, my face had aged a bit less, so I still looked like an 18-year-old, tall, blonde, leggy—I was wearing the short skirts and tight-fitting clothing. … If you want to get treated, in a sense you have to convince them, which means that you have to convince yourself. So you have to be, like, "Yes, I am classically transsexual. I have wanted to be a woman since I was three years old. I remember vividly thinking, 'Oh, I am a girl and why am I in this body?" And blah, blah, you know. The thing is, though, the most fascinating part of that whole process to me is you kind of like read it, and as soon as you read it on a website and you kind of understand, "Oh, this is what a transsexual looks like. These are the kinds of things they say. And it's only them who are actually given the, you know, privilege, the right to be able to physically transition. So I must be one of those people." So then you start backwards interpreting it, everything from your past into that format so that you can, like, suggest, like, "I am completely legitimate."

Alesha described how from the time she filled out her CAMH application, she carefully negotiated the pressure to conform to the dominant transgender narrative:

> A lot of it was fairly basic information, but then there were [optional] questions that were asking much more, like, "What is your story?" And at that point I was questioning too much to bother filling it out. I've gotten good at being able to frame my story in a very "fits their box" way, but at the time that would not have worked because at that point I had identified as non-binary, which would have been a problem. … I'm very fortunate in that sense that I'm very binary, very into dresses and femme as fuck, but I knew that was a thing.

Mark knew that he had to construct a narrative that would convince the CAMH gatekeepers to allow him to access gender confirming care, and explained how it changed his own perception of his past. Using the internet, Mark educated himself on the types of behaviours a child might exhibit to warrant access to gender confirming therapies. He explained how he reframed his childhood experiences to fit the dominant narrative:

> "Yeah, I really wanted to play with trucks, right? … Yeah, I had a Barbie collection [but] it was—it wasn't fun, like I never used any of the makeup or anything." But even that to me didn't fit the narrative, so I just kind of wrote it out or I wrote around it or I didn't mention it at all, right? So in that sense it's easy to game the system, and you just kind of memorize that story, and you take it on to yourself. So, actually, because I've had to live that narrative and, you know, memory is something that you—when you say something

> to yourself you actually replace the old memory, right? Memories aren't concrete and, neurologically, you just remember the memory of the last time, so what's interesting over time is that because of that—that I've had to tell that narrative so much, I think, actually, my own sense of my own past is a little warped. … CAMH was a nightmare. Like, there was a lot of IQ testing and stuff like that. But, again, you know, I basically had this narrative, and I knew what I wanted to say and I knew what I wanted out of it, so I stuck to the narrative, right?

Io explained how typical processes for accessing gender confirming procedures excluded non-binary people like themselves, leaving those who were not perceived as conforming to the dominant narrative or image at greater risk:

> I could almost assure you, they would not prescribe me hormones. … The reality is, all it does is put people in danger, especially when suicide rates are super high in trans people. When you make people wait for hormones, and when you make people wait for transitionary help, it's literally putting their lives at risk. … If I'm a person who doesn't have access to hormones for whatever reason—which is the case for a lot of trans people in Canada—sometimes it's you don't feel safe enough to present how you feel. … Whereas if they had hormones and, like, could start to feel more confident in themselves, could start to feel more safe, then maybe they would be able to dress the way they want. … To get the hormones, you need to dress this way, but you can't dress this way without facing numerous issues and it's difficult.

Strategic Navigation

In addition to ensuring that their stories conformed as much as possible to the dominant trans narrative as a means of improving their chances of being approved for access to gender confirming procedures, participants described how they used other strategic tactics to navigate through gender gatekeeping. Alexandra explained how she was ultimately able to get around the requirement to undergo multiple counselling sessions prior to starting hormones. She told the doctor she saw at her university health clinic that she had already been referred to a psychiatrist and he agreed to prescribe them for her immediately. As she explained, “That’s not the way it’s supposed to work but, I mean, thank God that he didn’t realize, you know, the stupid rules.” Mark relied on his “businesslike” self-presentation and the use of referral letters from his previous doctors (intra-acting with the letters’ thing-power to facilitate his goals) to ensure continued access to care. As both Alexandra and Mark pointed out, their white privilege likely played a role in enabling them to navigate the system in these instances.

Concerns about Ableism

While the beneficial mental health impacts of hormone therapy for trans people are now well-documented (Achille et al., 2020; Aldridge et al., 2020; White Hughto & Reisner, 2015; Tucker et al., 2018), it has often been the case that health care providers seek to address mental health issues other than gender dysphoria prior to initiating transition-related procedures. In the early 2000s, Alexandra was told that she could not be given hormone therapy because she was depressed. As Ashley (2019b) notes, this is still consistent with WPATH recommendations. Alexandra explained why this ableist expectation was so unhelpful for her, noting that she was depressed because she did not have access to hormones and was not being allowed to transition.

She asked, “How can you expect me to not be depressed when I have somebody controlling me in this way?”

Several other participants who had been labelled as having mental health difficulties or who were autistic feared that they might experience gatekeeping on the basis of ableism. After being referred by his family doctor to a GTA health clinic that often provides transition-related medical care, Ray explained that despite the providers’ familiarity with trans health care, he remained wary of their possible response to his history of psychiatrization at his intake appointment [Content Note: Ray referred to himself using the incorrect pronoun “she” to highlight the way he feared he would be viewed through the lens of pathologization]:

> I was really worried that they were going to look at my medical file and see the bipolar diagnosis and just not give me hormones because they’re like, “Oh, she’s having a manic episode,” or something. … I talked a bit about mental health and I said that my moods go up and down and they’ve been pretty steady for a good two years or so. … And I was really worried the entire time that I was doing this that somewhere along the way I would be told, “No, you can’t go on hormones,” and then [be] put back on psychiatric medicine.

Miriam thought that she might be on the autism spectrum, and described the ableist barriers that some of her autistic friends had faced in trying to access gender confirming medical care, giving an example of a friend in the United States who was told that they could not know their gender identity because they were autistic. Hermione had concerns that not only might clinicians consider their genderqueer identity to be problematic, but they might also have ableist attitudes concerning autism and mental health. They worried that these factors might impact their access to the care they were seeking, despite the fact that their experience with CAMH had gone relatively smoothly. Hermione described being “open about being on the autism spectrum with them, and being … a sexual trafficking survivor.” They explained that after their disclosures, “They were relatively transparent about, that they were probably going to recommend me … to continue on with the process.”

Among the 13 participants in this project, Hermione and Reuben had been diagnosed with autism, and Miriam was considering pursuing an evaluation in the future. This is not surprising, as gender diverse people are more likely to be autistic than cisgender people (Carlile, 2020; Warrier, 2020). There are multiple reports of autistic people facing additional barriers or being excluded from access to gender confirming care due to their health care providers’ ableist beliefs, including the perception that autistic people inherently do not fit the dominant trans narrative. This leads to predictably negative outcomes (Adams & Liang, 2020; Carlile, 2020; Shapira & Granek, 2019).[74]

Avoiding CAMH

Several participants discussed that some care options that were technically available to them were still inaccessible due to the fact that they would have to engage with the services at CAMH to access them and they were unwilling to do so. For some participants, this was because they had negative past experiences with the institution. For example, Ray explained that he preferred to go into credit card debt to access top surgery rather than risk having his capacity to consent to gender confirmation treatment be questioned by CAMH doctors. Francis had no direct experience with CAMH, but had previously undergone inpatient mental health treatment and had also witnessed their partner’s experience in seeking access to approval for gender confirming care through CAMH. They decided that if they wanted to access top surgery, they would pay privately.

As I explain in the next section, Reuben reported that he had previously had a negative encounter with the Gender Identity Clinic at CAMH. He told his endocrinologist that he would not need a referral to CAMH for approval to access gender confirming surgery because he had decided to use some inherited money to go to a surgeon who worked on informed consent principles and did not require a letter of support. Other participants decided to avoid CAMH gender-related services based on what they had heard about it from the community. Quinn described their health care interactions as largely positive and explained that although they had found a doctor who had prescribed hormone therapy on an informed consent basis, they still had concerns about having to experience any degree of medicalization. They considered themselves fortunate to not have been subjected to the CAMH process: “I couldn't imagine having to be in the situation where I was having to go through CAMH, and have to prove that you’re trans enough to be able to access things…”

Io was familiar with claims that had long been circulating that conversion therapy was practiced in the gender clinics at CAMH, and explained that she sought to avoid it because she disagreed with those practices:

> It’s the gatekeeper and, again, that causes problems when you have a doctor who actively supports gay conversion therapy who is still employed by CAMH and works with youth. Which, he’s entirely allowed to do, because when you’re working with youth, it’s all about the consent of the parents. So, if a parent, the way it is legally, if a parent says “I

> give you the right to, like, try to convert my kid," like, then that's totally okay. And, like, CAMH is okay with it. So, like, I have issues with the organization itself.

Io was referring to ongoing criticisms of the CAMH Child Youth and Family Gender Identity Clinic from trans activists and supporters, which were long-standing (James, n.d.; Martino et al., 2019; Withers, 2014) but had recently begun to intensify coinciding with the introduction of Bill 77, which sought to outlaw conversion therapy in Ontario (Martino et al., 2019, p. 307). An external review of the clinic had been commissioned in February of 2015 and the clinic's waiting list was closed in June of the same year. On November 26, 2015, the report of the review was published, and on the same day the leader of the clinic was dismissed from CAMH. The report stated that some former GIC clients reported having been traumatized by their experiences at the clinic; that some of the clinic's assessment processes were arduous and invasive (involving long interviews and extensive psychological and IQ testing); that some former clients felt that clinic staff sometimes misgendered them; and that some former clients believed that the clinic had delayed their access to trans-affirmative care by not providing information about other approaches and available resources. Clinicians asserted that they took what they referred to as a "developmental approach" to addressing children's gender identity—which has been described as aiming to "help children feel comfortable in their own bodies" (Singal, 2016)—before exploring options like social transition, the use of puberty attenuating medication, or hormone therapy. Advocates of the "developmental approach" have argued that it was supported by research demonstrating that a large percentage of children asserting a trans identity eventually desist (Radix & Silva, 2014).

The report did not conclude that the clinic's approach was equivalent to conversion therapy, but it stated that the clinic was not keeping pace with evidence-based developments in the care of gender diverse children. The report also contained statements from former clients who claimed that the leader of the clinic had made offensive and inappropriate comments to them. The clinic leader emphatically denied that he had made the comments and stated that the report contained mischaracterizations of clinical practices. In January 2016, he sued CAMH for defamation and wrongful dismissal and the report was withdrawn from CAMH's website at that time. In October 2018, CAMH settled with him for $586,000 (for legal fees, interest and damages) (Khabra, 2018) and issued a public apology to him, stating, "CAMH apologizes without reservation to [the clinic leader] for the flaws in the process that led to errors in the report not being discovered" (Rizza, 2018).

Medical Coercion, Harm and Misconduct

In addition to the pressure to engage with mental health care services due to gatekeeping requirements, gender diverse people are often coerced or even forced to engage with mental health services for a wide range of other reasons. Nina was brought into contact with mental health care as part of a court diversion program. She had been arrested after calling the police because her then-partner seemed to be out of touch with reality and was threatening her. The police alleged that signs of a physical altercation were found on her partner's body and not hers, so Nina was ultimately brought into custody and charged. Her partner was not arrested, even though Nina had called for help in response to his threats. While diversion programs are typically characterized as humane options that help to mitigate the criminal justice system involvement of people identified as dealing with mental health difficulties, some participants in these programs have reported feeling coerced to participate in such programs, or that their participation was not entirely voluntary (Cusack et al., 2010; Redlich et al., 2010). Nina did not specifically frame her participation in the diversion program as having been coercive, mentioning that she felt supported by her program doctor who was also Filipino, was but it is clear that her initial contact with mental health care was not the result of an unconstrained choice.

Pressure and Coercion from Family Members

Several participants described being pressured or forced by their parents or family members to engage with mental health care, for a range of reasons. Hermione's mother forced her to attend therapy in an ultimately ineffective attempt to assert control over her. Reuben felt "bitter about needing family therapy because my family was that messed up—or being told that I wasn't normal" when he was sent to counselling as a child in an effort to help him to cope with the problems that his family was facing. Io explained how her grandparents required her to attend grief counselling after her mother died, but she did not find it helpful and she was not provided with any other support despite her continuing struggles:

> So, that only lasted… maybe two sessions and then we just stopped going. … It was really hard. It was hard to raise me because I was dealing with things in a very specific way, and I think, looking back on it, I definitely experienced something that they should have gotten me extra help for.

When he was a young adult, Ray was coercively pressured by his mother to seek mental health treatment following an incident in which he physically resisted his brother's attempt to choke him during an argument. His mother accompanied him to his psychiatrist's appointment and ended up providing most of the responses that they used to label him with multiple diagnoses: [Content Note: As Ray recounted, during his evaluation appointment, his mother used she/her pronouns to refer to him.]

> [My mother] got the locks changed on the doors. And then she told me that until I got help for my problems I was not allowed in the house… "For the safety of the family," I couldn't be there. So then she said, "If you would like to be welcome in our home, what you have to do is go to the doctor and you need to get a referral to some kind of therapy or some kind of help" … I was referred to [a psychiatric clinic in the GTA]. My mom went with me and I sat there while this guy asked me all these questions about my behaviour like, "Do you have a history of staying up all night?" And I was, like, "Yes, because I'm in school." … Like, "Do you have a history of behaving silly?" And my mom would often sit next to me and just answer the questions for me and talk over me, like, "Yeah, she will often—she'll be quite silly and it'll seem like she's totally out of control and, like, her spending is crazy sometimes and, like…" Like, "Do you have any history of acting, like, do you feel so on a high that you feel like out of control?" My mom's like, "Yeah, she'll often just be totally silly, totally hyper, unable to calm down…" Just totally answering most of the questions for me and directing me how I should respond, basically. Like saying, "Yeah, there's been a history of her and her brother physically fighting." And I'm like, "Yeah, when we were, like, six and seven years old we'd get into physical fights. But nothing since then until recently." And she's like, "She attacked her brother," [but she] didn't even say anything the whole time about

> [how] he held me down on the floor and was choking me out and I had marks around my neck…

Harmful Encounters

Francis' first encounter with mental health care was both coercive and traumatizing. Francis recalled that they had been seen as a "fat kid," but as a teenager, they started to lose weight and soon they started to be perceived as excessively thin. One day, while attending a medical appointment for their asthma, Francis was suddenly brought from the clinic to a hospital in a nearby GTA city and admitted to an inpatient eating disorder treatment program. They saw parallels between their frightening and confusing experience and the tactics used in the "troubled teen" industry in the United States. Francis reported feeling like they had been kidnapped, "Literally I couldn't go home." They explained, "I literally just wanted to sit and eat for … a day and a half because if I—I just wanted to leave."

Reuben described a difficult experience at the Child Youth and Family Gender Identity Clinic at CAMH. He recalled that the assessment process was confusing, with him being given an IQ test while his parents were interviewed about his childhood. Reuben explained that because he was 16 and capable of making health decisions, he had assumed that the clinicians would speak with him directly at his next appointment several months later, but discovered that it was not the case. Reuben shared that he was diagnosed with autism as well as gender identity disorder, and that he was not offered the gender affirming treatment he sought. Reuben's recollection of the appointment may demonstrate that that as a clinic patient, he did not perceive a distinction between conversion or "reparative" therapy and what the clinicians have described as their "developmental approach." He recounted that the suggested treatment pathway was non-affirming:

> My next appointment was in January—again, long wait time. Uh, that was when they sat us all down in that room again and said, "So, yeah, he's got GID, we think he's definitely got autism based on his IQ performance." … "So we are going to get you back to the therapist," that I had last seen in Grade 7. … Um, and they actually said to my face that it was going to be a reparative therapy. And that—I knew what that word meant, and I looked at them—I just looked at them for a moment… It was silence, and they were looking at me, and I was just… My… I could feel my face getting very, very red, and my thoughts starting to swim, and I just wanted to scream at them! I knew what reparative therapy means.

Reuben also reported that when he objected to the treatment plan, a clinician offered the justification that since he appeared to develop gender identity disorder as a teenager rather than as a young child, this type of treatment would allow them to "fix it." Reuben recalled that a clinician gave him the additional rationale that "if [OHIP pays] for surgery, they want to make sure that, you know, that this is really the route that you want to go down."

During our interview, Mark also discussed his experiences at the Child Youth and Family Gender Identity Clinic at CAMH. While most of our conversation took place over a video call, some of this material was so sensitive and personal that Mark decided to type it into the chat box in the application instead of saying it out loud. He explained over the days of the evaluation, he and his mother were interviewed separately and he was subjected to psychological testing before they were brought into an office together to hear the assessment results. Mark described how he felt humiliated by the process and by the clinicians' unfounded claims that he may have been sexually abused as a child:

> But, I mean this is—this is maybe a little—a little hard for me to talk about… I mean they really were interested in my sexuality as well, which was a little negligible, but, you know, since starting testosterone I had a little bit of a sex drive since I hadn't before. … [Typing] … so like basically, there's this super embarrassing time where they asked me about my sexual experimentation and masturbation habits and i was honest, because, like, uh psych evaluation and i admitted that you know i wasn't comfortable with myself (who is???? at 17???) and although i had urges they were distressing and embarrassing and yada yada. So that's fine they make notes, we go on our happy way. now one thing the Freudian asked was if i had ever seen my father's penis or if there were any "incidents" with him. um and i said that i saw him walk down the hall with his fly down once? and then they said "and you noticed his penis and were envious of it?" (or something like that) and i rolled with it; i wasn't and i am not even sure if that event happened, like it wasn't swinging to the breeze or anything it was just an open fly with flesh tones inside at most, haha, but yeah i said, "sure" so that was weird thing #1. and then back to this masturbation thing.
>
> on the very last day they sit with my mom and i in a room to like, give me my grade to see if i got my little stamp to go to trans camp and before they start they ask if its ok if they go over things, with my mom there. but they give me no context as to what they'll

> be talking about or why. … i say yeah it’s fine. so i don’t remember much about the ramble around it but they start describing my masturbation habits to my mom and that’s where i ask them to stop and that we can continue privately. it fucked me up. it still fucks me up. [Speaking] Yeah, it was super traumatizing. … [Typing] yeah, so because i was “uncomfortable” with masturbation, they also diagnosed that possibly maybe, sometime, i was molested by a parent or adult. … i mean, contextually it’s nonsensical you can’t plant that idea in a patient’s head and that’s a well-documented issue in like, therapeutic care but also look at what you’re dealing with. 17 year old. trans person. what 17 year old is like “i’m comfortable with my everything” ??????? like i’m here because i’m uncomfortable?

Mark discussed how he had received several intensely negative messages from the therapist he had to see around the time of his transition, and the way they contributed to long-lasting difficulties in his life. For instance, he was pressured to conform to rigid and limiting behaviour expectations:

> A lot of her advice about relating to people and stuff like that has really kind of fucked me up now, and, yeah, it hasn’t maybe been the most helpful right? … So, yeah, so then the therapy was kind of getting ready for transition type of life skills thing, but it was pretty problematic in some ways because a lot of it was, I think, old thinking, you know? Like, I was not allowed to do a lot of things that a lot of teenagers do because I was threatened that I wouldn’t be allowed to transition. … It was like, you know, “Make sure that you find a safe bathroom, because if you don’t go to the bathroom you’ll hold it all

> day, you'll ruin your liver and then you can't get a phalloplasty because they won't take you." And, you know, it was like, "Don't smoke dope, don't get drunk, don't get arrested, don't go out partying because if you get a criminal record, they'll think that you're a criminal, and they'll use that to deny your transition." … Basically, the message I got is that I had to be absolutely, unemotionally perfect to keep the heat off this problem.

Mark also explained how as a teenager he received strong messages from his therapist and his mother that romantic relationships and socializing were threatening and off limits for him as a trans person. These messages stayed with him into adulthood. He recounted what his therapist said to him when he told her that he had a crush on someone:

> She'd just be like, "Well, you know, just take a deep breath and, you know, they're just emotions, and just let them pass and don't act on them." I mean the message was that there was no real hope to have a relationship, right? And it's better just to let these things go than to agonize on them… I'm not sure if the message was temporary or forever, but it came across as forever, and I think that it came across as forever because of that messaging. Also, because of kind of the typical trans narrative of the inherent danger, right? Again, you've got to think that this is, you know, 2000 and whatever, right? When I was wanting to go, say—I did have a friend who was a drag king and wanted to go out at night, or go out with friends, the reaction from my mom was, "You can't go out because you'll get raped." You know, because you're trans, right? … And then all the, the casual stories online of abuse and stuff like that have just kind of all compounded into

> that message. And the therapist didn't contradict that message, and I think that just kind of validated whatever instincts I may have had and then cemented them.

Alexandra's digital story focuses on the reprehensible behaviour of the psychiatrist she saw while seeking access to a letter in support of the gender confirming surgery she sought. Looking into the camera, she explained that the first question he asked her was, "So, what do you think about when you masturbate?" She continued, "It didn't get any less invasive after that: 'Who with? How often? Any kinks?'… I'm stuck seeing this one-man locker room for a full year." When Alexandra told her doctor that she wanted to get an orchiectomy, his reaction was even more egregious:

> He's never heard of anything so preposterous. "Of course I'd give you a letter for sexual reassignment surgery. Think of how many more men you could fuck if you had a vagina! If you were a woman with a penis and no balls, you'd be a freak! No one would ever love you." … He tells me that the patient after me asked if I was trans. He'd outed me, then he'd asked, would he fuck me? "Yes." Would he ever date me? "No! Never!" And that would be my fate if I didn't get vaginoplasty… So yeah, fuck doctor-patient confidentiality, but what was I supposed to do? (Figure 31)

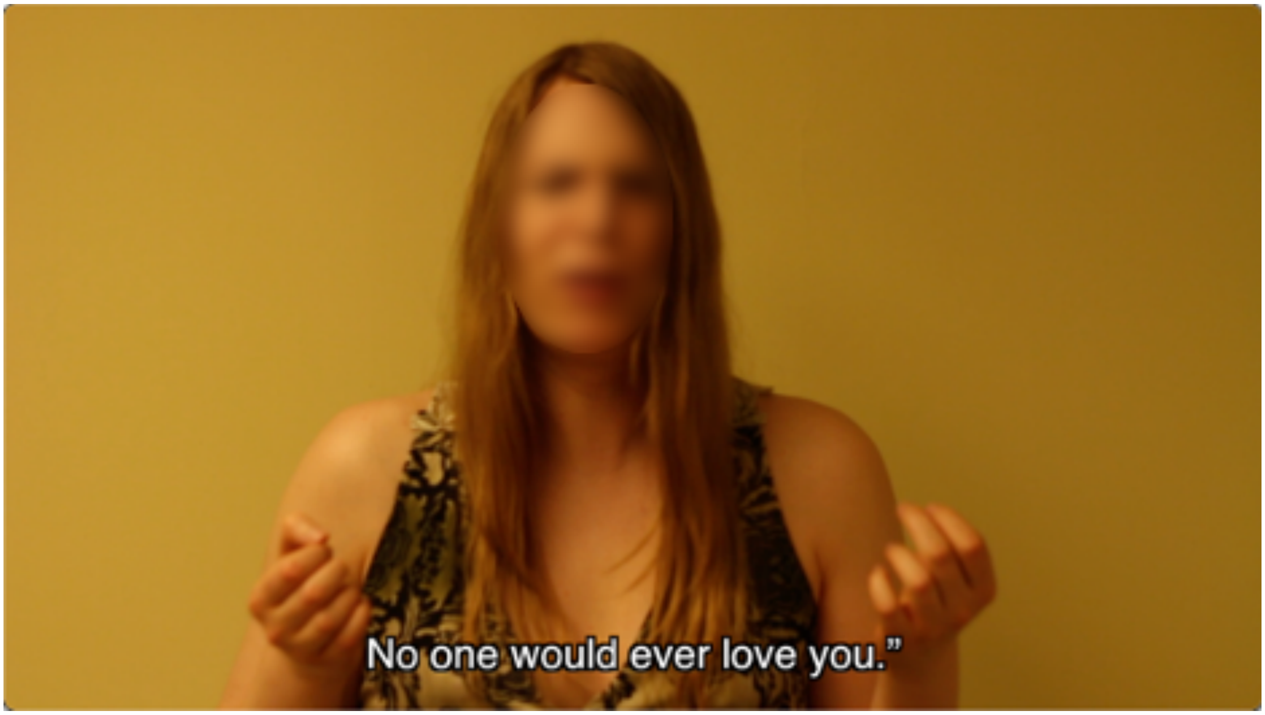


Figure 31: Alexandra tells her story

In her interview, Alexandra shared that the despite these and other violations, including an incident in which the doctor asked her if she was a pedophile after questioning her about who she was sexually attracted to and she responded that she tended to like feminine guys, she felt that she had no choice but to put up with this abusive treatment due to her lack of power as a patient:

> But I mean the entire way through was very much that kind of like leering men's gaze, "Oh, you are looking very nice. You're looking much better," you know. And I would just, like, [ask] "Can I have my letter for…" And then when I realized that he was never going to give me the letter, that's when I finally got rid of him… The thing is, like, I was afraid to do anything about it because as long as I was looking for a letter, I had no recourse as long as they had this over my head. You know, "Is this going to be a co-operative patient?" You know, "Patient is clearly depressive and attacking and

> aggressive," because, you know, they have all the power in that relationship. … I was worried about being kicked off hormones, even. You know, I wasn't sure about how all these things worked, and that's one of the reasons why I wanted the orchiectomy so that I would never have to worry about being kicked off hormones. I would never have any doctor have power over me, basically.

Psychiatric Hypersexualization

The extreme focus on sexuality that Alexandra and Mark both experienced in their interactions with transition-related health care reflects the way that trans people are often hypersexualized, perceived by others as "abnormally" and excessively sexual and/or sexually objectified without their consent (Sandlos, 2020; Seck, 2013). As Serano (2007) explains, trans people are subjected to hypersexualization in the culture more broadly and through everyday interactions (pp. 253–261), but also specifically within psychiatry, where especially for trans women (although as Mark's experience showed this can also apply to trans men, and likely also to non-binary people), identification with a gender or sex other than that assigned at birth is perceived as "being driven primarily or exclusively by sexual impulses" (p. 263). Mark explained that he had not been a victim of sexual trauma as a younger child despite the clinicians' claims, but the experiences of psychiatric hypersexualization that he endured were in fact a source of trauma for him.

Serano (2007) posits that the pathologization, objectification and hypersexualization of gender diverse people is a manifestation of cisgender people's baseless assumptions:

> Many cissexuals … choose to project their own assumptions about gender onto us. Often, such attempts center on naive cissexual notions about what a transsexual might socially gain from changing their lived sex: privilege, normalcy, sexual fulfillment, and so on. The idea that we transition first and foremost for ourselves, to be comfortable in our own bodies, is often never seriously considered. This is because transsexuals are generally viewed by cissexuals as nonentities: the processes of trans-objectification, trans-mystification, and trans-interrogation ensure that we are seen not as human beings, but as objects and as spectacles that exist for the benefit or amusement of others (pp. 188–189).

Projections, Identities and Becoming

A feminist new materialist reading of this tendency highlights the ways in which the project(ions) of psychiatry is(/are) rooted in humanistic assumptions that subjectivity and identity are largely fixed and unchanging, and that exclude to varying degrees those who do not approximate the ideal subject (Shildrick, 1997, p. 62), that being a heterosexual, cisgender, white abled man. An understanding of the intra-activity of the social and the material, including of our bodyminds with(in) environments, reveals that identity and subjectivity—including gender—are inherently unstable, continually shifting and becoming through intra-active entanglements (Barad, 2007; Jackson & Mazzei, 2012). The notion that being trans means having a consistently gendered mind at odds with a misfitting body (Rice, 2018), a mistake that can be "corrected" through medical intervention if and only if the person demonstrates their proficiency in this dominant narrative and is perceived as credible—i.e. adequately "feminine" or "masculine," or even as sexually attractive (Schilt, 2010, pp. 23–24; Serano, 2007, pp. 261–270)—by professionals is at odds with an understanding of bodyminds as fluid. Ray expressed his frustration with gatekeeping practices upholding the false notion of bodies as static and sacrosanct:

> Nobody's body is ever static, right? Like, everybody's body changes. Your cells change every seven years, so do you really have the same body that you had seven years ago? No, you don't. Right? Like we're constantly making choices about our bodies every day. Like, what we put in them, what we do with them. Like everyday practices and just also in terms of, like, people changing things that they just don't want with their bodies.

The hypersexualizing projections of psy professionals positioned as "objective" experts professing an ostensibly neutral perspective could be understood as manifestations of their performances of the stable, ideal, masculine subject. Their fetishistic/objectifying views of transgender people, and particularly of trans women, are disavowed and displaced onto the psychiatrized and medicalized bodyminds of their patients. Their own attachments and desires go uninterrogated and their authoritative status unchallenged unless the violations and harms they commit become so overt as to represent assault.

Medical Misconduct

While it goes without saying that any kind of mistreatment committed in the course of providing medical care is unconscionable, several participants mentioned that doctors with whom they had interacted had also committed other kinds of serious misconduct or even malpractice. Alexandra shared that the psychiatrist who had so badly mistreated her had also been put on trial for sexually assaulting his patients. She correctly recalled that the doctor was no longer permitted to practice medicine, but she also thought that he had been acquitted. This was true in the case of one patient, but in the same trial he was also convicted of sexually assaulting another patient. She also pointed out that many other people in the trans community had been referred to him, as one of the few psychiatrists in the area who worked with trans patients.

As I noted earlier, Reuben reported that his family doctor was convicted of malpractice, which did not surprise him given that the doctor had also given him health-damaging treatment without meaningful oversight or intervention. Several of the participants from Eastern Ontario had been clients of an endocrinologist who committed serious misconduct as a fertility doctor, covertly substituting his semen for that of clients on many occasions, resulting in his being the biological father of dozens of the children born to clinic clients. At the time of the interview, the full extent of the doctor's misconduct had not yet been revealed, and Miriam focused on the doctor's support of trans clients, understanding what had taken place at his clinic as "mix-ups" resulting from inadvertent errors. Alexandra explained that the doctor had been kind and helpful toward her (in contrast to many of the other practitioners she had encountered), but she also shared her worry that his misconduct and poor record-keeping meant that the sperm she had stored at his clinic prior to her gender confirming surgery might be unusable in future "because it's been contaminated by that scandal and they don't want to be held liable."

Subversive Care

In contrast to the negative and damaging situations discussed in the previous section, in some situations, mental health care providers resisted instructions or limitations that would have led to problematic outcomes for their clients.

Disrupting Problematic Parental Intentions

As recounted in a previous section, several participants had the experience of being pressured into accessing mental health services by family members. Health care providers are obligated to support the health and well-being of their clients themselves rather than to enact the wishes of parents or guardians, but this is something that particularly younger people are often unaware of (Roberson & Kjervik, 2012), or parents may be able to exert other forms of pressure that effectively require their children to comply with treatment.

In a few instances, the providers participants saw as a result were supportive of them in ways that directly undermined their family members' problematic intentions. For example, as recounted above, Hermione's mother forced them to see a therapist because she thought that Hermione's vegetarian diet was problematic and planned for the therapist to address this issue. In that instance, rather than critiquing their diet, the therapist worked with Hermione to address their childhood trauma—at least until Hermione's mother decided to stop allowing them to attend the sessions. In Quinn's case, they were initially brought into contact with mental health care after coming out to their parents as queer, as their parents believed that their non-normative sexual orientation was in itself a mental health issue. Fortunately, the therapist to whom Quinn was referred was queer-friendly and supportive. Instead of pathologizing their sexuality, the therapist created a space for them to process the issues that they were experiencing with their parents:

> Yeah! I told him I came out to my parents and this happened, [and he said] like, "Oh yeah, no, it's fine that you're exploring your sexuality." Like he was completely fine, and then the next sessions ended up me sitting and it being about my parents' problems.

Extending Access to Care

As De Geest and Meganck (2019) note, brief or time-limited therapy has become increasingly common due to pressures to contain health care costs, despite potential risks that brief treatment might be inappropriate or inadequate for some clients (p. 209). Several participants described how providers pushed past the stated limits of the "brief therapy" programs they accessed to provide longer-term counselling or psychotherapy. Although counselling did not end up being helpful for her at that time, Io described how the counsellor she worked with at the university she had attended was able to flex the six-to-ten session limit to allow her longer-term access, explaining, "She made it clear when she was like, 'This is kind of supposed to end when your second semester ends but if I feel like or if you feel like you need more, then we can keep going.'" Before he moved to a larger city, Bryce's counsellor saw him for an extended period of time, turning what was supposed to be eight sessions into almost four years of treatment.

Resisting "Reparative" Therapy

The most notable instance of subversive care comes from Reuben's story. As discussed earlier, when seeking access to transition-related care as a teenager, Reuben recounted that he underwent an assessment at CAMH, and instead of being given access to the hormones he sought, he was referred back to a counsellor he had previously seen for the purpose of undergoing treatment intended to stop him from transitioning at that time. Reuben described what happened with the therapist:

> She asked me, "Do you know why you're here?" I said "Yeah." She said, "Well, I've looked over your file, and they said that you've been diagnosed with GID, and they said

> you might also be autistic." And I said, "Yep." She said, "Okay, so do you have, do you have any thoughts about this?" I said, "I just want to get on bloody HRT." Like at this point they had—CAMH actually referred me to an endocrinologist to put me on blockers, so I was on that for a while by the time I saw my therapist, so I said, "Well, frankly, I just want to start HRT. So she said, "Okay, let me tell you my thoughts on this." And she was very candid, she said, "I think this is bullshit, we're going to talk about autism." So she said, "So I want OHIP to still cover the meetings, because I think we should still see each other often to talk about autism, autistic thought. Because if you really do have that, you've got a lot of catching up to do, because usually this is done a lot earlier on. I want us to meet frequently, so if OHIP is going to cover it only under the guise of reparative therapy, then I'll lie my ass off and say it's reparative therapy, but we're going to talk about autism." This is why I loved her!

Supportive Experiences

Participants also described many positive, genuinely supportive encounters with the mental health care system.

Strong Connections

Some participants described having strong connections with mental health care providers, explaining how these relationships have had long-lasting positive effects on their lives. The benefits of having a positive therapeutic relationship and a strong bond between therapist and client has been widely noted throughout the literature (Ardito & Rabellino 2011; Banerjee & Basu, 2016; Cahill et al., 2013; Kastrani et al., 2017).

Hermione's first contact with mental health care took place after she "flipped out" when a classmate drank from her water bottle to tease her, knowing she was afraid of germs and would never allow anyone to use her bottle. In response, Hermione threw the water bottle at her classmate. Instead of punishing Hermione, her teacher sent her to see the school guidance counsellor. Fortunately, Hermione found that the services she received were helpful. She explained how she had a positive relationship with the therapist with whom she was paired:

> This therapist that I was sent to for long-term therapy starting at age 15 helped me so much. She was able to unravel and name that I was abused by my mother and by my family. … She helped me unravel, like, the worst of my medical trauma. … We had a really good connection. So, additionally, I've always had very good fortune in getting the right people for me. … She was this sarcastic, witty, intelligent person who's been through hell and back as well. And was able to, like, help me pull through all the shit. It was a really good relationship, and I was so, so, so sad to go. … But, she was able to untangle so much of me, and it was through her help specifically that I was able to get involved with queer community and start to become an activist child and finding coping mechanisms and dealing, finding ways to just deal with shitty life.

Hermione had another positive relationship with a therapist they saw through an organization for queer and trans youth in the GTA, having found this resource through a referral from a young trans woman friend she had met through an online social network. Hermione appreciated that as a fellow queer Chinese Canadian, the therapist had a nuanced understanding of their background. They also valued the emphasis he placed on providing practical techniques for dealing with stressful situations as well as trauma and adversity:

> [He] was a very good fit for me as a therapist. He helped me get to the point where I was okay. … He helped me deal with the rest of my medical trauma. So, like, the ability to get a needle was the hugest thing that he did, helped me get through. And also, like, developing better capacity when it comes to resiliency and planning for, like, disasters. How to prepare best, and how to also do, basically harm reduction, and also picking yourself up afterwards.

Supporting Personal Growth

Participants explained that access to helpful mental health care helped not only to cope with their difficulties, but also to grow emotionally and personally in ways that they found to be beneficial for their lives. Reuben described how therapy had improved his social life, allowing him to make friends for the first time, at the university he attended.

Sandy explained how seeing a knowledgeable therapist who specialized in gender issues was helpful for her, enabling her to begin to process the difficulties she had faced and to start moving forward in her life in ways that reflected her identity and her values, becoming true to herself. Hermione described how her most recent therapist had helped her to gain perspective on her situation and develop practical coping skills that helped her to deal with the problems she faced. Discussing the therapist she had seen for several years as a teenager, she said, “I’m pretty sure she saved my life,” describing how the therapist had also helped her to establish her autonomy and “claw back power” from her mother.

Knowledge and Support of Gender Diversity

Some participants received care from professionals who understood and supported gender diversity as well as other intersecting identities and experiences. For instance, Nina found that the mental health care she received in her queer neighbourhood was respectful and understanding toward trans clients, and explained that her city's sanctuary city status made her more comfortable in accessing services as an undocumented immigrant, which demonstrates the importance of access to culturally competent/safe care.

Reuben explained how his long-term therapist had been helpful for him because she provided a space for him to discuss his concerns without making assumptions about what he should do, stating, "I'd talk about my anxieties about the whole process, and she just listened." Hermione described how their experience with seeking a letter of support for gender confirming medical care was successful, and that it also led to their finally being diagnosed as autistic. They described their relatively positive interaction with the psychiatrist who diagnosed her with GID and autism, saying that he was "completely forthwith about how fucked up the system was around trans things and autism things, so he just was transparent through the whole discussion."

After having accessed unhelpful private therapy, Alesha explained that they were finally able to work with a knowledgeable therapist through services at an 2SLGBTQQIA+-focused health clinic in the GTA. They described how the clinic provided a place where they could work through some of the issues they were dealing with without a time limit, and it ultimately had the positive impact of "stabilizing and offering [me] opportunities of room for growth and a little bit of clarity that I wouldn't necessarily have had otherwise." They also explained that this helped them to cope with especially difficult situations such as family relationships.

Helping Engage with Family Members

Quinn and Alexandra were both able to avail themselves of the assistance of health care professionals to help their family members to better understand what being transgender meant. Alexandra explained how she had attempted to take her own life after coming out as trans. Following this, her mother enlisted the support of a psychiatrist to help Alexandra's father to accept and support Alexandra as a trans person, relying on the doctor's position as an authority figure. She explained, "My father kind of—after that, he kind of saw what was what, and he was like, "Well, dead kid, trans kid? Rather have the live kid."

Quinn discussed how they were able to use the five month waiting time for a referral to an endocrinologist to discuss their choices with their parents and to go to a knowledgeable therapist with their mother, to be sure that she would fully understand the situation. Quinn also decided to bring their mother to their endocrinology appointment, which gave their mother the opportunity to get answers to all her questions.

Supportive Non-Medical Staff

Quinn noted that the endocrinologist's staff were knowledgeable and supportive, which is an example of the important role that welcoming and well-informed administrative and support staff in medical spaces play making gender diverse patients feel comfortable (Goldhammer et al., 2019, p. 321; Lawlis et al., 2019, p. 427). Several participants mentioned the importance of staff in promoting a safer and more accessible environment. Sandy described how her family doctor's staff was friendly and emphasized how that "secondary support" helped her to feel comfortable accessing care. Hermione agreed, describing how welcoming administrative staff, specifically a friendly receptionist, made a difference for her in making her feel comfortable at her doctor's office.

Making Connections with Other Services

Participants recalled that one of the particularly helpful dimensions of the care that they received was when they would be connected with a broader range of services in their community, or even within the same clinic. Connected or collaborative care models have been shown to offer a range of benefits to mental health care clients (Cappelli & Leon, 2017). Hermione discussed how the social services agencies through which they accessed therapy as a teenager also put them into touch with other community-based programs that contributed to their well-being, including a queer youth group and a gender art program focusing on performance art. Bryce explained how after they moved, their new counsellor helped them to connect with the services they needed, including a family doctor. Alesha highlighted the connected design and the "inclusive and multi-modal" approach of the GTA 2SLGBTQQIA+-focused health clinic where she had received services as an important contributor to her positive experience there. Alesha explained, I feel like they get it, and that is really apparent in interacting with them."

Spirituality, Religion and Pastoral Care

Due to the limitations of my own perspective as a non-religious person (albeit one who had been raised Catholic and had attended Catholic schools), it had not occurred to me to ask participants in this project about spirituality or the role that religious organizations might have played in their experiences with respect to mental health. My personal experience with religion in regard to mental health care was limited to a single (presumably well-intended but ultimately inappropriate) encounter with a psychiatric nurse who encouraged me to convert to Christianity during a counselling session that I attended as part of the inpatient program I was in as a teenager. Undertaking interviews with participants, I learned that spirituality and religion had been important sources of support and assistance in their lives, and I explore this theme below.

Negative Encounters

A few participants did recount negative experiences in relation to religion. Mark once had a somewhat similar experience to my own. He explained that many of the nurses working in the inpatient program he was placed in as a teenager were religious, often referring to their faith in ways that he recognized were not appropriate but he felt were less hurtful than they could have been:

> The nurses were all right. They also didn't quite know what to do. Like, a lot of them were very religious and Christian and stuff like that. But very, very careful about saying, you know, "Well, everyone has a cross to bear," right? And kind of that talk. I mean, I would take it over the "you're going to hell" type of stuff, right?

Hermione described how her mother had sometimes used religion coercively, describing how her mother's own struggles with mental health could manifest in ways that harmed Hermione, including a time when she abducted her to a Buddhist temple.

Spirituality and Religion as Support

People explained how they found religious and spiritual practices helpful. Alesha identified as a pantheist, explaining, "The universe constitutes a divine unity… It's just one, big flow of matter and energy, and that fundamental unity of everything is what constitutes divine." As a spiritual coping strategy, Alesha used their "anxiety rock"—a large, smooth pebble that they had found on a beach to centre themselves and cope with difficult situations "if you just, like, put it in the palm of your hand and focus on the weight, it is incredibly grounding." This practice can also be interpreted through the lens of new materialism: Alesha and the rock were entangled, its presence impacting their sense of safety and well-being, intra-actively enabling them to persist through the stressful, chaotic or triggering situations in which they were embedded. They alluded to the power and agency of the anxiety rock in a tongue-in-cheek critique of health care services: "This pebble is better for my mental health than basically all of the institutions there. Like, come on. Get on rock's level."

Mark turned to spirituality as an alternative to therapy after enduring so many negative, unhelpful experiences with therapists and community-based supports:

> I mean, I just gave up, honestly. I gave up. I started going to a Korean [Buddhist] temple instead, which helped, kind of. I just kind of figured there's no help in therapy, there's no help in the community. It's maybe another route that needs to be taken to kind of give me the resilience and the tools that I need.

Faith was a very important part of Miriam's life. She attended church throughout her life and when she went back to university, she decided to attend a religious institution, where she continually advocated for the adoption of trans and queer-friendly policies. She shared that her decision to come out as a trans woman was sparked by the listening to a gay couple from her church discussing their experience of accepting themselves. Miriam explained that there is often a disconnect between faith communities and the queer and gender diverse communities and discussed some of her work to bring these communities together:

> In queer communities, we don't talk about faith. And in many faith communities, we don't talk about queer stuff. I am one of the few people that's bridging that. I've facilitated two workshops at Anglican churches in [an Eastern Ontario city], or three over the past year. Two at one church and one at another. And I did the congregational resource day at the Diocese—I did a workshop about trans issues, mostly.

Positive Encounters with Religious-Based Services

Gender diverse people have previously reported a range of positive and negative experiences in relation to religious-based counselling (Buser et al., 2011). In this project, religious-based mental health and social services were significant sources of support for several participants. While Miriam was attending university, she was able to access counselling from a church that offered counselling support to students. Although this did not work out well because the counsellor was inexperienced, she was then able to turn to another religious-based counselling service and found a counsellor there who was a better fit for her. Sandy described how although she was ultimately unready to proceed with a longer therapeutic relationship and needed to move on with another medical referral, she did feel welcomed by the counsellor she saw at a religious social service organization:

> It was through a religious organization, so I kind of took it from a distance. She was nice, though, and… I explained to her I was atheist, and I hoped that didn't change anything. And she said, "Well that's not the issue at all. Don't worry about it." I went there for about three or four sessions.

Pastoral Care

Alexandra and Miriam both received pastoral counselling from clergy members. Alexandra described her positive relationship with a chaplain whose lecture she had attended:

> So I go to see this guy and he's, like, super—he ended up being the chaplain at our wedding, actually. … We pretty much made weekly meetings, and he's the chaplain for [the university], so he could just book me in, and it was free through the university. He was just, like—let me do most of the talking and tried to give insights back and in general was always just very actually helpful and understanding. And obviously had probably a deeper understanding about mental illness and depression and a lot of these things than a lot of the psychiatrists did because he just, like, loves people and, you know. I found him an amazing resource for getting through that whole period.

Miriam told me how the pastoral counselling offered by the priest at her church was important to her as a young adult, explaining that she appreciated that he was easy to talk to. Later, Miriam's church also offered her material support: After she was left without enough money to pay her bills due to having been required to pay out of pocket for multiple therapy sessions when seeking access to hormone therapy, Miriam was fortunately able to access direct financial assistance from her church, something that is not typically available from other kinds of services offering counselling:

> If you’re so depressed that you’re barely functioning, how can you fill out the paperwork to get your Trillium benefit?[75] Because it’s all fine and dandy for the psych to say you can apply for it, but then not provide any assistance with actually getting paperwork done. And then, I think it was the end of that month… I did get some financial support from the church through the … rector’s discretionary fund, which is really common in Anglican churches. … The way it works at that particular church is there’s a separate bank account, and the rector has a bank card. If somebody’s in need, they can just get cash or get grocery cards, and it doesn’t have to be written down, so complete confidentiality.

Informed Consent

Informed Consent Challenges Gatekeeping

As evidenced throughout this chapter, informed consent-based care was important for those who were able to access it. While it is now somewhat more available, it was still far from being the norm at the time these interviews took place. The importance of enabling people to make their own decisions about their bodies and lives comes into particularly clear focus when considering the contrast between participants’ worry-inducing, negative and even traumatic experiences with gender-related gatekeeping, and the positive and relief-inducing experiences they described in relation to informed consent-based care.

Ashley (2019a) critiques the gatekeeping model of transition-related health care that dominated the experiences of most of the participants in this research, and which persists in the current WPATH Standards of Care. In contrast, she explains how the informed consent model works:

> The informed consent model shifts focus away from the assessment of gender dysphoria and the provision of mental healthcare and instead sees the obtention of appropriate informed consent as the primary role of [transition-related care] providers. Providers working under the informed consent model typically record consent on a document listing the potential benefits, risks and limitations of HRT [or other gender confirming procedures]. Working under the informed consent model includes discussions of the patient's expectations, decision-making process, understanding of risks and benefits, support structures and general health, but does not involve an evaluation of their gender or whether they are truly trans. The goal is not to assess but to facilitate thoughtful decision-making. The model ensures that the decision was not made in haste without appropriate knowledge and forethought, while preserving patients' own authority over their experiences and avoiding the dehumanising process criticised in the present article (p. 480).

Schulz (2018) explains that in regard to transition-related services and procedures, the informed consent model was developed by trans patients along with health care providers who recognized the gatekeeping model as a barrier to accessing care (p. 83). Ashley (2019a) argues that the epistemic authority of people who seek transition-related care should be recognized. She points out that being trans is not pathological, but a part of human diversity, and that desiring access to transition-related care can be motivated by factors other than gender dysphoria, including gender euphoria ("enjoyment or satisfaction caused by the correspondence between the person's gender identity and gendered features associated with a gender other than the ones assigned at birth") and creative transfiguration (which "sees the body as a gendered art piece that can be made ours through transition-related interventions") (p. 481). Schulz (2018) concurs that being trans is by no means a uniformly negative experience, nor one that is accurately and entirely captured by the dominant, binary trans narrative (pp. 78–81). She notes that gender dysphoria itself may arise in response to the intense societal discrimination that trans and gender diverse people face (pp. 77–78), representing another pathologization of a social and political situation by the DSM (Riggs et al., 2019). Cavanaugh et al. (2016) point out that eliminating the gatekeeping role could also make mental health care more beneficial for trans clients, with greater trust and an emphasis on the client's actual needs (p. 1150).

Informed Consent and Transition Care Access

For Reuben, finding a surgeon who worked on an informed consent basis meant that he no longer required a referral letter, which gave him the freedom to stop seeing his counsellor when the sessions were no longer helpful to him because of the counsellor's continued insistence on focusing on relationships and sexuality, despite Reuben's disinterest in those topics. Quinn asked their doctor for a referral to a supportive endocrinologist they had heard about through a friend. The doctor agreed to make the referral, which allowed Quinn to access hormone therapy without having to deal with the CAMH waiting list or being required to undergo multiple counselling sessions to prove that they were "trans enough."

Io explained that they had recently decided to start hormone therapy, explaining that they planned to go to a clinic in their area that operated with an informed consent model and allowed self-referrals.

After Alexandra's arduous and costly quest to get a letter of support for her orchiectomy did not succeed, her endocrinologist finally referred her to a surgeon who would perform the procedure without the letter. Although she had to endure yet another bureaucratic intake process, she expressed that once she had the procedure, she felt less worried about the possible future impacts on her body of being barred from access to hormones by medical practitioners:

> Finally I didn't—I felt kind of free from psychiatrists because it was like I had my letter. You know, if they take me off of hormones I'm not going to grow, like, hair on my ass.

Ray argued that it is nonsensical to put cisgender people who uphold the outdated and limiting transnormative narrative in the position of assessing whether trans people's identities are valid:

> If I want to take testosterone, I should be able to get it. I shouldn't have to go through this ridiculous screening process where, like, how trans I am is measured on a scale that someone's checking off in an office… And the whole time you're going through this, you're worrying about, "Am I trans enough for this cis person? And what the fuck does this cis person know about being trans?" All of these self-appointed experts have put themselves in these places, and they're all cisgender. What the hell do cisgender people

> know about being trans? Don't make it one narrative that you have to have and if you're not conforming to this then you're not trans.

Miriam discussed the importance of allowing people to undertake risks in an informed way:

> The latest standards of care are fairly broad around a number of things, but we still have a lot of practitioners who are very narrow… It shouldn't be up to the doctor. If somebody's medical history has contraindications for something like hormones, the doctor doesn't want to prescribe because of the risks. But … what other harms are you doing by not prescribing?

Limitations of Informed Consent

While it represents a positive step away from a paternalistic, gatekeeping-based model and has led to meaningful improvements in access to care for some trans and gender diverse people, the informed consent model retains some problematic elements that are likely to result in ongoing exclusion from access for people located at the intersection of multiple marginalizations. Shildrick's (1997) embodied feminist analysis of deontology-based health care ethics reveals that they are not truly neutral or universal despite their claims (p. 2). She explains that although medical practitioners often objectify patients (pp. 76–77), the ethical ideal within health care is "a transaction between two self-determining moral agents" (p. 8). Because the ethical framework within medicine is humanistic, decontextualized, masculinist, white supremacist, ableist, sanist, heteronormative (and, I would add, cisnormative), its concept of the rights-bearing subject excludes those whose identity differs from that of the ideal subject (pp. 62, 70, 83, 107). It is also a disembodied ideal. The objectification and rejection of the body and embodiment within health care ethics is enormously problematic. As Krieger (2005) notes, embodiment is a "multilevel phenomenon"—a construct, a process, and a concrete reality that is always bound up with the psychic, cultural, social, political, ecological and historical (p. 351). Social inequalities such as systemic racism are expressed through embodiment (p. 353). This shows that people's bodyminds and lives cannot be adequately understood or accounted for through a disembodied and objectifying lens like the one upheld within traditional health care ethics.

The persistence of a disembodied ethical ideal within health care also has particularly problematic impacts for those perceived as other than rational due to their relationship to embodiment, which is often the case for cisgender women (p. 81) and is likely also the case for transgender people seeking access to gender confirming care, as they too inhabit "bodies which they have failed to transcend" (p. 81). Shildrick (1997) points out that exclusion from the notion of the rational, self-determining subject may mean exclusion having the capability to consent, at which point paternalistic professional judgments are reasserted (p. 85, 119). Shildrick calls for changes to health care ethics to understand moral agency as embodied and contextual, replacing "objectivity" with reflexivity (p. 138), and a limited view of subjectivity with one that expands to account for the "constant reformation" of the subject "in specific, local and temporary configurations" (p. 154), replacing binaries with multiplicities (p. 157).

Conclusion

Participants stories show that what gender diverse people need in regard to mental health care and gender confirming care—is a wider range of options that are accessible through publicly funded insurance and that are offered on the basis of informed consent. Further, the concept of informed consent itself requires interrogation, to move beyond the cisnormative, racist, and misogynous ideologies that constructed transness as undesirable and aberrant in the first place, and to ensure that the subjectivities of diversely situated trans people are genuinely recognized, and their needs truly met. An embodied health care ethic would account for the multiple dimensions of the physical, social, cultural, and political that shape becoming bodyminds. For mental health care this would involve having access to a choice of providers working from within a wide range of therapies/modalities, using both medical and non-medical approaches. As Alesha and Mark's contrasting experiences with gender diversity-aware service providers shows, what works well for some may not be the right option for others, which is why having access to options is so important. For gender confirming care, some progress has been made, as the CAMH monopoly was finally eliminated, but the bottleneck is not close to being resolved. As I mentioned earlier, the ongoing impacts of the COVID-19 pandemic have significantly exacerbated this problem, with many procedures cancelled or postponed (Donato, 2020). The problem of a lack of choice of providers and procedures also persists, with only limited progress having been made. For example, as I mentioned, at the time these interviews were undertaken, Canada's only vaginoplasty provider was in Montreal, and as of 2020, there are now two additional providers, one in Toronto (Bresge, 2019) and one in Vancouver (Vancouver Coastal Health, 2020). Gender confirming care is not equally accessible to all gender diverse people due to persistent barriers in regard to equity, including ongoing structural racism within health care. Further, the long list of non-funded procedures remains, making financial inaccessibility an ongoing reality.

Alesha praised a GTA 2SLGBTQQIA+-focused health clinic where she had accessed supportive care, suggesting that it could be a helpful model for how health care could be delivered in ways that foreground the reality of intersectionality in regard to people's lives and health:

> So, like, if one positive thing came out of my experience with the mental health care system it's—at least there are models that are on the right track, and that is [the clinic]. I cannot say the same for other places. I also feel like to some extent it's probably that the people there are all—it's a very queer space. The politics of the whole thing seem to be super-duper on point, which seems like it would be hard to do outside of a [large city]. It's a good model, but I also think it is a particular manifestation of a lot of good politics and a lot of good effort coming together in a way that's like, yes. To the extent that we can do it, this is what mental health care should look like because there's so much going on, and there's a lot of respect for, like, talking about intersecting identities and intersecting forms of health. And that's really great, but it's a lofty goal. And it's a moving target and, doubtless, there's so much room for improvement…

The supportive, positive encounters shared by participants show that mental health supports can promote individual resilience and improve well-being. What brings together the positive experiences with services and practitioners from a wide range of modalities is that they were all situations in which clients were able to make meaningful choices and were treated with respect by staff and clinicians. The harmful, negative encounters that participants discuss show that there are too many ways in which coercive care has continued to predominate and care that respects autonomy remains inaccessible geographically, financially and culturally. In regard to the provision of individual supports for mental health difficulties and trauma, what should happen is that a much broader range of non-pathologizing supports should be funded by the government, giving people access to options that work for them. What is actually happening is quite the opposite, as waiting lists increase, the medical model solidifies its position of authority, and services reliant on “cost-effective” service delivery models such as brief therapy (De Geest & Meganck, 2019) and online CBT programs proliferate (Linton, 2020).

The fact that most of the participants with whom I spoke had survived difficult, exhausting, and traumatic encounters with a system that was supposedly put in place to help them shows that members of the gender diverse community are already resilient. The dismantling of the gatekeeping system that forced/forces people into contact with the mental health system to access transition-related procedures and services must continue and an equitable informed consent-based system with adequate capacity must be created.

The question of what a more genuinely supportive health care system would look like for diversely-situated gender diverse people is a critical one. It cannot simply be a matter of expanding access to programs that medicalize and individualize problems rooted in injustice. Discussing Global North-led efforts to “scale up access to mental health services and psychotropic medications” for poor and racialized people living in low and middle income countries, Mills (2015) argues that this represents an “oppressive synergy” of poverty and psychiatrization that will result in even worse outcomes for those who already face oppression (p. 219).

Chapter Twelve: Conclusion

When I asked participants what kinds of changes to society and institutions they thought would help improve their lives, they shared valuable insights about how to make things better for trans and gender diverse people, and for everyone. I will share their perspectives throughout this concluding chapter.

Improving Mental Health Care for Trans and Gender Diverse People: Promoting Culturally Competent/Safe, Equitably Accessible and Community-Led Care

Although some participants mentioned times when they had received helpful, supportive care within the mental health care and related social services systems, many also described facing transphobia and transmisia. Some of the "care" participants received was deeply harmful and damaging. Participants were subjected to programs that failed to acknowledge the existence of trans people; assessments and "therapies" that promoted the idea that being trans is negative or shameful, something that should be denied and hidden rather than accepted and embraced. Lacking access to a choice of providers willing to provide care for trans and gender diverse patients, some participants encountered practitioners who had committed misconduct and malpractice.

These experiences demonstrate the importance of promoting access to culturally safe services for diversely-situated trans and gender diverse people across the health care and social services. Bryce and Io argued that mandating the inclusion of information about 2SLGBTQQIA+ people in education and training programs for all health care and social service professionals could help achieve this goal. As Bryce put it,

> All of these professionals, all of these doctors and counsellors and everything, they need to be educated on people that are queer, people that are trans… You can't help people if you don't know anything about it.

Training could help more trans and gender diverse people to access care, as it would provide the requisite competency to more practitioners. Culturally competent and safe care for 2SLGBTQQIA+ people must be intersectional, responding to the specific needs and interests of differently situated community members, including those who are racialized, Indigenous, newcomers, otherwise-disabled (Withers, 2013), and on a lower income, as these dimensions of social location have specific and interlocking impacts on health and well-being, including particular structural and attitudinal barriers to accessing services within a health care system damaged by neoliberalism-driven underfunding and still dominated by colonial, racist and white supremacist, ableist, sexist/cissexist and classist values. Beyond a training mandate, further work to decolonize and counter oppression in health care must also take place, including by centring and working in partnership with communities to create relevant and safe programs and services; and challenging the primacy of the model of individual pathology that shores up ableism and negates the impacts of the social, political and cultural (Dryden & Nnorom, 2021; Janz 2019; Neilson, 2020; Tremblay, 2020).

Not only must health care be culturally safe for 2SLGBTQQIA+ community members, such care must also be available and accessible across all intersections of the community. Some participants shared that they had sometimes entirely lacked access to the mental health care they sought. Care was sometimes inaccessible due to the geography of health care resource distribution in the province. Immigrant status was also a barrier to accessing care for some participants and their family members. For most participants, the financial inaccessibility of private mental health care or support also played a major role in limiting access. Because so many trans people live on a low income and face employment discrimination, improvements to the accessibility of publicly funded mental health care and counselling services across the province are especially important for trans and gender diverse people. Alesha explained how better funded and more trans-inclusive health care would improve her well-being and reduce her stress:

> If all health care always was free… medications were free, we just actually did a health care system like we said we would, then it would be oodles better… The majority of my stress around access to care would just not be there, which would be beautiful. It would feel like there would be these bright new shiny moments of knowing kind of what cis privilege feels like. You can walk in to a health clinic and expect your needs to get met.

Several participants cited counselling and psychotherapy as services that they had found helpful, or that they wished they could access. These services are often less accessible than more medicalized, medication-based options intended to address distress. The options for OHIP-funded counselling and psychotherapy are limited and often have long waiting lists, and trans people are less likely to be able to afford to pay privately or to have workplace insurance covering these costs. Participants also shared that they often encountered providers who were not familiar with 2SLGBTQQIA+ clients. This poses an additional barrier to accessing this type of support, given the importance of developing and maintaining trust and understanding with a counsellor or psychotherapist (Cahill et al., 2013; Kastrani et al., 2017). Hermione described how her work with culturally safe, supportive counsellors had improved her life:

> Honestly, I should be a good example for a model of… how to do the mental health care system. My life is a better example. Because I needed an intervention. I had a lot of support that got me in to develop my strengths in some amazing ways so I wouldn't fall between the cracks, as I was bound to do. But I still faced barriers.

She envisioned a world in which she could move beyond basic survival:

> Therapy was great. Mental health service was great. It got me to the point where, like, I should be really successful, but I'm still falling between the cracks at the end of the day because the world is horrible and built to try to destroy me. I can survive, it's just not—I'm not thriving.

Transforming Transition Care

The shift away from having the CAMH gender clinics as the sole gatekeeper determining access to transition-related care toward a more decentralized system was an important step forward, but it did not completely end the practice of gatekeeping. As Hong Lam & Abramovich (2019) point out, in Canada, guidelines for the prescription and monitoring of gender affirming hormone treatment and for referrals for surgery are now available to family physicians. This means that access could be much more readily available, but this shift has retained physicians as gatekeepers, and many doctors still feel unprepared to support trans patients' transition care needs (Blodgett et al., 2017), which results in ongoing limitations to access. Programs designed to educate family physicians and other health care providers about trans health care—such as those delivered by Rainbow Health Ontario—must continue and be ramped up to facilitate more equitable access to health care for 2SLGBTQQIA+ people across the province.

Around the time of the CAMH gender clinic closures, participants had hypothesized that addressing the bottleneck they caused would speed up access to transition-related care, but since the move toward decentralization took place, the bottleneck has persisted. Because there are so few OHIP-covered options for transition-related procedures, long waiting lists have remained in place. As several participants pointed out, many of the kinds of procedures that people require remain unfunded and inaccessible. To meet the transition-related care needs of trans and gender diverse people in Ontario, additional resources must be provided to address the current causes of bottlenecks. Reuben pointed out the importance of providing timely care, noting that the lack of access is harmful and may cause additional demands upon the health care system, as those waiting for care might need mental health supports, to "help them get to the surgery."

Despite a long-standing critique of these gaps in coverage, it remains the case that only a limited range of gender-confirming procedures that are covered by provincial health insurance in Ontario. Among those procedures that are covered, few choices in regard to types of procedure are available. Participants described how they were negatively impacted by the provision of suboptimal gender confirming surgeries and a lack of options to accommodate a much broader range of physical differences and preferences. They argued that more categories of procedures should be covered by OHIP, and that access to higher quality care should also be made available. Ontario policy makers can potentially look to Yukon as a model for how to begin to address these needs: In response to many requests from the trans and gender diverse community and in recognition of the importance of access to transition care for many community members' well-being, a much more comprehensive list of gender confirming procedures is now covered by the territory's insurance program (d'Entremont, 2021; Government of Yukon, 2021).

In addition, as participants pointed out, a shift toward an informed consent-based model of transition-related care could help to address the ongoing issue of gatekeeping by medical practitioners, as well as the unfair requirement that those seeking access to transition care must meet DSM criteria for Gender Dysphoria, which is by no means universally reflective of community members' experiences. At the same time, because the concept of informed consent itself is rooted in an ethical framework that does not recognize the moral agency of oppressed people (Shildrick, 1997), movements in this direction must also intervene in the notion of informed consent itself to ensure that exclusion is not perpetuated.

Addressing the Social Determinants of Health, Promoting Well-Being for Trans and Gender Diverse People

Like Hermione, all participants had experienced difficulties in regard to the social determinants of health, in ways that substantially affected their well-being. Alesha described the embodied, emotional and social impacts of the multiple dimensions of systemic discrimination facing trans people:

> It's not actually even a bad thing that I'm trans. It's just there's so much negativity and systemic bullshit around it that, like, basically it's not bad that you're trans, it's just every aspect of your "transness" will come with some shitty piece. It's not bad that you're

> trans, it’s just that you have to take the time to medically transition. It’s not bad that you’re trans, but you have to take the time to transition your voice. It’s not bad that you’re trans, it’s just that you’re going to spend a lot of time depressed and not working. It’s not bad that you’re trans, it’s just you’re going to have, like, anxious outbursts. It’s not bad that you’re trans, it’s just transmisogyny’s a thing, so you don’t like your body and can’t fucking orgasm easily. Yeah. So, like, not having those things would be awesome, and the benefit would be, then, I could function on the level of a cis person. And wouldn’t that be nice if everyone could be happy and productive citizens at the level of privileged cis peoples?

Social changes to promote the inclusion of trans and gender diverse people were a focus of many participants. Alexandra and Sandy hoped that gender norms could be eliminated, which would free them and others to express themselves outside of the constraints of the binary gender system. As Sandy explained,

> I think, like, it would be ideal to remove this whole sort of gender norm or this, you know, male-female thing… Instead of expanding the fence to include certain types of people or framing them in a certain polarized way, just to remove the fence altogether.

She thought that having clear laws and policies acknowledging the human rights of trans and gender diverse people would be one way to work toward this goal. Alexandra, Ray, Quinn and Io argued that formal education could play a key role in promoting the well-being of trans and gender diverse people by advancing understanding and inclusion, noting that curricula acknowledging the existence of trans people would help trans youth to understand themselves and help promote greater social acceptance. Referring to the 2015 updates to the sexual health education curriculum in Ontario that finally included content about trans and queer identities (Larkin et al., 2017)—changes that were initially rescinded but later largely reinstated by the subsequent PC government (Laucius, 2019a)—Quinn explained,

> I had no access to information… I didn't know any of this. I had to find out like through meeting people and then online, other informal mechanisms. Like the fact that sex education is changing in Ontario now, that's huge…

Io described how their life would be different if all youth had access to information about gender and sexuality:

> In a world where people are more knowledgeable and, like, in a world where people learn these things at a young age… I would be living in less fear. I would be living with less self-hatred.

Many participants had faced difficulties with accessing employment due to anti-trans discrimination, as well as intersecting discrimination on the basis of disability, race and immigrant status. Participants who were receiving income support or who were unemployed struggled to afford basic expenses, especially as food and housing costs rose during a time when very little was done on a policy level to mitigate these problems. This put some participants into precarious situations and even caused Nina to lose her housing all together. Housing discrimination also impacted some participants. These stressors had significant impacts on the health and well-being of participants throughout their lives.

Hermione argued that efforts to put trans, racialized and disabled people into positions of power could help to address the problems of social and economic exclusion facing community members:

> I want to see people like me in positions of authority. What they need to be working on is finding and training and supporting people with those identities.

Some participants critiqued neoliberal capitalism as a root cause of the difficulties facing the trans and gender diverse communities. Sandy and Io critiqued the pinkwashing of mainstream 2SLGBTQQIA+ Pride events, pointing to their connections to the same dynamics of exploitative capitalism that immiserate the trans and gender diverse communities as well as other oppressed people in Canada and transnationally. Quinn and Alexandra suggested that a guaranteed income could help mitigate the impacts of discrimination, while also challenging ableist ideologies of "deservingness" and providing a sense of security. As Quinn explained, with guaranteed income, "You eliminate that anxiety of, 'Where's my next paycheque going to come from?'" Income is a key dimension of the social determinants of health, facilitating access to better housing and food as well as to social participation and inclusion, so reforms to provide adequate, liveable income could contribute to substantial improvements in the well-being of trans and gender diverse people.

Challenging Neoliberalism in Mental Health Care

The trajectory of mental health care policy in Ontario has long been consistent with neoliberal ideologies of individualism and responsibilization. As I described in Chapter Four, the policy in place at the time this research took place—captured in the then-current Liberal government's *Open Minds, Healthy Minds* document—constructed good mental health as an individual property that can be cultivated through education promoting individual resilience. This positioned the improvement of people's personal capacity to withstand adversity as a goal of the policy.

At the same time, the policy statement also appeared to recognize the importance of the social determinants of health for mental health and well-being, but the practical implementation of related policies pertaining to the social determinants of health revealed that these were not truly government priorities. For instance, promised investments in social housing have not kept pace with the needs of Ontario residents (Ontario Non-Profit Housing Association, 2016) and while rent control was extended, vacancy decontrol was retained (Centre for Equality Rights in Accommodation, 2021), contributing to an ongoing affordability crisis in housing and high rates of homelessness (Financial Accountability Office of Ontario, 2021). Increases to the minimum wage and some improvements to labour laws were made, but these changes still left many Ontario workers far below the minimums needed for a living wage or a "good" job (Evans et al., 2021; Luxton & McDermott, 2021). Pharmacare was introduced for children and young adults through the OHIP+ program, but those over the age of 24 were excluded (Levy et al., 2019). Many lower-income post-secondary students were given access to non-repayable grants with the 2016 changes to the OSAP program, improving access to education (Ontario Ministry of Finance, 2016), but existing provincial student debt was not forgiven.

After the Progressive Conservative government was elected in 2018, they rescinded most of these incremental changes, limiting rent control (Centre for Equality Rights in Accommodation, 2021), eliminating statutory paid sick days (Vander Weir, 2019) and cancelling future increases to the minimum wage (Canadian Press, 2018), restricting access to OHIP+ such that those under 24 who had access to private drug coverage, even if inadequate, were no longer covered (Levy et al., 2019), and converting OSAP back to loans, leaving people worse off and more vulnerable (Laucius, 2019b). Their mental health policy statement, *Roadmap to Wellness*, invoked the individualistic, neoliberal discourse of "wellness," eliminating nearly all references to "well-being." The policy's neoliberal thrust is clear, with almost no recognition of the social determinants of health, very few mentions of the health care and social provisioning needs of oppressed communities, and maintaining a strong emphasis upon individual, medical and psychological intervention as a primary means of promoting mental health in the service of economic productivity. The policy's embrace of cost-effective "new technology" and its orientation toward surveillance, standardization and efficiency are also consistent with a neoliberal ethos. As a result of these regressive changes, the lack of funding for the kinds of mental health care supports identified by participants as especially helpful, such as counselling and psychotherapy, persists. There is no plan to systemically address the dearth of 2SLGBTQQIA+-friendly practitioners, and no efforts to address the social determinants of health are forthcoming.

The underfunding of health care and the continued lack of meaningful response to social inequality as captured by the social determinants of health has worsened the COVID-19 crisis and the policy response to it. This has disproportionately negatively impacted racialized and Indigenous people, people living on a low income, as well as women and gender diverse people.

These impacts may be further compounded for people located the intersections of these dimensions of marginalization. The crisis has made plain the unsustainability and cruelty of neoliberal policies that disregard the health, well-being and basic safety of oppressed people, further clarifying the importance of supporting policies that centre the needs of people, rather than the interests of businesses and investors.

Directions for Future Research

To further contribute to the understanding of the experiences of trans and gender diverse people in Ontario, there are several areas raised in this research that could be explored in greater depth in future research. For example, research could be undertaken to understand the impacts of ongoing gaps in access to transition-related care. This could more directly address the effects of long waiting lists, the lack of OHIP coverage for many of the transition-related procedures that people may need, and the limited availability of choices and options for the procedures that are covered—including access to advanced and specialized procedures that may result in more positive outcomes for the people receiving care. Because so much of transition-related care is still considered “cosmetic” in Ontario and is only available privately, trans people essentially already live in a two-tier health care system, with access to transition care determined by ability to pay.

This project reflects the situation at a pivotal moment for trans health care in Ontario: As I discussed, the monopoly of the CAMH gender clinics over OHIP-funded access to gender confirming health care was terminated just as I was conducting interviews, so most participants’ experiences with transition-related health care gatekeeping took place prior to the changes. It would be useful to compare these experiences with those of people who have navigated the more decentralized system.

It would also be illuminating to explore trans and gender diverse people's experiences in regard to the most recent developments in mental health care policy and practice in Ontario, including the new emphasis on telephone and internet-based mental health coaching and CBT programs, currently positioned as responses to the stresses caused by COVID-19 pandemic (Government of Ontario, 2021). Because these programs were not primarily designed to respond to diversely-situated people's specific social locations, it would be helpful to learn about trans and gender diverse people's experiences with them.

As a methodological point, because research focusing on the trans and gender diverse communities is necessarily intersectional, I believe that it would be best undertaken collaboratively, ideally with community organizations to form a team of diversely-situated investigators and stakeholders. As Clark et al. (2017, p. 171) and Clark and Hunt (2011) note, undertaking intersectional research work with a team can prioritize community perspectives and benefit from the diversity of researcher perspectives and locations, while allowing for a better understanding of the positionalities and experiences of community members.

Finally, researching the topic of the mental health care experiences of members of an oppressed group is obviously likely to elicit stories of difficulty, trauma and hardship. While it is important to examine and consider the problems faced by oppressed groups so as to understand what needs to change, the dominance of stories of pain can preclude the telling of other stories. As trans advocates have pointed out, it is just as important to create space for stories of trans joy, to highlight possibilities, freedoms and fulfillment in the lives of trans and gender diverse people (Burt, 2019; Dale, 2021; de la Cretaz, 2021).

Conclusion: Resilience in the Trans and Gender Diverse Community

I believe that this research has shown that despite facing discrimination and oppression in many aspects of life in Ontario—including within the health care system—trans and gender diverse people have demonstrated remarkable resilience, especially considering the many difficulties they face. Although resilience is often understood as a purely individual, internal resource, it is more accurately conceived as arising relationally, in intra-actions and interactions between material, social, cultural and political contexts (Kimhi, 2014; Southwick et al., 2011). The stories of the participants in this research abound with evidence of their strength and their capacity to persevere in incredibly difficult situations, finding a way to withstand circumstances where few financial resources and limited social and emotional supports were available. Participants survived poverty, abuse, violence, racism, colonialism, unjust immigration policies, ableism, sanism, sexism, queermisia, transmisogyny and transmisia. These dynamics had challenging and even damaging emotional and social impacts, but even the participants in the most difficult situations were continuing on through exclusion and injustice. The participants in this project demonstrate the hollow unhelpfulness of neoliberal mental health policies emphasizing individualistic medicalization while ignoring the embodied and embedded social and political realities of people's lives. Sins Invalid (2019) describes the disability justice principle of the leadership of those most impacted as follows:

> When we talk about ableism, racism, sexism & transmisogyny, colonization, police violence, etc., we are not looking to academics and experts to tell us what's what—we are lifting up, listening to, reading, following, and highlighting the perspectives of those who are most impacted by the systems we fight against. By centering the leadership of those

> most impacted, we keep ourselves grounded in real-world problems and find creative strategies for resistance (p. 23).

The perspectives and ideas of the participants in this research show that trans and gender diverse community members should be leading the way toward the goal of collective liberation.

Notes

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[1] Well-being is the focus of this research because its promotion is a stated objective of the mental health policy current in Ontario at the time that interviews and digital storytelling workshops were undertaken (Ontario Ministry of Health and Long-Term Care, 2011, p. 4), and it is both more holistic and sensitive to context than "mental health," which is typically regarded primarily as rooted in individual pathology. I discuss this concept alongside the related concepts of wellness and resilience in Chapter Three of this dissertation.

[2] The term "enby" is a popular short form for the term non-binary, formulated in reference to the way the initialism "NB" is pronounced. Many people use "enby" rather than "NB" because the initals "NB" are already in use in the acronym "NBPOC," meaning "non-Black people of colour," so the variation enby is meant to respect the established usage for the initialism and clarify that "NBPOC" refers specifically to non-Black people of colour, and not non-binary people of colour (Mardoll, 2018).

[3] My use of these terms as well as the acronym 2SLGBTQQIA+ [Two Spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex, asexual + other sexual and gender identity labels] are intended to enable me to capture some of the diverse identities of members of these communities while avoiding the repeated listing of numerous identity categories. As Hardy et al. (2020) explain, placing 2S/Two Spirit at the beginning of the acronym serves to centre Indigenous identity "in an otherwise white-washed movement that takes place on stolen Indigenous land" (p. 2). This project is inclusive of a broad range of non-normative gender identities and the terminology used is intended to indicate this, but not every participant necessarily identifies with these—or any—specific labels. Identity labels and categories are constantly shifting and changing across gender diverse communities, and often vary over time for individuals themselves. Enke (2011a) provides a list of identity labels that gender diverse people have used. Some of these labels may now perceived as outdated or even as offensive (especially when used by outsiders or people who do not claim them for themselves), but this gives a sense of the diversity of the terminology that has been used by gender diverse people to refer to themselves:

> Transgender was … first a social movement organizing principle and came also to be the name of an identity that many people adopt to describe themselves. The ever-evolving list of trans-ing identities that now fit under the "transgender umbrella" may also include FTM, MTF, genderqueer, trans woman, trans man, butch queen, fem queen, tranny, transy, drag king, bi-gender, pan-gender, femme, butch, stud, Two Spirit, people with intersex conditions, androgynous, gender fluid, gender euphoric, third gender *and* man and woman – and that list barely scratches the surface (p. 4).

[4] I recognize that these statistics are problematic in that they are drawn from a quantitative research study that utilized mainstream, medicalized understandings of "depression" and "suicidality." I present them here with the objective of demonstrating that many gender diverse people in Ontario experience emotional distress. These statistics do not reveal anything about the reason why gender diverse people might be so distressed. One of the objectives of this research is to provide contextualized information about the causes behind these numbers.

[5] Serano's work popularized the use of cisgender to identify non-transgender people in a way that problematizes the construction of their identities as natural or taken-for-granted. On her blog, Serano (2011) cites a 2002 listserv post by Koyama (2002) as having introduced her to this usage. To quote Koyama: "According to Donna Lynn Matthews, the term 'cisgender' was first coined by Carl Buijs, a transsexual man, in 1995 (source: http://cydathria.com/ms_donna/tg_def.html)."

[6] While completing my work on this project, I inadvertently came across news articles indicating that this psychiatrist was charged with historic sexual assault and sexual exploitation of a minor. In the wake of this news, several of her former patients and their family members came forward to speak out against what they describe as the harmful treatment to which they had been subjected. One parent commented that she believed that her child had been overmedicated with risperidone, and others pointed out that they had filed complaints against the psychiatrist, but to their knowledge she was never sanctioned (Mazur & Mohamed, 2021; Pineau, 2021). The psychiatrist pleaded guilty to a charge of sexual assault and was given a conditional sentence of two years less a day, to include a year of house arrest and six months of nightly curfew (Martin, 2021).

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[7] I draw the term "bodyminds" from disability studies scholar Price (2015), who uses it to describe "the imbrication (not just the combination) of the entities called 'body' and 'mind'" (p. 270). As Schalk (2018) explains,

> The term *bodymind* insists on the inextricability of mind and body and highlights how processes within our being impact one another in such a way that the notion of a physical versus mental process is difficult, if not impossible to clearly discern in most cases (p. 5).

[8] Gender identity is now a prohibited ground of discrimination within the Canadian Human Rights Act as well as provincial and territorial human rights codes (Canadian AIDS Society, 2017). All provinces and territories allow trans people to change their birth certificate information without gender confirmation surgery. It is now possible to get a Canadian passport with a neutral gender marker (Immigration, Refugees and Citizenship Canada, 2019), and some provinces now offer a neutral gender marker option on driver's licenses. As noted earlier, in 2015, Ontario banned "conversion" therapy for minors and delisted it from OHIP (Ferguson, 2015). The Canadian government introduced a bill intended to put in place a similar nationwide ban of the practice in March 2020, but the bill was killed when parliament was prorogued several months later (Gajdics, 2020). The bill was reintroduced and passed the House of Commons in June 2021 and received Royal Assent in December of 2021 (Taylor, 2021; Treisman 2021).

[9] As Mills (2015) explains, the term psychiatrization refers to a specific form of medicalization, whereby people's lives increasingly come to be understood as "concerns for psychiatry" (p. 217).

[10] I use the word "queer" as an umbrella term to refer to people who are sexually and/or romantically attracted to people recognized as being of the same sex/gender to which they belong, and who (at least to some extent) incorporate this aspect of their lives into their identity. People in this group may identify themselves as Two Spirit, lesbian, gay, bisexual, pansexual, or queer, among other labels. Trans and gender diverse people may also identify themselves as sexually queer, but the subject matter of this chapter requires that I make some distinction between gender diverse people and queer people. That noted, I would like to note that I do not intend to exclude gender non-conforming people from queerness. Further, I try to avoid the use of the term "homosexual" unless I am referring to it as a diagnostic or historical entity, as I agree with Katz (1995) that it has pathologizing and "shameful" connotations (p. 1).

[11] In his writings on the history of madness, Foucault (2006) calls the widespread placement of mad people in asylums that took place during the 17th century in Europe "the great confinement," and argues that not only did the confinement of the mad have the effect of marginalizing them and rendering the general population more easily controllable, but it also produced the non-mad members of society as normal (pp. 48–77). Foucault's historical methods have been widely critiqued. The "great confinement" in the terms that he described it only took place in France. Elsewhere in the West and colonial contexts, there was a general increase in the number of people identified as mad and subjected to confinement, but this took place in a somewhat piecemeal fashion (Porter, 1987, p. 167; Deacon, 2003, p. 21; Peterson, 1982, p. 238). In fact, many of the institutions that people identified as mad were placed in were private, and not at all under the purview of the state (Porter, 2002, p. 100). Further, Foucault's contention that the tendency to confine those labelled as mad in asylums arose because madness was shifting away from being perceived as a state of moral disorder and toward being understood as a type of illness (2006, p. 86), is not borne out by historical evidence. In fact, the situation was reversed: When they were confined by the state, mad people were initially placed in *hôpitaux généraux*, workhouses, almshouses or poorhouses (Peterson, 1982, p. 111) along with non-mad needy people (Porter, 1987, p. 17).

[12] While theories such as those of Szasz and Laing characterized schizophrenia as solely a politicized diagnosis with no biological basis (Gray et al., 2000, pp. 40–42), many recent critics of the dominance of the biomedical model believe that conditions like that identified as schizophrenia may have some biological components, but this does not mean that the only way to approach them is to address only the biological factors that might be associated with them, or that it is even necessarily desirable to treat someone with the aim of eliminating the biological basis of their difference, particularly when the biologically-based treatments are often physically and mentally damaging. Some researchers have posited that psychiatric drug treatment may sometimes be the underlying cause of the symptoms

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that come to be understood as evidence that a patient has a diagnosable mental illness (Breggin & Cohen, 2007, pp. 15–21).

[13] While in many of the countries of continental Europe, lesbian sexual activity was illegal, no such laws existed in Britain (Donoghue, 1996, pp. 60–61), and expressions of sexuality between women tended to pass unnoticed and unremarked upon (Faderman, 1981, p. 32).

[14] Other bizarre treatments targeting men labelled as homosexual that were used in the 19th and 20th centuries include long, tiring bicycle rides, hydrotherapy, the forced purchase of sexual services from women sex workers, and X-ray "therapy" (Cruz, 1999, pp. 1306–1307; Murphy, 2008, pp. 17–20).

[15] It would appear that not all psychiatrists took heed of the change in the nature of this diagnosis. For instance, in the late 1970s and 80s in Scotland, gay men who consulted their general practitioners when having problems coping with the homophobic social environment were usually given tranquilizers such as valium, or referred to a psychiatrist for Freudian analysis or aversion therapy (Davidson, 2008, pp. 126, 130-2). Those who sought help from social workers generally received unhelpful, "potentially misleading" advice (Davidson, 2008, p. 134).

[16] As Feely (2016) points out, the idea that there is no meaning outside of language leaves people who do not use language in a problematic position. He notes that their situation may be a matter of philosophical consideration within social constructionist/poststructuralist thought, but this does nothing to address the exclusion of people in these circumstances. In contrast, he argues that because new materialist perspectives recognize the imbrication of the material, the discursive and the political, this can lead to more productive questions as to why a non-speaking person is being perceived as unable to communicate. These questions could include what the person's capacities are, what technologies could be used to support them, what access to resources they have, what political and social norms constrain or facilitate access to needed supports, and so forth (pp. 873–874).

[17] In fact, the uprisings that took place at Compton's Cafeteria in San Francisco in 1966 and at the Stonewall Inn in New York City in 1969 that are recognized as fueling growth in the movements for 2SLGBTQQIA+ pride and rights were led by trans women of colour (Pasulka, 2015).

[18] While the majority of research on childhood gender nonconformity was conducted on boys (Bryant, 2007, pp. 76–79; Lev, 2005, p. 51), girls were not entirely spared. For example, Burke (1996) discusses the case of an eight year old girl named Becky who was diagnosed with "female sexual identity disturbance"—which was not a standard *DSM* diagnosis—in 1978 and was subjected to experimental treatment under the supervision of psychologist George Rekers (who conducted research on boys as well as girls [Bryant, 2007, p. 132]). Rekers had been granted funding from the federal government of the United States to study treatment methods for gender non-conforming children (Burke, 1996, pp. 4–5). Becky's tomboyish behaviour and comportment were closely monitored in a psychological testing lab, where she underwent 32 sessions of behaviour modification "therapy" in order to get her to conform to the incredibly rigid gender expectations held by her parents and the therapists. As Bryant (2007) notes, this type of experimental design was common among researchers of gender non-conforming children (pp. 124–127; 132–141). Becky's treatment was considered a success when she consistently "chose" to play with a toy iron and kitchen set, rather than sports equipment, began to wear dresses, makeup and perfume and expressed romantic interest in the boys in her class as well as Rekers himself (Burke, 1996, pp. 16–19). Burke (1996) notes that Rekers advocated for the widespread adoption of the types of interventions he used in Becky's treatment in his 1995 *Handbook of Child and Adolescent Sexual Problems*, which was commonly used in clinical settings (p. 19).

[19] The Clarke Institute was named after Dr. Charles Kirk Clarke, who was an important figure in the Canadian eugenics movement, advocating for "mental hygiene." In addition to supporting forced sterilization, Clarke also promoted strict immigration restrictions, arguing that European countries were ridding themselves of citizens with mental health difficulties by sending them to Canada (Ball, n.d.).

[20] Wilchins' preferred terminology and spelling.

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[21] Responding to the question, "But what about the enormous amounts of time and money which go into your particular performance of gender? Isn't that something to be avoided if possible?" Wilchins (1997, p. 190) writes,

> On the contrary. Other than the surgery, which did cost me several thousands of dollars and a few weeks of downtime from work, I spend almost nothing on my performance of gender. I don't wear any special clothes, act in any particular way, or bother to "correct" people's pronouns, whether they use *Sir* or *Ma'am*. You, on the other hand, appear to me to be putting lots of effort into your performance of gender. You've work the "right" suit and tie, you take great care not to cross your legs the "wrong" way. You wouldn't be caught dead on the street in a dress and give a wide berth to ladies' lingerie counters. You make sure your voice stays in a low, unmodulated range, buy only men's colognes, lift weights, and would probably freak if some guy addressed you as *Ma'am* or insisted on holding the door for you. But while you ask after my surgery, you don't ask about the enormous time, effort, and money that goes into your *own* performance of gender, or whether we should be doing away with—not surgery, which affects a miniscule number of people—but the gender system, which affects nearly everyone while consuming millions of hours and dollars for compliance, monitoring, and enforcement. This is because your gender is "normal." Mine, of course, is queer (pp. 190–191).

[22] It is important to point out that other trans people do not want surgery (Kailey, 2005, p. 4; Rosario, 2011) or may not wish to undergo any medical interventions at all (Denny, 2004, p. 33; Drescher, 2010, p. 453). Some mental health professionals have expressed judgmental attitudes toward trans people who live outside the gender binary. For instance, in his 2007 clinical guidebook for the management of GID, Barrett (2007) suggested that non-binary people are "very uncommon," and that they have "cold, schizoid, personalities, … lack humour," and "tend to have a poor ability at … interpersonal relationships" (p. 43). Other clinicians have even refused to acknowledge that non-binary people exist at all (Chiland, 2003, p. 10) and have been reluctant to support any wishes that prospective clients might have to hormonally or surgically change their bodies without the ultimate goal of conforming to dichotomous gender norms (Shelley, 2008, p. 5).

[23] This Work Group was led by the then-leader of the Child, Youth and Family Services Gender Identity Clinic at CAMH in Toronto. His appointment to the group was controversial, and was met with protest by 2SLGBTQQIA+ advocates, who argued that his appointment to the group was inappropriate because, as the National Gay and Lesbian Task Force explained, he was "clearly out of step with the occurring shift in how doctors and other health professionals think about transgender people and gender variance" (Kamens, 2011, p. 44). Ultimately, this protest was not successful, but the GD label did reflect some of the recent developments in trans health care, such as an emphasis on alleviating dysphoria (Hill et al., 2006).

[24] Paternotte & Kuhar (2017) point out that movements opposing 2SLGBTQQIA+ rights as manifestations of ostensible "gender ideology" are a transnational phenomenon that is not limited to the English-speaking world. They note that similar and connected movements have been recognized as gaining traction within Africa and Latin America, as well as across Europe.

[25] While TERF ideology is less widely accepted and has less political power in Canada than in some other countries, it is not without its supporters. For example, CBC News recently published an opinion piece by a trans woman who denounced the "toxic, in-your-face" activist efforts of trans community members (such as the people who peacefully demonstrated against the Toronto Public Library's decision to rent space to a group hosting a talk by a Canadian "gender critical feminist" in 2019), blaming trans rights advocates for "creating animosity toward the trans community" (Triff, 2021). Around the same time, a controversy emerged when Margaret Atwood used her Twitter account to promote a Toronto Star opinion column in which Rosie DiManno made the absurd claim that the practice of using trans-inclusive terminology to refer to pregnancy and menstruation meant that the use of the word "woman" was prohibited (Gregory, 2021).

[26] Writing about the use of the term intersectionality, Davis (2008) describes a "buzzword" as one that captures attention and serves as a "catchy and convenient" way to refer to an idea without exploring it in any depth (p. 75).

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[27] Despite Myerson's laudatory comments concerning the eugenics movement here, As Trent (2001) points out, he was in fact relatively critical of many of the claims promoted by those advancing the eugenics cause, conducting empirical research showing that while some heredity might in some cases make a contribution to the development of a mental health condition, the theory of "degeneracy" across generations could not be supported (p. 37). In his 1925 work, *The Inheritance of Mental Diseases*, Myerson further critiqued the notion that mental health difficulties and intellectual disabilities were purely inherited and therefore best subject to elimination through eugenic means, arguing instead that social and environmental factors appeared to play more significant roles in their development (p. 46). He would also later criticize the inherent racism of the eugenics movement (p. 48). That noted, Myerson did not entirely reject the eugenics movement and its aims: When serving as the chair of the American Neurological Association's Committee on Eugenic Sterilization, he critiqued "excesses" in the practice of "eugenic" sterilization, but argued that it was still useful and appropriate in at least some cases (p. 48). In the context of this project, it is also important to note that Myerson was a strong proponent of electroshock treatment (Myerson et al., 1941), claiming that it was safe, with no negative long-term cognitive or physical effects, as well as effective in the treatment of a range of mental health conditions (Myerson, 1942).

[28] Reflecting his rejection of political analysis, Seligman devotes a significant portion of his book *Flourish: A Visionary New Understanding of Happiness and Well-Being* (2011) to the excoriation of journalist Barbara Ehrenreich and her work critiquing the dominance of the US cultural imperative to engage in positive thinking regardless of the material difficulties one might encounter, including physical illness (Ehrenreich, 2009). Seligman refers to her as "Barbara 'I Hate Hope' Ehrenreich" throughout his book. He claims that Ehrenreich's analysis ignored scientific evidence showing that positive psychology principles are valid predictors of health outcomes, including with respect to longevity and response to cancer treatment (pp. 201–204). He ultimately concedes that there is little evidence that a sense of well-being is a protective factor against dying of cancer, but counters that positive psychology research has shown that well-being does protect against death from cardiovascular disease, renal failure and HIV (p. 204). The question of whether these protective effects might be confounded by the social determinants of health is neither asked nor answered by Seligman.

[29] Neumeier and Brown (2021) define transmisia as follows: "[Transmisia] refer[s] to systemic and structural oppression targeting transgender people. … The suffix 'misia' derives from the Greek term for hate or hatred, which … reflects the nature of oppression, including internalized oppression" (p. 76).

[30] The persistent underfunding of mental health care in comparison with other aspects of the health care system reveals a power differential within medicine itself, where fields understood as based in "hard" science, with identifiable and quantifiable causes and treatments privileged in relation to "soft" social or humanistic disciplines (Cassell, 2002). No discipline in medicine was more vulnerable to accusations of "softness" than psychiatry, which was, until the mid-20th century (in the West), which boasted few (or, arguably, no) effective somatic treatments, and was often informed by perspectives drawn from Freudian and other psychoanalytic perspectives, theories of mind and emotion without a clear basis in scientific evidence, let alone in biological facts. I have already discussed the rise of the "bacteriological" model of mental health, but the preoccupation with scientific legitimacy within psychiatry has also taken place in other fora: With the publication of the *DSM*'s third edition in 1980, the American Psychiatric Association sought to promote the notion of psychiatry as based in "description," "empiricism" and "scientific medicine" by applying a category-based system to psychiatric diagnosis, focusing on observable data, rather than subjective interpretations or speculations as to causality (Lewis, 2006, pp. 2–5). The shift toward understanding mental health as primarily rooted in biological factors represents another attempt to seek scientific legitimacy, with the prestige, research funding and opportunities for the development of lucrative pharmaceuticals that accompany it.

From a public policy perspective, promoting an understanding of mental health problems as based in biology may be helpful in gaining access to health care funding: As Corrigan and Watson's (2003) research demonstrated, many people (voters and legislators alike) have tended to regard mental health problems as matters of individual moral weakness and therefore as volitional, rather than as the instances of uncontrollable misfortune that the biological model would suggest that they are. Funding for mental health services is therefore understood as fostering dependency. If mental health treatment can be recast as addressing biological—instead of personal—

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dysfunction, it may become a stronger funding priority for members of the public and decision-makers (pp. 503–504).

[31] These cuts to social spending at the provincial level followed the federal Liberal government's cancellation of the Canada Assistance Plan, which they replaced with the Canada Health and Social Transfer, which, as O'Connor et al. (1999) explain, "g[ave] funds to the provinces to run their own welfare plans with fewer federal mandates and no guarantee of assistance" (pp. 128–129).

[32] In 1995, Ottawa sports journalist Brian Smith was killed by a man later identified as schizophrenic and found not criminally responsible for the killing (Walker, 2008). Smith's death was followed in 1997 by three additional violent incidents in Ontario involving people identified as mentally ill: First, in Hamilton, a two-year-old Zachary Antidormi was killed by his neighbour, a woman identified as having untreated psychosis. A few months later, a man labelled as mentally ill killed Charlene Minkowskie by pushing her in front of a Toronto subway train (Everett, 2001, p. 8; Szigeti, 2001, p. 67). In the third 1997 incident, Edmund Yu, a man who had been diagnosed with schizophrenia, was involved in an altercation with Toronto police. Yu was "armed" only with a small hammer, but was subdued by a force of several armoured officers wielding guns, and was shot to death by the officers. It was later found that negative stereotypes concerning people with mental illness were endemic in the culture of the Toronto police force (Reaume, 2002, p. 405). Commenting on public reaction to Yu's death, Everett (2001) writes, "According to public/media opinion, if Edmund Yu had taken his medication, attended his appointments, and kept his housing, he would be alive today" (p. 8). These four violent incidents provided the impetus for legislators to change the Mental Health Act to increase control over people identified as mentally ill. As I will discuss, one of the means by which this took place was through the introduction of the Community Treatment Order (CTO) law (Fabris, 2006, p. 42), which created a mechanism whereby psychiatric patients living in the community could be compelled to take medication and submit to other forms of control and surveillance. Szigeti (2001) points out that this series of events is not an isolated one: In several American jurisdictions, CTO programs were mandated by law following the occurrence of highly publicized incidences of violent acts perpetrated by attackers identified as mentally ill (p. 68).

[33] This is not to suggest that this was a new idea: The link between mental illness and dangerousness has been part of mental health policy in Ontario from the beginning. By 1877, legal provisions were in place for the commitment of "dangerous lunatics" (Gray et al., 2000, p. 107). Pollock (1974) explains that as psychiatric hospitals were built, they were purposely separated from communities in an effort to protect society from the dangers believed to be posed by people considered mentally ill (p. 31). Most of the asylums that were built in the 19th century closely resembled prisons (Goodwin, 1997, p. 6).

[34] Many CTO proponents defend their views by emphasizing the "violent risk" that people identified as seriously mentally ill are said to pose to others in the absence of treatment with medication: For instance, arguing in favour of the CTO law in Ontario, Gray et al. (2000) write that psychiatric medications' "side effects must be contrasted with the effects of not taking the medications which can include homicide" (p. 237). Similarly, Chaimowitz et al. (2008) argue that mentally ill people should be encouraged to take medications such as antipsychotics and mood stabilizers for the specific reason that these drugs are thought to have an "aggression-dampening" effect (pp. 21– 22). This argument illustrates Breggin's (1994) observations about the function of these kinds of psychiatric drugs. He writes:

> There is no significant body of research to prove that neuroleptics [antipsychotic drugs] have any specific effect on psychotic symptoms, such as hallucinations and delusions. To the contrary, these remain rather resistant to the drugs. The neuroleptics mainly suppress aggression, rebelliousness and spontaneous activity in general. This is why they are effective whenever and wherever social control is at a premium (p. 148).

[35] This is not to say that these laws and policies have achieved their stated objectives. For instance, the Accessibility for Ontarians With Disabilities Act, 2005 has been criticized for its extended timelines for the implementation of accessibility standards, and for its inclusion of many opportunities for exemption from compliance (Titchkosky, 2010). Prince (2009) explains that the liberal rights focus of the disability rights movement in Canada is incompatible with the neoliberal orientation of Canadian governments (pp. 197–198), so disability advocates'

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success in promoting the creation of policies that adopt a rights approach has not led to the true recognition of the citizenship rights of disabled people. Prince argues that this has taken place because disability advocates understand disability rights advancement as necessitating government expenditure (p. 10), but Canadian governments understand citizenship rights in a liberal, non-Keynsian sense, and take a biomedical and functional approach to disability that tends to "emphasise selective services, discretionary programs, and … earned benefits" in order to reduce spending (p. 9). For this reason, Prince argues that disability policies render disabled people as "absent citizens" (p. 3) who are largely excluded from full participation in society, culture and politics (p. viii).

[36] As Fierlbeck (2011) explains, the Canada Health Act requires that provincial health insurance plans cover "medically necessary services that are provided within hospitals" but does not require that the province insure outpatient treatment of any kind (p. 7). Fierlbeck (2011) also notes that the Canada Health Act is not binding upon the provinces, so provinces are able to decide whether or not to provide public health insurance (p. 22).

[37] Writing about the situation in the United States, Wilson (2006) disputes the claim that psychiatric drug treatment is cost-effective for governments. He argues that because many people identified as mentally ill receive social assistance and are therefore eligible for pharmacare, government expenditures for psychiatric medication "represent a very large proportion of the budgets of already financially strapped government health programs" (96). Discussing uptake of psychiatric drug treatment in Canada, Mulvale and Hurley (2007) explain that many non-insured Canadians find the cost of psychiatric drug treatment prohibitive.

The extent to which health policy is influenced by those with financial interests in promoting medication-focused treatment has been a matter of concern in Canada and around the world (Lexchin, 2001; Goldner et al., 2011, p. 63). Serious questions have also arisen about the efficacy and safety of most of the drugs used in psychiatric treatment, with many drugs proving no more effective than placebo in trials, and many of even the relatively more recently-developed (and ostensibly "safer") medications being associated with significant risks to health (Haddad & Dursun, 2007; Goodwin, 1997, pp. 130–132). Discussing some of the implications of the influence of the pharmaceutical industry upon conceptualizations of mental health, Brody (1993) writes,

> Perhaps the most powerful, unregulated, twentieth-century influence on health policy is the development of biomedical technology. This includes psychoactive drugs for treating psychiatric illness. Drug ("psychopharmacological") treatment, aggressively promoted by commercial interests, has accelerated in the developing world at the expense of Indigenous, community-based therapeutic and social-support approaches, and in the industrialized world at the expense of the psychotherapies. This development has been influenced both by the scientific and professional establishments, and the diminished availability of resources for interpersonal care (pp. xvi-xvii).

[38] Goodwin (1997) explains that because so many people labelled as mentally ill are poor, they tend to be in a "dependent" position, which gives them less access to a choice of services, and also puts their interests behind those of the government or charitable institutions that fund mental health services. He writes,

> One common characteristic that has united the vast majority of people with mental health problems is poverty. As a potential client group, relatively few are able to purchase private services, and most tend to rely upon what is made available by the state and by charitable organizations. In consequence, the income and status of the psychiatric profession are dependent upon addressing the concerns of service providers, rather than upon meeting the stated or perceived needs of people with mental health problems (p. 80).

[39] Puttee (2002) cites a specific example of the operation of policy incoherence in Canada: Objectives relating to the "equitable and efficient distribution of adequate benefits" included in federal and provincial disability income support policies are "frequently not met" (p. 6).

[40] Drawing from the work of Bernstein (2001), Singh (2017) describes pedagogization as a "means for governing whole populations through training and retraining schemes, to cope with continuous change in work and everyday life" (p. 146).

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[41] In the original source, the social determinants are listed in alphabetical order. Here I have changed the order of presentation to be consistent with the thematic groupings I use in this chapter and in my later discussion of the social determinants and well-being in Chapter Ten.

[42] The labelling of the "identity-based" social determinants (gender, disability, race, immigrant status and Indigenous ancestry) could be considered as problematic in that they name identities themselves as determinants rather than the relevant structural factors that result in their playing a role in health. For instance, I would argue that colonialism is more accurately a social determinant of health than Indigenous ancestry in itself. Similarly, social determinants pertaining to gender might be more usefully labelled as sexism, misogyny and patriarchy. Equally, the exclusion of gender diversity and sexual identity is problematic, and if included they could be conceptualized as cissexism/transmisia and heterosexism/queermisia. Despite this critique, I have defaulted to identity-based category naming in the interest of being consistent with the literature on the social determinants of health and mental health, but I recognize that this is a matter for future analysis and debate.

[43] For instance, Armstrong (2016) writes, "There is a materiality to the body and there are significant differences related not only to reproductive and sexual organs but also to hormones, body size and body processes. Only women get pregnant, menstruate and lactate. And that matters" (p. 545). While she then goes on to explain that sex and gender are not binary but "continua along which we can find multiple variations" (p. 545), there is essentially no mention of trans people or of any kind of gender diversity in her subsequent comments.

[44] The COVID-19 death of Dr. Susan Moore—who was only 52 years old and herself a medical doctor—is a recent example of the mistreatment that Black women face in the health care system. In a video posted to social media, Moore stated that she had been denied care and treatment by medical staff, who did not believe that she was short of breath, refused to prescribe anti-viral medication to her, and accused her of drug seeking when she sought relief for her pain. She attributed the poor care she received to racism, saying in a social media video, "I put forth and maintain if I was white, I wouldn't have to go through that." Moore was discharged to her home, where her condition worsened. She was ultimately readmitted to hospital but did not survive (Eligon, 2020).

[45] The term "transmisogyny" was coined by Serano (2007, p. 15). Krell (2017) explains that it describes how "the abjection of femininity in conjunction with transgenderism constitutes a particular form of oppression that trans women face" (p. 232).

[46] As Żuk and Toporowski (2020) point out, the intensification of neoliberal policies across the West took place following the end of the Soviet Union and the Eastern bloc. Prior to this, Western liberal and conservative politicians faced pressure to "outperform their competitors on the left" in the realm of social policy to limit possible growth of support for socialism (p. 160).

[47] Carbin & Edenheim (2013) argue that retroactively applying the label of intersectionality to previous Eurocentric considerations of the interactions between social locations or identities serves to obfuscate the racism of white feminist theory. Having initially regarded intersectionality as threatening, liberal white feminists now deploy it as a means of "institutionaliz[ing]… a liberal, 'all-inclusive' feminism based on a denial of power as constitutive for all subjects" (p. 234).

[48] McCall's (2005) three categories of intersectional analysis are as follows: The anticategorical approach focuses on the position of the individual subject relative to structures, which draws from poststructural approaches (pp. 1777–1780) in claiming that social life and subjectification processes are too complex to meaningfully locate subjects within stable and broadly-applicable identity categories (pp. 1773, 1779). The intracategorical approach "focuses on particular social groups at neglected points of intersection" and "acknowledges the stable and even durable relationships that social categories represent at any given point in time" (p. 1774), and often uses case study methodologies in order to engage in thick description (p. 1782) so as to better illustrate "the complexity of lived experience within such groups" (p. 1774). Finally, the intercategorical approach (also called the "categorical approach" [p. 1784]) "provisionally adopt[s] existing analytical categories to document relationships of inequality

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among social groups and changing configurations of inequality along multiple and conflicting dimensions" (p. 1773). This approach "treat[s] … categories as 'anchor points'" that can shift by themselves or in relation to other points (p. 1785).

[49] At the same time, Rice et al. (n.d.) point out that despite their power to change perspectives and open new possibilities for understanding, audiences might persist in interpreting stories in line with "taken for granted" dominant discourses. They argue that unintended readings or even "misuses" of stories are manifestations of the process of "interference" that shape the production, circulation and reception of stories, especially within the research context.

[50] Bamberg (2007) argues that the rise of the "expressivist" approach reflects the turn toward "textualization," wherein "experience, actions, lives, and persons" are all subjected to reading and interpretation as though they were literary texts. Bamberg argues that textualization discounts people's agency and responsibility, and can fail to consider the interactive context in which the "text" was produced (pp. 168–169). These critiques seem to me to demonstrate the incommensurability of Bamberg's humanistic theoretical framework with approaches rooted in postmodernism/poststructuralism. I would argue that this project, with its roots in feminist new materialism and intersectionality theories, addresses these issues by acknowledging the context in which the research took place, and by positing a theory of identity that accounts at multiple levels for the dialectic of agency and embeddedness.

[51] Braun and Clarke (2006) explain that contextualist perspectives "acknowledge the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'" (p. 81).

[52] As a student researcher working by myself on a small, unfunded project, I sensed that participants generally did not perceive me as a person with particularly high status, but I was careful to remain aware of this dynamic.

[53] Recognizing this problem, I specifically attempted to recruit Black participants. To do this, I used snowball sampling and also reached out to friends and acquaintances to ask whether they had suggestions for potential avenues for recruitment, or if they knew of any potential participants in their networks. These efforts were unfortunately not successful. One participant asked several of their friends if they might be interested in participating, and shared with me the feedback that their friends would not be comfortable participating in a research project on this topic led by a white, cisgender researcher.

This encounter revealed the limitations inherent in undertaking a project of this type as a sole researcher, with whom prospective participants may or may not feel comfortable or safe. It is absolutely fair that any potential participants of colour might not trust that my work would uphold an antiracist perspective, or indeed demonstrate any awareness of the existence and consequences of white supremacy, colonialism, racism generally as well as anti-Indigenous racism and anti-Black racism specifically. The history of racism in academic research is a long one, and remains an ongoing reality. Although I always attempt to centre anti-racism in my work, my positionality as a person who benefits from white supremacy and white privilege means that my perspective is limited. As West (2013, pp. 15–16) notes, the nature of thesis or dissertation research typically precludes significant collaboration at the stage of writing, which limits the perspectives that can be reflected in the final text. I believe that these kinds of limitations could be mitigated in future research of this type if it were undertaken by a team reflecting the diverse social locations and experiences of participants, ideally in concert with community organizations that could both direct and benefit from the research.

Additionally, I would like to note that while it did feel slightly frustrating to have my non-binary identity misrecognized by the participant who had sought to assist me with recruitment, it is absolutely true that as a non-binary femme who was assigned female at birth, my experiences are very different from those of a trans or non-binary person whose gender presentation is subject to more scrutiny and hostility in our cissexist society. Speaking for myself, I experience misrecognition and erasure as uncomfortable, but I understand that my being perceived and understood as a cisgender woman unless I disclose otherwise means that I am less likely to be subjected to violence and discrimination targeting my gender identity. As such, this project is being undertaken by a researcher who does not share the experience of having been directly personally harmed by transphobic/transmisic violence, and it is

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completely reasonable that people might not wish to engage with a researcher who does not share those experiences, especially given the personal and potentially emotionally-charged nature of the topics addressed in this project.

[54] Because one of the workshop participants, Sandy, was an Indigenous trans woman, May's expertise and support, as well as her profound generosity in allowing us to screen her video art piece played a crucial role in disrupting the dominant positioning of film/video as a colonized and heteropatriarchal medium (Rice et al., 2020b) and in creating a space that was more welcoming to the story that Sandy wished to tell.

[55] Gender diverse people have not been represented in media in ways that accurately reflect the experiences and identities of community members. Beginning in the middle of the 20th century, trans people began to be acknowledged in mainstream news and entertainment media, but were typically depicted in extremely problematic ways: as curiosities, as threatening, as absurd, or as tragic victims (Cavalcante, 2018, p. 14; Ryan, 2009, pp. 10–19). More recent media depictions of trans people are often less sensationalistic—at least in English-language North American media—but in many cases have still upheld a cisgender gaze, with people from outside the trans community writing the stories, starring in the roles and framing the narratives (i.e. *Transamerica*, *The Danish Girl*, *Transparent*). Despite this, genuine trans/gender diverse perspectives have begun to come to the forefront in both entertainment and in journalism and the stories and voices of community members have become more prominent (Konst, 2018, pp. 1–7, 54–65). In 2014, what many commentators characterized as the "transgender tipping point"—following the title of a Time cover story (Steinmetz, 2014)—took place. As a result of increased news coverage of the trans community's struggles for legal rights and recognition as well as better representation in entertainment media, more people are now aware of the existence of gender diverse people and of the struggles that community members face, but this increased visibility has been accompanied by a backlash, leading to the rise of "gender-critical" activism, as I discuss in Chapter Two.

[56] Lambert writes that "the story circle is often critical for a storyteller's writing process" (2013, p. 55). My own experience with creating a digital story during a workshop for the Through Thick and Thin research grant in 2015 highlighted how the collaborative process can help storytellers to creatively express their thoughts. I came to the workshop with a draft script that recounted how as a teenager, I was influenced in my problematic dieting and exercise by a popular young adult novel that told the story of a girl who was undergoing treatment for an eating disorder. After reading my script in the story circle, I asked for feedback and I mentioned that I was considering using visuals depicting food and eating. One facilitator suggested, "Why don't you eat the book?" and I thought that was a hilarious idea. With the help of facilitators I filmed an ending to my story in which I am shown spreading margarine on some pages of the book, tearing one out and eating it (for the record, it tasted as bad as might be imagined), then triumphantly burping. Although I did not come up with that imagery, I felt that it reflected my feelings and thoughts much more clearly than anything I had independently envisioned.

[57] Matthews and Sunderland (2017) point out that the terminology of "listening," "hearing," and "voice" can have audist connotations (p. 7). Like them, I wish to use the term in the metaphorical sense only, and not to imply that the ability to hear sounds is in any way required in order to attend to, interpret and respond to any kind of information, stories included.

[58] In June 2020, the US Supreme Court ruled that LGBT people are protected via the anti-sex discrimination provisions of Title VII of the 1964 Civil Rights Act, which bans employment discrimination based on sex, race, colour, religion or national origin (Totenberg, 2020).

[59] Mark's characterization of the racism in his field was necessarily shaped by his own white privilege, which would have an impact on his capacity to perceive and interpret racism. And of course, even "subtle" racism negatively impacts racialized employees, contributing to the creation of a hostile work environment and damaging their career prospects (Deitch et al., 2003; Jones et al., 2017; Offerman et al., 2014).

[60] As I discussed in Chapter Eight, as a white person working alone as a researcher, it is possible that racialized and Indigenous participants may not have felt welcome or comfortable to discuss experiences of racism with me, so I

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remain cognizant of the fact that if they did not report to me that they had experienced racist discrimination, this does not necessarily indicate that they did not experience racism.

[61] I am aware of the importance of naming and recognizing specific First Nations. Although Sandy did tell me the name of the specific Algonquin First Nation to which she and her family were connected, I have not included this information in the interest of maintaining her privacy.

[62] Hermione also pointed out that participating in paid research studies was another means by which she could earn some money but this was also tokenizing:

> It feels, sometimes, like the researchers are salivating over me. So I am kind of... It's like I demonstrate, through my lived experiences, all the things they are trying to prove and talk about and try to do, but the thing is that, like, I'm everyone's diversity card.

[63] Reaume (2002) points out people identified as having mental health difficulties have similarly been unjustly and inaccurately labelled as dangerous. Reaume (2021) also notes that some lesbian, gay and transgender activists were supporters of the mad movement in the late 20th century, recognizing that the othering and pathologization facing the communities were intertwined, even after the removal of the diagnosis of Homosexuality from the DSM (p. 318).

[64] Here, "social capital" refers to the usage defined by Putnam (2000). The Bourdieusian sense of the phrase also has relevance to this topic, and could describe the way in which gender diverse community members often have less access to the networks of social connections that could enable them to advance their interests (Siisiäinen, 2000).

[65] Alesha described a queerplatonic relationship as "a non-sexual and non-romantic relationship, but it sort of transcends what one would normally consider a friendship." Crosslin (2017) explains that queerplatonic relationships challenge the primacy of the heteronormative and capitalism-driven monogamous nuclear family by recognizing the importance of close friendships and the possibilities of relationships outside of the dominant model.

[66] The term "gray ace" is a short form of "gray asexual" or "graysexual," which is defined by Coombs Fine (2019) as referring to a person who experiences lower than normative levels of sexual attraction (p. 2).

[67] While trans children often have difficulty accessing puberty blockers, as Rice (2018) notes, the same medication is often given to girls regarded as having severe disabilities without their consent so as to prevent what is seen from an ableist, sexist and adultist perspective as an inappropriate mismatch between their mental and physical development. The simultaneous underprescription and overprescription of these medications for different groups of children serves to maintaining normative ideals at the expense of children's embodiment.

[68] As Withers (2013) notes, the lifetime cost for a testosterone prescription in Canada could amount to $100,000.

[69] A well-known and tragic example of what is at stake when trans people are denied access to health care is the story of Robert Eads, an American trans man who died from ovarian cancer at age 53 after having been rejected as a patient by over a dozen doctors due to their anti-trans bias (Davis, 2001).

[70] "Cis het" is an abbreviation for cisgender heterosexual.

[71] At the time of writing, the dangers of lack of access to transition care are being demonstrated in the UK following the success of a lawsuit supported by anti-trans activist organizations on behalf of a woman who had been given access to puberty blockers as a teenager and subsequently underwent hormone therapy and surgical gender confirming procedures as young adult. The woman later decided to detransition, and claimed that the consent she gave to treatment as a minor was not valid. The judge agreed with this argument, and imposed a moratorium on the provision of puberty attenuating medication via the National Health Service to children. Trans children and their supporters reported that children whose access to blockers was withdrawn experienced severe emotional distress due

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to being involuntarily subjected to permanent and irreversible physical changes that were inconsistent with their identities and wishes (Parsons, 2020).

[72] Trans people appear to be more likely than average to take antidepressants, reflecting the higher rates of diagnosis with anxiety and depression experienced by community members (Mueller, 2020).

[73] Alexandra explained the problems inherent in the discredited theory of "autogynephilia" (a theory positing that trans women sexually objectify themselves, fetishizing the idea of themselves as women/feminine):

> And, like, you know, "So, have you ever worn women's clothing and masturbated? Have you…" You know. Well, I mean, I don't think that there's—you know, a lot of trans people want to insist that there's this necessarily huge difference between transvestitism and transsexualism. And I don't think … that needs to be the case. I mean, I wouldn't want to stigmatize that expression of sexuality or say that there is no crossover between the two or that, like, just because you—I don't know—you were young and you wore women's clothing and you masturbated you don't deserve to be on hormones if that's what you want to do. If you think about the entire lingerie industry… Actually there was a researcher recently who did this study, basically he took Blanchard's category of autogynephilia and tested [cisgender] women against the same questionnaire [Moser, 2009]… And there were, like, something like 94 percent of [cisgender] women showed autogynephilic symptoms according to his thing and, like, 20 percent of them could be rigidly defined as autogynephilic according to Blanchard's methodology basically.

Alexandra's memory was very accurate. In his 2009 study, "Autogynephilia in Women," Moser found that 93% of cisgender women reported having ever experienced "erotic arousal to the thought or image of oneself as a woman," with 28% reporting "frequent" instances of "autogynephilic" experiences (p. 539).

[74] As Pyne (2020) points out, trans and autism communities are also connected through their relationship to conversion therapy, with many members of each/both communities having been subjected to abusive, harmful interventions designed to force them to conform with social norms (p. 342). Pyne notes that Rekers, who was a leader of the research targeting gender nonconforming children that I described in Chapter Two, was supervised by Lovaas, the originator of Applied Behavioral Analysis. Working together at UCLA, Lovaas and Rekers co-developed a behaviour modification program aimed at enforcing gender conformity (p. 349).

[75] The Trillium Benefit is a payment from the Ontario provincial government that lower income Ontario residents can receive to help offset sales and property taxes as well as energy costs. Although Miriam could have been referencing this program, I believe that she was more likely referring to the similarly named Trillium Drug Program, which is another provincial government program that provides coverage for prescription drugs for Ontario residents whose prescription drug expenses are high relative to their income.

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Appendix A: Narrative Interview Questions

Trans, Genderqueer, Non-Binary and Gender Non-Conforming People's Experiences with Mental Health Care in Ontario

Narrative Interview Questions

1. Could you tell me about yourself and the ways that you self-identify?

Prompts:

- What do you think is important to tell me about yourself?
- Which communities do you consider yourself belonging to?
- How do you identify your gender, sexuality, ethnicity, race, class, other dimensions of your identity and social location?
- Could you tell me a bit about how you've come to identify in this way?

2. Could you tell me about how you came into contact with mental health care? That can be any support that you received for emotional issues or distress from institutions or professionals, including doctors, psychiatrists, other health care practitioners, psychologists, counselors or therapists, teachers, or community organizations.

Prompts:

- Was your contact with mental health care related to your experiences with gender, or with your transition process? What happened?
- Was your contact with mental health care prompted by a difficult situation you were facing? What happened?
- Was your contact with the mental health care system prompted by contact with medical care? What happened?

3. Did you ever get informal support outside of the health care system or institutions for emotional issues or distress? This could be with friends, support groups, online, or elsewhere. Could you tell me about that?

4. What were your experiences with mental health care?

Prompts:

- Could you tell me about the care or treatment you received? When and where did it take place? What was it like?
- Could you tell me about what the health care providers and staff were like? How did they treat you?
- Could you tell me about any impacts your experiences with mental health care had on you, in the short term and later on?

5. Could you tell me about some of your other experiences as a trans/non-binary/genderqueer/ gender non-conforming person?

Prompts:

- Could you tell me about your experiences with family members or friends?

- Could you tell me about your experiences in communities to which you belong (i.e. places where you live or have lived; social circles; identity-based communities; online communities)?
- Could you tell me about your experiences around employment or finances?
- Could you tell me about your experiences with housing?
- Could you tell me about your experiences with institutions (i.e. schools, social services, general health care)?

6. Based on your knowledge and experiences, what kinds of changes in society and in institutions do you think would help support your well-being?

Prompts:

- Could you tell me what you would like to change, and why?
- Would these changes include better access to mental health care, different mental health care, or something else?
- Do you think that the way things are currently organized in society and institutions works well for you? Why or why not?

7. How do you think you would benefit from the kinds of changes that you mentioned?

Prompt:

- What might be different in your life if these changes were implemented?

8. Is there anything else you would like me to know before we finish?

Appendix B: Digital Storytelling Workshop Package

DIGITAL STORYTELLING WORKSHOP SCHEDULE AND AGENDA

SCHEDULE

DAY 1

9:00-9:30	Vari Hall 1156	Refreshments, Signing of Consent Forms
9:30-11:00	Vari Hall 1156	Acknowledgement of Indigenous Peoples and Territory, Introductions, Workshop Overview, Accessibility and Safety Discussion, Icebreaker
11:00-12:00	Vari Hall 1156	Realities and Representations of Gender and Mental Health: Presentation and Discussion
12:00-1:00	Vari Hall 1156	Lunch
1:00-2:30	Vari Hall 1156	Story Circle
2:30-5:30	Vari Hall 1156	Script Writing and Review; Storyboarding
2:30-5:30	HNES 405	Voiceover Recording

DAY 2

9:00-9:30	Vari Hall 1156	Refreshments, Signing of Consent Forms
9:30-10:30	Vari Hall 1156	Introductions, Video Editing Tutorial
10:30-10:45	Vari Hall 1156	Anonymity Discussion
10:45-12:30	Vari Hall 1156	Open Studio (Storyboarding; Image Preparation; Construction of Digital Story in Final Cut Pro)
10:45-12:30	HNES 405	Voiceover Recording
12:30-1:30	Vari Hall 1156	Lunch
1:30-5:30	Vari Hall 1156	Open Studio
1:30-5:30	HNES 405	Voiceover Recording

DAY 3

9:00-9:30	Vari Hall 1156	Refreshments
9:30-12:30	Vari Hall 1156	Open Studio
9:30-12:30	HNES 405	Voiceover Recording
12:30-1:30	Vari Hall 1156	Lunch
1:30-3:00	Vari Hall 1156	Open Studio
3:00-4:00	Vari Hall 1156	Export Stories
3:00-4:00	Vari Hall 1156	Signing of Release Forms
4:00-5:30	Vari Hall 1156	Premiere of Digital Stories

DAY 1 AGENDA

9:00-9:30
REFRESHMENTS, SIGNING OF CONSENT FORMS

9:30-11:00
ACKNOWLEDGEMENT OF INDIGENOUS PEOPLES AND TERRITORY, INTRODUCTIONS, WORKSHOP OVERVIEW, ACCESSIBILITY AND SAFETY DISCUSSION, ICEBREAKER

ACKNOWLEDGEMENT OF INDIGENOUS PEOPLES AND TERRITORY

E:

- I would like to begin by acknowledging that York University is located on the traditional territory of the Haudenosaunee, the Métis, and most recently, the territory of the Mississaugas of the Credit River. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. This territory is also covered by the Upper Canada Treaties. Toronto is still the home of many Indigenous people from across Turtle Island. I am grateful to have the opportunity to work in this community, on this territory.

INTRODUCTIONS

- Facilitators and assistants introduce themselves: What brings us to this work, our backgrounds and interests related to the project.
- Participants introduce themselves: Also share a sentence about their story.

WORKSHOP OVERVIEW

E:

- Objective of the Workshop
    - The aim of this digital storytelling workshop is to provide trans, genderqueer, gender non-conforming and non-binary folks who have had experiences with mental health care an opportunity to express themselves in ways of their choosing, through storytelling, photography, videography, art and music.
    - I chose to include a digital storytelling component in my project because it provides a way for participants to choose how to represent themselves and their stories, which highlights how participants are knowers and creators of knowledge in their own right.
    - This also gives participants an opportunity to create their own representations, which is particularly important for folks who are so badly under- and misrepresented in media.
    - The artistic aspect of digital storytelling is also important: Participants' artistic processes can be assisted by facilitators, but the pieces they create are their works of art, reflecting their own creativity, talent and ideas.

K:

- Examples of Digital Stories
    - There's no one way to create a digital story. Although we're all going to be using the same process, everyone's final pieces will be very different. You may have already watched some of the digital stories produced in the Through Thick and Thin project, which Elisabeth sent links to in an e-mail a few weeks ago. We'll have a look at a few sample stories from Project Re•Vision now, as well as one of my own short films, to show some of the different approaches that storytellers and filmmakers have taken toward expressing themselves.
        - Elisabeth's story
        - Jill's story
        - Bridget's story
        - Kiley's film

E:

- Agenda for Workshop, Guidelines
    - In this workshop, we will be spending most of the first day developing and refining storytellers' scripts. Folks who have completed their scripts can also complete their audio recording today.
    - The second and third days will be devoted to completing audio recording, learning how to use Final Cut Pro (which is the video editing software we'll be using), creating any new images that storytellers might want to make, and then putting together the stories using the software.
    - Later in the afternoon on the third day, we'll export the completed stories and for those who want their stories to be shown to the group, we'll premiere them!
    - Today, lunch will be at about 12:00, and it will be at about 12:30 on the next two days. Please feel free to snack throughout the day, of course!
    - Please do not leave open liquids near the computers.
    - You can of course take breaks whenever you would like, and we'll have group breaks between some of the activities. Ideally, if you could try to stay for the whole story circle, that would be helpful, but no worries at all if that isn't possible.
    - Does anyone have any questions about this?

ACCESSIBILITY AND SAFETY DISCUSSION

K:

- The most important thing in this process is that everyone here works to make this space as accessible, equitable, safe, and open as possible. People will be telling stories that are very personal. As the sample digital stories showed, people's stories vary a lot. Some are serious, and some have funny elements. Some might be emotionally intense or upsetting, both for the storyteller and for the audience. As much as we possibly can, we should try to be aware of how we are feeling, and how others are feeling. If you ever feel like you need a break, please feel free to take a break, get a snack, go for a walk or do whatever you need. If you need help or to check in, please feel free to talk with any facilitator.

B:

- During this workshop there are times when you may feel uncomfortable. I would ask you to hold any feelings of discomfort. Your discomfort – and your other feelings – are valid. This is a space for learning, and learning can be really frightening, challenging and uncomfortable. I would appreciate if you're able to challenge yourself to think differently, and try to get out of your comfort zone. I'm really fond of the words of Ms. Frizzle (from *The Magic School Bus*): "Take chances, make mistakes, get messy!"

E:

- As we get to know each other over this weekend, we'll learn about where we're all coming from, and what some of our experiences have been. Everyone in this room is coming to this project with a unique perspective. It's possible that people might not share the same values or beliefs, and that's generally okay. We can recognize that we're all at a different place in our journey of learning, and that we might not always agree about everything, but we can still show respect toward each other.

K:

- It's important to come to this space with an understanding that our own views are always partial. This is true for everyone, but at the same time, it is also true that people who have personally and directly experienced the impacts of oppression are the most able to understand and define what oppression is – as well as what privilege is.
- I hope that we can commit to coming to this space – and to the relationships we're building here – with positive, caring intentions.
- We can also be aware that despite our intentions, we can never totally eliminate the impacts and reverberations of oppression, even in a space like this.

E:

- We can understand that in some ways, our intentions do matter. I'm sure we've all had the experience of unintentionally hurting or offending someone.
- I think this is particularly true for those of us who have not personally and directly experienced the impacts of forms of oppression such as racism, colonialism, poverty, classism, ableism, sanism, transphobia, transmisogyny, misogyny, queerphobia, fatphobia, antisemitism, Islamophobia and so forth. Folks who occupy positions of privilege relative to these and other forms of oppression have a responsibility to be careful in regard to experiences that are not their/our own. Privileged folks should always be thinking – as much as possible – about the potential impacts on oppressed people of the things they/we say and do.
- This doesn't mean that everyone is going to be perfect.
- Even with good intentions, we might hurt or offend someone. To defend ourselves against feeling bad or guilty, we might want to deny that we were responsible for

hurting them, or we might claim that they are oversensitive. I believe that these reactions are understandable (and I have them myself), but they aren't ultimately helpful. They don't help anyone who is hurt, they aren't helpful to ourselves (we can't learn anything from that), and they don't help achieve the objective of creating a better, equitable world.

B:

- Instead, in these interactions, we should try to centre the perspective of the person or people who has more lived knowledge. It can be difficult for the person who has done the hurting, but they should listen to the person they hurt, meaningfully apologize for what they said or did, learn from the interaction and try not to repeat the hurtful thing they did. Ultimately, impacts are more important than intentions.

E:

- If I do or say anything hurtful or offensive, please either let me know myself, or tell another facilitator if you don't want to speak with me directly. I will do anything I can to make it better and to apologize. If you ever want to approach me or any other facilitator to talk about any interactions you've had with anyone here, please feel encouraged to do that.

B:

- With that in mind, we can create a group agreement, which is a list of statements that people can agree on for how we are going to work together this weekend.
- Examples of agreement terms:
  - Emphasize respect
  - One diva, one mic (one person speak at a time)
  - Step up, step back (give space for people who are less talkative, more marginalized)

ICEBREAKER

B:

- To get to know each other a little better and to get us into a storytelling mindset, we'll play a game called "Fact or Fiction"
  - Each person will write three "facts" about themselves, two of which are true and one of which is not. We will take turns reading our list of facts to the group, and the group will try to guess which of the "facts" is really a fiction.
  - Please don't feel any pressure to mention anything you would rather not discuss, or to participate in any way that you don't feel comfortable with.

11:00-12:00

REALITIES AND REPRESENTATIONS OF GENDER AND MENTAL HEALTH: PRESENTATION AND DISCUSSION

E:

- As I mentioned before, I wanted to include a digital storytelling component in this project because I think it's really important for people participating in research to be able to represent themselves in the ways they choose. And of course, it's particularly important for people whose stories are often represented in media in ways that are stereotypical or inaccurate—if they are represented at all to have opportunities to create their own representations of their lives and their stories.
- In this talk and discussion, I'll provide some more of the context that has shaped my research, and discuss some of the experiences and information that participants shared in their interviews. We'll also discuss whether the realities of that trans, genderqueer, gender non-conforming and non-binary folks face generally, and with respect to mental health, make it into the media.

- Ontario's current mental health policy statement is called *Open Minds, Healthy Minds*.
- Like previous mental health policies, this one upholds a biomedical understanding of mental illness and a plan to increase access to medicalized mental health care.
- What's new about the policy is that it also seems to recognize the social determinants of mental health (which include a range of social factors that have been shown to impact people's physical and mental health, such as income, employment, race, gender, disability, and so forth.)
- The document includes statements such as, "All Ontarians deserve access to the basic elements of a safe and healthy life – education, employment, income and housing – as well as opportunities to participate in meaningful ways in their community"; "Ontario is working to eliminate the individual and social injustices that contribute to mental illness and addictions"; and "We need to look beyond the health care system to other factors that enhance mental health and create supportive communities where Ontarians with a mental illness and/or addictions no longer have to suffer alone or in silence."

- The document states that marginalized communities and populations are at greater risk of "mental health and addictions problems," and mandates education and other interventions targeting members of these groups to promote their capacity to "become much more resilient and to better cope with adversity."
- Trans, genderqueer, gender non-conforming and non-binary people are not specifically mentioned in the policy statement, but its applicability to members of these communities is clear. In Ontario, people under the trans umbrella face multiple dimensions of exclusion
- Despite the lip service paid to the notion that all Ontarians deserve access to the necessities of life in *Open Minds, Healthy Minds*, the Ontario government has done very little to ensure that people's basic needs are taken care of. Employment standards are lax and badly enforced. Rates for the province's general and disability-specific social assistance programs are extremely low. Poverty is rampant. There has been no overall improvement in access to affordable housing. These are problems affecting everyone in

Ontario, but trans, genderqueer, gender non-conforming and nonbinary people often face additional barriers to accessing employment and social services, and as a result of transphobia, many are unable to rely on financial or housing support from family members.

- Marginalization and lack of support are recognized as major contributors to the high rates of mental health difficulties among trans, genderqueer, gender non-conforming and nonbinary people documented in the literature.
- Obviously, trans, genderqueer, gender non-conforming and nonbinary people may also encounter the mental health care system for reasons relating directly to gender nonconformity or gender identity.
- This project aims to find out whether trans, genderqueer, gender non-conforming and nonbinary people people's contacts with Ontario-based mental health care have promoted their well-being; and given the structural nature of many of the problems faced by members of trans communities, whether the mental health policy's focus on promoting individual "resilience" is helpful.
- I undertook narrative interviews with 13 participants in the fall and winter of 2015. Questions addressed social location, experiences with mental health care, and experiences within communities and institutions. Here are the preliminary findings from the interviews, organized thematically.

- <u>Social Experiences</u>
  - Income and Employment
    - Most participants in this project have low incomes. Only a few participants have full-time, well-paying employment. Some participants are students and understand their financial situations as temporary, but for others, poverty is a result of their lack of employment in a province with an extremely limited social safety net. Some participants have been unable to get employment as a result of transphobic discrimination, while for others, transphobia intersects with their mental health difficulties. Several participants receive general or disability income assistance. One participant who is undocumented is not eligible for any income assistance and therefore lives in extreme poverty and engages in survival sex work. Participants note the impacts of poverty, precarious employment, unemployment and poor working conditions on their mental health.
  - Housing
    - Many participants discussed problems they have experienced with housing. Some participants have lived in unstable situations with housemates they don't like or trust, or with family members with whom they do not have good relationships. Some participants mentioned the difficulty of finding an apartment as an ODSP or OW recipient. Some participants have faced evictions, due to their inability to pay rent, or have lost their housing when they had to focus on survival and so couldn't launch human rights complaints against transphobia-based

evictions. The participant who is undocumented is homeless and sleeps in a park because the conditions in the shelters are so hostile and inaccessible. They cope by telling themselves that humans can get used to anything, and their situation is only temporary.

  - Family, Friend and Partner Support
    - Some participants have good support from their families, whether emotional, financial or both. Other participants have little support from family members. Participants who experienced childhood abuse by family members describe their family relationships as a cause of distress rather than support. Most participants receive good emotional – and sometimes material – support from friends and partners.

- <u>Mental Health Care Experiences</u>
  - Mental Health Care as Detrimental to Well-Being
    - Mental health care services were sometimes unavailable when participants sought them out, or “available” services were in reality inaccessible to trans, genderqueer, gender non-conforming and nonbinary people due to the ignorance or transphobia of providers. This was especially problematic for those living outside of major cities. When trans-friendly services were theoretically available, they were often not covered by OHIP and were therefore financially inaccessible to most participants.
    - Participants who accessed mental health services during childhood sometimes found the care they received unhelpful. Several participants were labelled with personality disorders rather than PTSD despite disclosures of having suffered abuse. A participant who sought approval for transition through the gender identity service at CAMH was asked many extremely humiliating and intrusive questions in front of their parent. Another participant who was looking for approval from the gender identify service to begin hormone therapy during their late teens shared that they were instead referred for “reparative” therapy.
    - Participants also came into contact with overtly transphobic and abusive “care” providers as adults. Several participants mentioned being subjected to extremely inappropriate sexual comments and questions.
    - Participants were often pushed into contact with mental health care as a requirement for their transition, which was more burdensome than helpful, particularly for participants who were forced to deal with the gender clinics at CAMH, where participants reported needing to be strategic in their disclosures in order to access care. Numerous participants reported that their previous negative experiences at CAMH made seeking approval for OHIP-funded gender confirmation medical procedures a complete impossibility, even though this meant that they would have to pay several thousand dollars for private, informed consent-based surgical care.

    - Mental Health Care Promoting Well-Being
        - Some participants have received good support through the mental health care system, including from OHIP-covered psychiatrists. Several participants mentioned that they have received good care at LGBT-focused community health centres. Some of the services that participants accessed as adolescents were extremely helpful: The participant who was referred to a counsellor for conversion therapy ended up receiving support from that counsellor for their social difficulties rather than “help” to change their gender identity. Participants with workplace benefits or enough income to pay out of pocket for counselling were generally able to access very good support.

- While mental health care services have sometimes been helpful, promoting personal growth and providing relief for stress and distress, for many participants, the mental health care system has also been a source of suffering and trauma.
- It is clear that the participants in this research *are* resilient – their stories abound with evidence of their strength and their ability to persevere in incredibly difficult circumstances. Every day, participants experience the impacts of poverty, abuse, racism, colonialism, unjust immigration policies, ableism, sanism, sexism, transmisogyny and transphobia. And yet they keep going.
- At this point, what I’m wondering is how much *more* resilient should people become? How much *more* adversity *should* people be able to cope with? Could the folks who decide against funding “the basic elements of a safe and healthy life” cope in the circumstances that some of the participants in this project have faced?
- When I asked participants what kinds of changes to society and institutions they thought would help improve their lives, people discussed their ideas for ways to end the conditions of poverty, isolation and violence that they and so many other trans people live in. Participants’ interviews revealed the many ways that they are working toward this goal: Involvement in politics; promoting anticolonial education; publishing articles on trans rights; running support and education projects for trans people; doing research on economic reform. My opinion is that the participants in this project don’t need resilience education: They are the ones leading the way toward a better society, and they should be the ones making policy decisions.

- <u>Realities vs. Representations</u>
    - So, when we look at whether these realities are represented, it seems that, generally, they haven’t been.
- Research on representations of folks labelled as having mental health difficulties as well as trans, genderqueer, gender non-conforming and non-binary folks shows that both groups have been portrayed in overwhelmingly negative ways in mainstream media (as violent, dangerous, untrustworthy, and even subhuman)—when representations overlap (and a person who is trans or gender non-conforming is also depicted as having mental health difficulties), the negativity of the representation is compounded. (There

aren't many mainstream representations of genderqueer and nonbinary folks, so I couldn't find any relevant research discussing this, or even think of any examples.)

- There's some evidence that things are changing to some extent—mad/consumer/survivor/ex-patient activism and efforts at self-representation (particularly online) has helped shift representations of mental health difficulties. Very similarly, activism and representation work by folks under the trans umbrella has contributed to changing discourses around trans people's lives, although problematic representations seem to remain dominant.

K:

- With respect to representations of people experiencing mental health difficulties as well as representations of trans, genderqueer, gender non-conforming and nonbinary people…

    - What representations have you seen?
    - What changes have you seen over time/across cultures?
    - Where do you see representations? Are there differences between mainstream and community/alternative media representations?
    - Do you see producers of cultural knowledge in positions of power?
    - Do the representations you've seen reflect your own identity and experiences?
    - How have the representations you've seen impacted you?
    - What would you like to see in representations of these communities?

12:00-1:00
<u>LUNCH</u>

2:00-3:30
<u>STORY CIRCLE</u>

E:

- When you're thinking about how to further develop your story, you might want to keep in mind the Seven Steps for Digital Storytelling. I put a copy of the Seven Steps in your red folder, in case you want to refer to it.
- The story circle is a time to share where you are with your story so far. Whether you have a developed script, or just a few ideas, this is an opportunity to tell your story and receive feedback to support you to further develop your story.
- As a story circle participant you also have an opportunity to hear your fellow participants' stories, and to offer helpful responses and feedback.

B:

- We'll begin with a few guidelines:

Timeframe

- Each storyteller will have about 10 minutes to read their script and/or talk about their ideas, and to hear feedback from other members of the circle.
- Should we have a timekeeper?

Feedback

- At the beginning of each storyteller's turn, we'll ask what kind of feedback they would like to receive. You can decide if you want applause or no applause, if you want no feedback at all, or if you do want feedback, if you want personal resonances, questions, ideas for further development, or suggestions for changes.
- Ideas for further development could be for the script, or for possible concepts for images, videos or sounds to create or use.
- Please avoid telling storytellers what they *should* do. Everyone is free to tell their own story in their own way.

Respect

- Everyone's story is valid; Please be non-judgmental – try to avoid negative expressions and body language, or sounds that indicate disinterest or disapproval.

Confidentiality

- What is said in the room stays in the room.

K:

Consideration

- Let each person talk until they are finished presenting their script/story idea before you offer any comments or questions.

Focus

- Try to focus on the storytellers and the discussion.
- If it's possible, please turn your phone off.

Emotions

- This can be an emotionally difficult process.

Silence

- If someone is struggling with what to say, they shouldn't be pressured to figure it out quickly.

Other suggestions?

- Does anyone have any other suggestions for guidelines?

FACILITATOR QUESTIONS

- Appreciative comments:
    - I really liked (fill in the blank) about your story. A phrase/something that jumped out for me was (fill in the blank). That was very brave, and I appreciate you sharing that story.

- Point of View:
    - Why are you choosing this piece of writing now? Who do you see as the audience for this story?

- Dramatic Question:
    - After hearing your story, I can think of many different ways you could write/structure it. I have these ideas (share ideas), but what are you thinking about, in terms of a direction to go in for your script?

- Detail:
    - I heard something about (fill in the blank) in your story, and I'm curious to hear more about that. Is there a specific incident that comes to mind? What would be a way to "create a scene" in your story?

- Clarification:
    - It sounds like you're talking about (fill in the blank). Is this right, or did you mean something else?

- Suggestion for Additional Content:
    - I really like what you've shared, and given that our topic is (fill in the blank), I'm thinking that you might *also* want to touch on (fill in the blank).

- Creating a Scene:
    - Your story is very powerful, and I feel like what might make it even more so would be to have some detail about a specific moment in time. For instance, you might think about writing a paragraph that really spells out what it felt like when (fill in the blank) or what happened when (fill in the blank).

- Economy:
    - What images do you have in mind for your story?

- Support:
    - Are you open to feedback? Is there anything else you would like us to give you feedback on? Do you have enough feedback to move forward?

- Summarizing (to end with, before going on to the next person):

    - Do you have any more questions for us, or for the group? Do you feel like you have enough to work with, to take the next step with your script?

Closing the Story Circle

E:

- *End the story circle with supportive and positive comments that thank everyone for their honest and open participation. Let everyone know that they can check in with instructors on an individual basis to continue to develop their script ideas.*

2:30-5:30 (VARI HALL 1156)
SCRIPT WRITING AND REVIEW; STORYBOARDING

- *Assist storytellers if they have any questions or require support in expressing themselves.*

2:30-5:30 (HNES 405)
VOICEOVER RECORDING

- *Help those storytellers whose scripts are complete and finalized record the voiceover and sound-effect (if any) components of their digital stories.*

DAY 2 AGENDA

9:00–9:30 (Vari Hall 1156)
REFRESHMENTS, SIGNING OF CONSENT FORMS

9:30-10:30 (Vari Hall 1156)
INTRODUCTIONS, VIDEO EDITING TUTORIAL

INTRODUCTIONS
Since we have a couple new people here, if we could all do a brief introduction, that would be great!

VIDEO EDITING TUTORIAL
Today, Erin MacIndoe Sproule from Project Re•Vision/REDLAB is with us to teach us how to use Final Cut Pro X.

10:30-10:45 (Vari Hall 1156)
ANONYMITY DISCUSSION

10:45-12:30 (Vari Hall 1156)
OPEN STUDIO (STORYBOARDING; IMAGE PREPARATION; CONSTRUCTION OF DIGITAL STORY IN FINAL CUT PRO)
Support storytellers to develop their storyboards and images, and assist them in using Final Cut Pro.

10:45-12:30 (HNES 405)
VOICEOVER RECORDING
Help storytellers record the voiceover and sound-effect (if any) components of their digital stories.

12:30-1:30 (VARI HALL 1156)
LUNCH

1:30-5:30 (VARI HALL 1156)
OPEN STUDIO

2:30-5:30 (HNES 405)
VOICEOVER RECORDING

DAY 3 AGENDA

9:00–9:30 (Vari Hall 1156)
REFRESHMENTS, SIGNING OF CONSENT FORMS

9:30-12:30 (Vari Hall 1156)
OPEN STUDIO

9:30-12:30 (HNES 405)
VOICEOVER RECORDING

12:30-1:30 (VARI HALL 1156)
LUNCH

1:30-3:00 (VARI HALL 1156)
OPEN STUDIO

3:00-4:00 (Vari Hall 1156)
EXPORT STORIES
Teach storytellers how to export their completed stories from Final Cut Pro X, converting the files to .mov format, and exporting the .mov files and working files to centralized storage media.

3:00-4:00 (Vari Hall 1156)
SIGNING OF RELEASE FORMS

4:00-5:30 (Vari Hall 1156)
PREMIERE OF DIGITAL STORIES
Watch the completed stories as a group. Ask storytellers to provide brief introductions to their stories.

FACT OR FICTION?

NAME:

1.

2.

3.

SEVEN STEPS FOR DIGITAL STORYTELLING – STORYCENTER

1. Owning Your Insights

- Finding your story: What story do you want to tell? What do you think your story means?
- Clarifying your story: What is your story about – really?

2. Owning Your Emotions

- Emotional honesty. Identifying emotions. Conveying emotions.

3. Finding The Moment

- Is there a single moment that illustrates your insight? Finding the moment of change. Integrating the moment of change.

4. Seeing Your Story

- How will the images shape your story? What images come to mind when recalling the moment of change/the entire story? What do these images convey?

5. Hearing Your Story

- Voice. Ambient sound. Music.

6. Assembling Your Story

- Structure. Integration. Economy. Pacing.

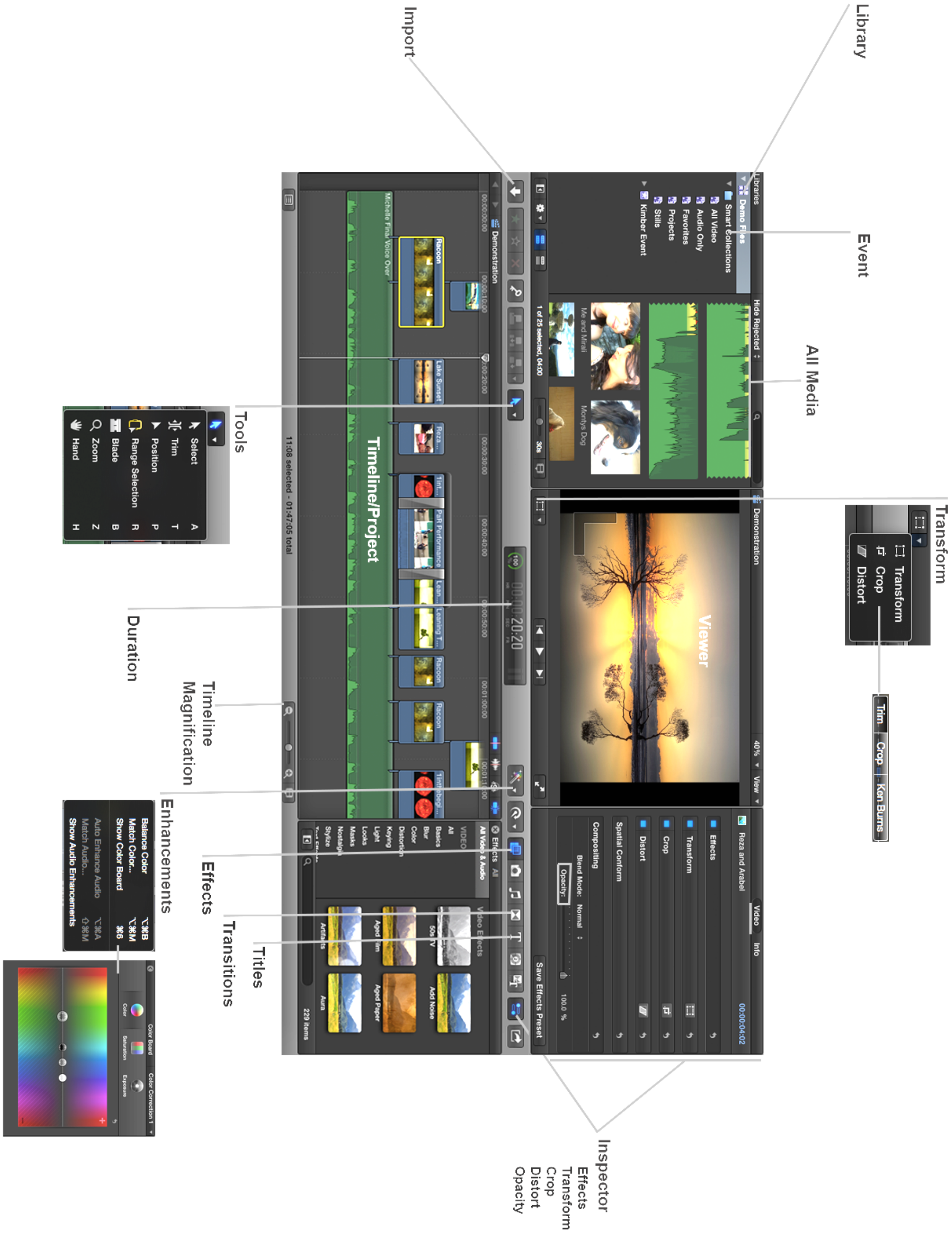
7. Sharing Your Story

- Audience. Purpose. Presentation.

WHO CAN HELP?

TASK	HELPERS
Script Development	
Ideas for Visuals	
Drawing/Crafting	
Photography	
Videography	
Ideas for Voice Work	
Sound Recording	

FINAL CUT PRO X CHEAT SHEET



DISCLOSING YOUR IDENTITY AND PROTECTING YOUR ANONYMITY IN YOUR DIGITAL STORY

Although your digital story will touch on aspects of your experience, it is not necessary to disclose your identity in your story if you do not wish to do so.

Instead of using your own name, you may wish to create your digital story under the pseudonym you chose for the interview phase of this project.

CONSIDERATIONS FOR PROTECTING YOUR ANONYMITY:

IN YOUR SCRIPT

- Use pseudonyms for yourself and any other names you mention
- Avoid mentioning specific places that could be linked to your identity (i.e. the specific name of a school you attended, or the city or town you come from—instead, you could refer to “my high school” or “a city in Eastern Ontario”)
- If you are concerned that people who know you might be able to infer your identity because of something you want to refer to, consider omitting or changing some of the details
- Consider creating a story that is symbolic, rather than a retelling of events from your life

IN YOUR IMAGES

- Do not use images showing your face or other readily recognizable aspects of your appearance—if you want to use any such images, we can help you to obscure your identity using image editing software
- Instead of including photographs, consider using art that you have created – drawings, doodles, paintings, sculptures, etc.

IN YOUR VOICE RECORDING

- If you are concerned that someone might recognize your voice, you can have someone else read your script on your behalf, or we can disguise your voice in Final Cut Pro using audio effects

STORYBOARDING PAGE

REMAINING EDITS

NAME:

EDITS TO MAKE:

CREDITS TO ADD:
