

Practice Based Research Paper GS/SOWK 5450.3

**Exploring Polysexual Experiences within Mental Healthcare and
the Negotiation of In/Visibility: A Qualitative Arts-Based Inquiry**

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A Practice-based Research Paper submitted to the School of Social Work
in partial fulfillment of the requirements for the degree of
Master of Social Work

School of Social Work,
York University, Toronto, Ontario
April 25, 2020

Abstract

Contemporary research has found that polysexual people (who are sexually and/or romantically attracted to multiple genders) report poorer mental health when compared to monosexual people (Arnett, Frantell, Miles, & Fry, 2019; Bostwick, Boyd, Hughes, & McCabe, 2010; Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Flanders, Gos, Dobinson, & Logie, 2015; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). Furthermore, data from the 2003 and 2005 Canadian Community Health Surveys found that, “Bisexuals were more likely to report unmet [physical and mental] health care needs, compared with heterosexual Canadians” (Tjepkema, 2008, p. 62). Thus, this study explored the research question: “How do polysexual identified individuals wish to be seen, understood, and/or engaged within the specific context of mental healthcare?” The framework for this study was based on Daley’s (2013) theory of “negotiating in/visibility” in psychiatric service spaces. In the current study, six people participated in a semi-structured interview and four participants additionally completed a reflexive photography exercise (which included photographs and text). All mediums of data were brought together to discuss the following four themes: intersectionality; relevance; physical, online and community presence; and resistance. Findings revealed (respectively) that polysexual people wish to be seen as intersectional bodies, for their sexuality to be understood through their own perspectives as it relates (or not) to mental healthcare, to be engaged with through queer politics, and for therapeutic services to not be yet another space where they must resist oppression. While these results are not revolutionary by any means, they convey – often unmet – needs of polysexual people, from which service providers can reflect upon their own practice.

Keywords: heterosexism, monosexism, polysexual, reflexive photography, sanism.

Acknowledgements

This research was an exciting and challenging undertaking that consumed most of my time for the past 8 months. It would not have been possible without the endless encouragement I received from my family, friends and classmates. A special thank you to my queer pals who provided invaluable insight along the way. Additionally, I would like to thank my supervisor, Shamette Hepburn. Without her persistent faith and support, the goal of this project would not have been realized. Lastly, but certainly not least, I wish to express my deepest gratitude to the study participants. This would not have been possible without those who selflessly volunteered their time to discuss very personal experiences. Thank you.

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Chapter 1: Introduction

Research Problem

Contemporary research has found that polysexual people report poorer mental health when compared to monosexual people – including heterosexual, gay, and lesbian individuals (Arnett et al., 2019; Bostwick et al., 2010; Brennan et al., 2010; Flanders, Gos, et al., 2015; Steele et al., 2009). Furthermore, data from the 2003 and 2005 Canadian Community Health Surveys found that, “Bisexuals were more likely to report unmet [physical and mental] health care needs, compared with heterosexual Canadians” (Tjepkema, 2008, p. 62). Based on these statistics, qualitative research is needed to better understand the experiences of polysexual people who access healthcare.

The term polysexual is used throughout this research as an “umbrella term” to define a person who is sexually and/or romantically attracted to multiple genders, which can encompass several sexual orientation identities including – but not limited to – bisexual, pansexual, omnisexual, ambisexual, queer, fluid, or no label at all. This definition is not based on behaviour nor the socially constructed gender binary, as these caveats may not accurately reflect the identities and experiences of all polysexual people (Flanders, LeBreton, Robinson, Bian, & Caravaca-Morera, 2017). Trans* and gender-queer people are not specifically included on the basis of their gender identities. However, many trans* and gender-queer people may additionally identify as polysexual (as defined above). Such individuals are, thus, included under this definition. Furthermore, due to the limited scope of this research, the term polysexual does not include a focus on two-spirit identities. Two-spirit refers to an Indigenous person who identifies as having both a masculine and a feminine spirit, and may be used to describe their sexual, gender and/or spiritual identity (Filice, 2015). Although some two-spirit people may identify as

being attracted to people of multiple genders, this is an identity grounded in Indigenous cultural and spiritual understanding. As a settler and “guest” (Koleszar-Green, 2018) on the traditional territory of many nations, I strive to advocate for the research and services impacting Indigenous peoples to come from an Indigenous worldview. I do not want to wrongfully amalgamate the unique experiences of Indigenous two-spirit people with that of non-Indigenous, Western queer experiences. As such, two-spirit experiences with mental healthcare are regrettably not included in the present study.

Research Question and Significance

As a response to the issues identified by extant research, this study explores the research question: “How do polysexual identified individuals wish to be seen, understood, and/or engaged within the specific context of mental healthcare?” The study approaches this question through both qualitative and arts-based research, in order to gain a more thorough and intimate understanding of polysexual peoples’ experiences. The objective of this research project is to explore how in/visibility may be experienced uniquely by polysexual mental health service users and consider how this may contribute to (perceived) outcomes of those same services. Ultimately, this research project will contribute to existing knowledge about polysexual people who seek mental healthcare.

This study will illuminate perspectives through semi-structured interviews and reflexive photography. The latter is not a commonly used research method, however, has much merit in this context as a conduit for creative expression. It can support the understanding and sharing of difficult or complex experiences beyond words (Amerson & Livingston, 2014). Additionally, this method can offer a “[...] robust vehicle for self-reflection [...]” (Amerson & Livingston,

2014, p. 207). Overall, the hope of this study is to shine a light on oppression in “therapeutic” spheres and improve services for polysexual people.

Situating the Research

Much research around the topic of polysexual experiences with mental healthcare lacks a nuanced understanding of polysexual “in/visibility” (Daley, 2013) by either: (a) looking solely at alternate/monosexual queer identities (i.e., mainly lesbian experiences), or (b) grouping all queer people – and experiences – together. Research that references queer people as a collective may serve to essentialize queer experiences, constructing them “[...] as a homogeneous group of people with fixed attributes [...]” (Poon, 2011, p. 148), thus failing to consider the unique experiences that people face depending on their particular identity. However, some scholars may argue that division of 2SLGBTQIA (two-spirit, lesbian, gay, bisexual, trans*, queer/questioning, intersex, asexual) people continues to position queer people as marginalized and oppressed, which, “underscores heterosexual practices as dominant and normative” (Mackinnon, 2011, para. 3). The intention of this qualitative research project is to not frame heterosexuality as normative, but to recognize that in a world where queer and polysexual people are frequently ‘othered,’ there can be real impacts. Those potential impacts are explored through the present research, within the context of mental healthcare.

There have been a few studies that inquire about polysexual peoples’ experiences of mental healthcare (Eady, Dobinson, & Ross, 2011; Flanders, Dobinson, & Logie, 2015; Johnson, 2016; Page, 2004); however, there remains gaps evident through this research. Firstly, much of this research primarily utilizes quantitative methods, which does not allow for the unfiltered voices of polysexual people and thus, may be lacking important information (Johnson, 2016;

Page, 2004). Such a focus on polysexual experiences of mental healthcare (as explained by polysexual identified people) may lead to different conversations and understandings. The remaining qualitative studies exclusively take a psychology-based minority stress approach and/or do not present a nuanced understanding of the interaction between sanism, heterosexism, and/or monosexism (Eady et al., 2011; Flanders, Dobinson, et al., 2015). This research aims to fill those gaps by providing a more robust understanding of polysexual experiences with mental healthcare.

These issues are largely remedied in a series of interrelated studies by Andrea Daley (2010, 2012, 2013), which explored feelings of visibility and affirmation felt by lesbian womxn¹ within psychiatric and mental health service settings. While Daley's work was incredibly unique and important, it is limited in its generalizability beyond lesbian womxn. The current research will, thus, extend Daley's work to polysexual people; utilizing her conceptual framework of "negotiating in/visibility" (2013), which depicts intersecting surfaces of body space, intersubjective space, "real" space and social forces. Thus, the rationale for the proposed study is to begin to explore the impact of heterosexism, monosexism, and sanism when receiving mental health supports, as this may gravely impact polysexual people who are already (as a whole) reporting increased mental health concerns (Arnett et al., 2019; Bostwick et al., 2010; Brennan et al., 2010; Flanders, Gos, et al., 2015; Steele et al., 2009).

¹ The term "womxn" is an alternative for "women" or "woman," which serves to explicitly include transgender womxn and womxn of color, while simultaneously rejecting the etymology of man being the root of womxn.

Researcher Position

This project was inspired by this researchers personal experiences as a bisexual/queer person who has accessed mental health services. Negative experiences have fuelled interest in learning about both similar and dissimilar involvement with mental health services in order to improve service user experiences and expand service provider knowledge. It is important to note that as a result, my personal biography has certainly shaped the study, and therefore has varied implications. While my personal resonances with the study topic may provide a unique perspective, I by no means am able to (or aim to) speak for all polysexual and queer people who have accessed mental healthcare (Alcoff, 1991). This is a common trap that one can fall into when working with people who have shared subject positions (Wong et al., 2003). It is particularly problematic when failing to consider the intersectionality of ones identities. I hold much privilege, as a white, able-bodied, cisgender person. Consequently, my privileged positionalities may limit my understandings of polysexual participants with other subjugated positionalities. Furthermore, my power as “the researcher” is undeniable, no matter how the research is framed. Thus, I must acknowledge the multiplicity of experiences and positionalities that both myself and the study participants hold, as they will undeniably impact the type of knowledge that will be produced throughout this research project.

Overview of Paper

This paper will first delve into the existing research on the topic of polysexual peoples’ experiences with mental healthcare, in order to understand how scholars have learned about and conceptualized polysexual mental health and experiences to date. Next, this paper will consider the current study paradigms and frameworks, as well as the resulting methodology and study

design. The research findings – based on both semi-structured interviews and reflexive photography – will then be presented. Finally, limitations, implications for social work practice, and areas of future research will be discussed.

Chapter 2: Literature Review

Context of Literature Review

This chapter outlines a review of extant scholarship focused on polysexual peoples' experiences with mental healthcare. In order to gain an understanding of the key discussions on this topic, several fields of study were consulted. Literature has primarily flowed from fields of psychology, sexual health, sociology, medicine, gender and sexuality studies, social work and social justice. Scholars have largely examined the following subject areas: how polysexual mental health may be different from that of heterosexual people or people with other queer identities; utilization of different frameworks to conceptualize such disparities; first hand reflections of polysexual people who have accessed mental healthcare; and subsequent implications for clinical social work.

There are a large number of studies on queer experiences with mental healthcare in the literature; however, much of this research does not focus solely on polysexual people. Many studies do not distinguish between the plethora of identities within the 2SLGBTQIA community. Rather, studies have combined data from queer people into overall results, regardless of whether identity groups were equally represented in the sample. In such cases, polysexual individuals are often underrepresented (Jorgensen, 2012). Additionally, analyses of 2SLGBTQIA people in aggregate, "[...] obscure potentially important differences [...] across specific sexual minority identities" (Salway et al., 2019, p. 90). Other studies may focus on alternate/monosexual queer identities (i.e., lesbian, gay). Although such studies may not be directly applicable, related data and concepts may prove useful for the present study. Thus, as the focus of this research is on polysexual people's experiences of mental healthcare, literature that diverges from this specific group and/or context was not reviewed in full and is only referenced as deemed appropriate.

These scholarly works have been organized thematically, based on how the topic of polysexual experiences of mental healthcare was operationalized. Themes explored have been divided into the following sections: polysexual mental health; minority stress model (Meyer, 2003); cultural competency; queer theory; polysexual experiences “negotiating in/visibility” (Daley, 2013); and implications for social work. The review utilizes a wide scope, examining research from diverse scholarly fields, in order to accurately represent the range of perspectives, voices, experiences, and subjectivities present within scholarly literature.

Overview of Polysexual Mental Health

As previously stated, much research has noted a disparity of reported mental wellness between polysexual and monosexual people (Arnett et al., 2019; Bostwick et al., 2010; Brennan et al., 2010; Flanders, Gos, et al., 2015; Steele et al., 2009). Mental health is understood by the American Psychological Association (2013) as the absence of symptoms that negatively impact social or occupational functioning. Studies employing a psychiatric perspective have shown that there is a higher prevalence of diagnosed mental illnesses/disorders among polysexual identified people than the general population – when including categorizations of heterosexual, gay, lesbian, and bisexual people (Johnson, 2016; MacLeod, Bauer, Robinson, MacKay, & Ross, 2015). A quantitative study that received 600+ online survey responses from polysexual people across several countries including the United States and Canada showed that of its respondents, “82.4% had been diagnosed with depression, 56.7% with generalized anxiety disorder, [...] 35.8% with social anxiety disorder [and] 9.23% had struggled with alcoholism or substance abuse” (Johnson, 2016, p. 389).

With the grim history of pathologizing and psychiatrizing queer people in Western society, it is important to include a review of literature that goes beyond describing the incidence of mental illness/disorders in this population. Reviewing only data framed through psychiatric models may not foreclose the experiences of queer and polysexual people. For example, a recent study of mental wellness within the polysexual community stated that while many people reported symptoms that could be argued to be related to psychiatric disorders, “some [respondents] cited specific reasons for not having an official diagnosis [...]” (Johnson, 2016, p. 391). Further to that point, many of such respondents indicated that this hesitation to engage in the psychiatric classification of diagnoses, “[...] was related to sexual orientation, [as] it is often difficult for individuals who are bisexual to get mental health care, because their orientation is pathologized” (Johnson, 2016, p. 391). These accounts show that although homosexuality is no longer a diagnosis in the Diagnostic Statistical Manual (DSM), its heritage has lasted. Furthermore, while there has been improvement by means of removing that diagnosis, there remains a more subtle pathologizing of sexuality in the DSM. To provide one example, in a review of sexual behaviour included in the diagnosis of Borderline Personality Disorder (BPD), Sansone and Sansone (2011) make explicit that BPD includes, “[...] greater sexual impulsivity as indicated by higher levels of sexual preoccupation, earlier sexual exposure, more casual sexual relationships, a greater number of different sexual partners, promiscuity, and *homosexual experiences* [emphasis added]” (p. 17). Thus, a more holistic view – distanced from the medical model – may be important when researching the mental health/wellness of polysexual and queer people.

An alternative definition offered by the World Health Organization (WHO) defines mental health as, “[...] a state of well-being in which the individual realizes [their] own abilities,

can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community” (2001, p. 1). While the application of a more holistic view of mental health and wellbeing as outlined by the WHO was scant throughout current scholarship, it was at times made visible by studies that provided relevant outcomes not solely attached to mental illness/diagnosis. A recent systematic review and meta-analysis of disparities in mental wellbeing among polysexual peoples (in comparison to gay, lesbian, and heterosexual people) found that while all, “sexual minorities are at increased risk of suicide [...]” (Salway et al., 2019, p. 89), “a consistent gradient was observed [...], whereby bisexual respondents reported the highest proportion of [lifetime] suicide ideation or attempt, lesbian/gay respondents the next highest proportion, and heterosexual respondents the lowest proportion” (Salway et al., 2019, p. 89). Furthermore, many studies also noted that though respondents indicated that they have not been medically diagnosed with any mental illnesses, they experienced symptoms or states of being unwell such as, experiencing panic attacks, endorsing self-harm behaviours, feeling withdrawn, and reporting a lack of self-acceptance (Johnson, 2016; Taylor, Power, Smith, & Rathbone, 2019).

Given the disparity exhibited in contemporary research, many studies have sought to investigate why polysexual people experience poorer mental health. A quantitative survey of diverse LGB people from New York City found that identity valence (i.e., negatively valued sexual identity) had a significant impact on mental illness symptoms, specifically depression (la Roi, Meyer, & Frost, 2019). Furthermore, the aforementioned systematic review suggested that these observations may be attributed to three interwoven phenomena: “structural and interpersonal experiences of monosexism, bisexual erasure and invisibility, or lack of bisexual-affirming social support” (Bostwick & Hequembourg, 2013; Salway et al., 2017, as cited in

Salway et al., 2019, p. 89); “pervasive erasure and invisibility of bisexual people in society” (Salway et al., 2019, p. 90); and “[...] a structural deficit in bisexual-affirmative social and healthcare support is a by-product of the social processes of biphobia, monosexism, and bisexual invisibility and erasure” (Salway et al., 2019, p. 90). Thus, much literature has tied poor mental health/wellness and negatively valued polysexual identities to oppression, which relates to the minority stress model (Meyer, 2003).

Minority Stress Model

The Minority² Stress Model was formally extended to queer people by Meyer (2003) as an, “[...] explanation for the cause of the higher prevalence of disorders among LGB people [...]” (p. 2). Stress in this context has been described as, “[...] external events or conditions that are taxing to individuals and exceed their capacity to endure, therefore having potential to induce mental or somatic illness” (Meyer, 2003, p. 2). This model offers a conceptual framework for understanding how marginalized people may be experiencing unique stress that is added on top of the general stress experienced by all humans, as “[...] stigma, prejudice, and discrimination

² Use of the word “minority” to discuss groups of people can be perceived as oppressive, as it is an essentialist term that can work to further perpetuate connotations of inferiority; rather than calling out the real issues of colonialism and capitalism within our society. When referring to subject positions and identities that face oppression, the terms “marginalized,” “oppressed,” or “subjugated” are preferred in place of “minority,” as they recognize the impact of power relations. However, the term “minority” will be used throughout this research solely to refer to the theoretical concept of minority stress, as described by Meyer (2003).

create a hostile and stressful social environment [...]” (Meyer, 2003, p. 1). Such stresses have been discussed as “insidious trauma” by scholars. This trauma has been defined as, “[...] repeated devaluations endured by a person who belongs to, or is perceived to belong to, a social identity group other than the dominant groups that hold power in society (e.g., White people, men, heterosexual people)” (Arnett et al., 2019, p. 2).

The model is divided into nine distinct processes, which as a whole depict, “stress and coping and their impact on mental health outcomes” (Meyer, 2003, p. 8) (see Figure 1). However, Meyer suggests that there are four broad processes of minority stress relevant to queer people: “[...] (a) external, objective stressful events and conditions (chronic and acute), (b) expectations of such events and the vigilance this expectation requires, [...] (c) the internalization of negative societal attitudes [and (d)] concealment of one’s sexual orientation” (2003, p. 5). Expanding upon this initial framework, Hatzenbuehler (2009) proposed that, “[...] distal stressors (e.g., heterosexist discrimination) may be associated with detrimental physical and mental health consequences through the mediating role of proximal stressors, including internalized heterosexism and sexual identity concealment, as well as psychological factors (e.g., social isolation)” (as cited in Polihronakis, 2019, pp. 27–28). This model is mainly employed as a theoretical framework by sociological and social psychological academics, and has frequently been utilized as the main model to understand unique difficulties faced by polysexual and queer individuals. A focus group study of young (ages 16-29) bisexual womxn found that several factors were identified as damaging to their mental health including, the lack of an accepting community, social marginalization, and biphobic stereotypes (Flanders, Gos, et al., 2015). Additionally, researchers have found that, minority stress as a result of internalized biphobia and discrimination were positively correlated with higher levels of depression, symptoms of anxiety,

obsessive compulsions, lower levels of self-esteem, higher levels of interpersonal sensitivity, and lower levels of social support (Beaber, 2008; Jorgensen, 2012; Lambe, Cerezo, & O'Shaughnessy, 2017). In addition, as previously stated, researchers have related experiencing such instances of antibisexual discrimination to the development of post-traumatic stress symptoms, which in turn, had implications for mental health (Arnett et al., 2019).

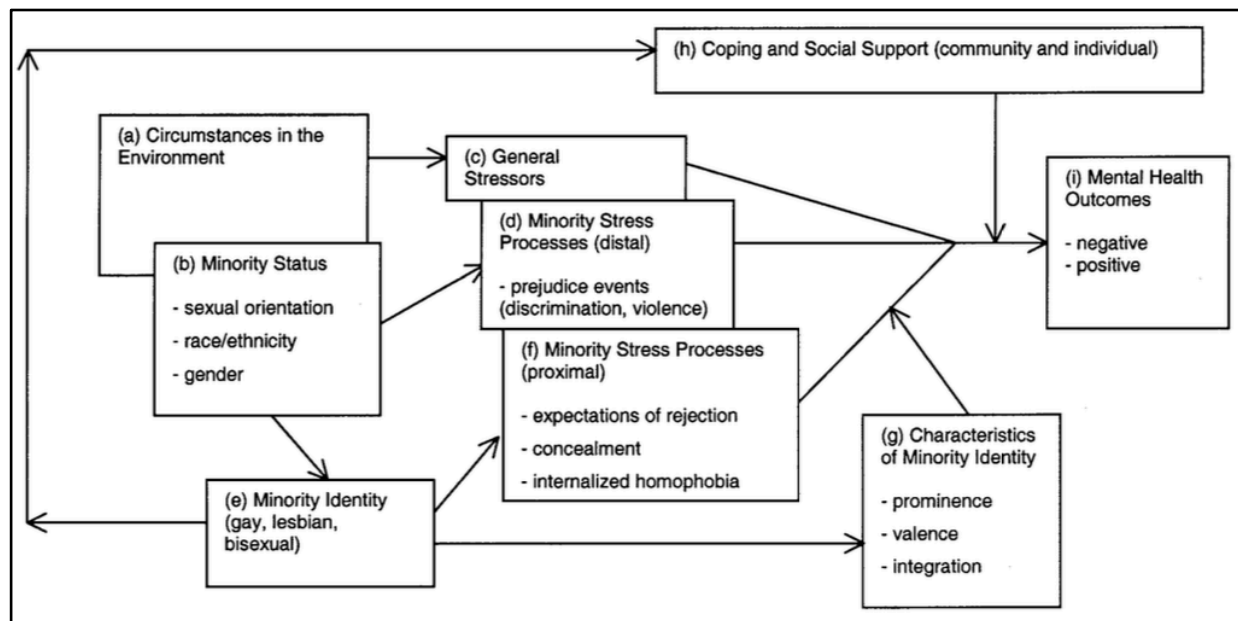


Figure 1. Minority stress model processes (Meyer, 2003, p. 35).

Several studies employing this framework have found that minority stress may be mitigated by active coping strategies (versus avoidant strategies) (Bertsch, 2014), perceived support in multiple contexts (Lambe et al., 2017; Meyer, 2003; Monaghan, Steenbeek, Snelgrove-Clarke, & Langille, 2018; Taylor et al., 2019), and – unsurprisingly – partners who understand and affirm one's sexual identity (even beyond the current relationship, if applicable) (Taylor et al., 2019). Furthermore, an Australia based study on polysexual mental health interestingly found that polysexual participants, “[...] who were in heterosexual relationships reported significantly poorer mental health than those in same-sex relationships” (Taylor et al., 2019, p. 141).

Taylor and colleagues (2019) suggested that, “This finding challenges the long promulgated belief that bisexual people in [*perceived*] heterosexual relationships are afforded ‘heterosexual privilege’ because they are less exposed to the stressors associated with being in a same-sex relationship, such as having a more visible sexual minority status” (p. 141). Rather, the opposite seemed to be true, as queer support may be more accessible to polysexual people when queerness is affirmed in *perceived* queer relationships. This points to the fact that finding queer support can be difficult for polysexual people, given the prevalence of monosexism. Ochs (1996) argued that, “[...] attacks of prejudice and stigma may also be launched from members of lesbian and gay communities” (as cited in Jorgensen, 2012, p. 22) against polysexual identified people for this very reason. Overall, while monosexism can undoubtedly impact mental health, it is not a sexual orientation that is to blame, but rather the societal oppression they face (Johnson, 2016). Minority stress can similarly be heightened when a person identifies with multiple marginalized subject positions – beyond a polysexual and/or queer identity (e.g., racialized queer people, queer people with a disability, etc.). Understanding how minority stress impacts the queer community and other subjugated populations requires an examination of systemic, group, and individual oppressions people may be facing.

While it is important to acknowledge the differences that unjustly predicate real hatred and oppression in our society, there is also danger in hinging everything on learning about differences. Critiques of the minority stress model argue that it, “[...] reinforces a fixed hetero/queer binary [...]” (Mackinnon, 2011, para. 3), which “[...] underscores heterosexual practices as dominant and normative, with “LGBT” identities understood as marginalized and oppressed” (Mackinnon, 2011, para. 3). Furthermore, Mackinnon argues that, “[...] this framework pedagogically implies that “straight allies” must (and can) become culturally

competent around queer issues” (2011, para. 3). This connection is clearly exhibited in a qualitative study of polysexual peoples’ reported mental health and experiences with mental healthcare. After reviewing statistics on the disparities in mental health (similar to data reviewed in the current literature review), the authors stated, “It is therefore important that mental health service providers are able to provide *culturally competent* [emphasis added] care to bisexual people” (Eady et al., 2011, p. 378). This comment exhibits how the use of a minority stress model may make it easy for well-intentioned clinicians and researchers to default to cultural competency as a remedy for oppression.

Cultural Competency

Cultural competency is the, “[...] notion that one could become “competent” at the culture of another” (Dean, 2001, p. 624) via education about the history, behaviours, norms and expectations of a given community, which may be, “[...] assigned according to particular aspects of identity such as race, ethnicity, class, age, gender, sexual orientation, or able-bodiedness” (Dean, 2001, p. 625). Many scholars have discussed why cultural competency is both problematic and mythical. First, in definitions of cultural competency, “[...] cultural categories or groups are treated as if they are static and monolithic with defining characteristics that endure over time and in different contexts” (Dean, 2001, p. 625). A study by Wong and colleagues (2003) found that clinician/service provider “knowledge and experience did not necessarily guarantee cultural competence” (p. 149), even within one’s own same cultural group. Thus, scholars argue that discourses of cultural competence essentialize culture, “as stable and uniform” (Wong et al., 2003, p. 151), which transforms complex bodies into topics that are researchable, fixed, and knowable (Mackinnon, 2011; Poon, 2011).

Pon (2009) takes this one step further by terming cultural competency “new racism” (p. 60). He explains this by stating that, “New racism is difficult to recognize as racism because racist discourses are interwoven with discourses about social cohesion, cultural preservation, and nationalism, which discriminate without actually using the word race” (Pon, 2009, p. 61). The same can be said for other ‘cultures’ including ‘queer culture,’ and can be further complicated by intersections of various subject positions. For example, Poon (2011) extends these critiques to racialized queer culture. He states: “Against the backdrop of (White) queers, who are assumed to have no race and thus no national origin or ethnicity, queers of colour are marked by their difference of national origin and ethnicity [...]” (Poon, 2011, p. 147). An anecdotal illustration of the essentialization of racialized queer people may be to assume that they are not accepted by their non-white – presumed ‘non-progressive’ – families. Thus, cultural competency centers white, cisgender, heterosexual (and so on) people as the “norm,” while cultures and identities that they are aiming to be “competent” in working with are by deduction deemed to be the ‘other.’

In more contemporary views based in relativism, “culture is believed to be individually and socially constructed” (Dean, 2001, p. 625). Based on this paradigm, even ones narratives about their own culture are not “a reflection of their “true” experiences,” but merely, “a representation of [their] lived experiences co-constructed both by [themselves] and [the ‘interpreter’]” (Poon, 2011, p. 146). Scholars have offered concrete ways to challenge discourses of cultural competency in practice and research. Wong and co-authors suggest allowing, “[...] practitioners to work with the clients in negotiating multiple narratives and meanings of culture” (2003, p. 162). Furthermore, Dean (2001) stated:

This is not to say that becoming informed about the history and central issues of a particular cultural group at different periods in time is not an important aspect of clinical

work. Nor do I intend to denigrate learning about culture from books, newspapers, and other forms of discourse. These sources of information can provide a beginning step in the process [...] as long as they don't lead to a presumption of knowledge or competence. Once we presume to "know" about another we have appropriated that person's culture and reinforced our own dominant, egocentric position. I am proposing that we distrust the experience of "competence" and replace it with a state of mind in which we are interested, and open but always tentative about what we understand. (p. 629)

Thus, when intervening in the lives of others, clinicians/researchers must acknowledge and embrace their perpetual, "lack of competence" (Dean, 2001, p. 624), while continuously striving to learn more about the unique individuals they are working with.

Queer Theory

The term "queer theory" was coined in a 1990 conference presentation by Teresa de Lauretis, which was "deliberately disruptive" (Halperin, 2003, p. 340) for the times, as the movement to reclaim the word queer as a gay-affirmative term had not yet reached academic spaces. Since then, many scholars have adopted this concept and expanded upon its initial theorizations. Sedgwick (2008) – who was retrospectively said to be one of the founders of queer theory (Halperin, 2003) – maintained in her second publishing of *Epistemology of the Closet* that, "[...] the specificity, materiality, and variety of sexual practices, among with their diverse meanings for individual lives, [cannot] be done [...] justice [by] abstractions that claim to define sexuality [...]" (p. xvi).

Thus, dissimilar to the minority stress model and discourses of cultural competence, queer theory does not deem heterosexual and queer identities to be, "mutually exclusive groups or fixed categories" (Mackinnon, 2011, para. 1). Rather, queer theory posits that, "One's sexual practices, tastes, styles, desires, subjectivities and identifications vary over periods of time, changing even sometimes by the hour" (Mackinnon, 2011, para. 1) and therefore invites, "[...] a

questioning of all sexuality and a critical unpackaging of how we know what we think we know” (Mackinnon, 2011, para. 2). Furthermore, queer theory rejects the, “[...] the tendency to minimize differences within queer communities [...]” (Mackinnon, 2011, para. 8) and refutes the creation of a “[...] universal queer experience which leaves no room for complexities, ambiguities, or multiple subject positions” (Mackinnon, 2011, para. 8). In sum, Mackinnon (2011) states that such pedagogies (including minority stress and cultural competence) are far removed from the many intricacies of human sexuality.

It is through viewpoints such as these, that sexual fluidity has gained increased acceptance in both academics and society. However, specific representation of polysexual identities have unfortunately been lacking in works of queer theorists (Callis, 2009; Erickson-Schroth & Mitchell, 2009). As a result, the utilization of queer theory as a framework for conceptualizing polysexual peoples’ mental wellness and experiences with mental healthcare is largely missing from the literature. This researcher was unable to locate any sources through 47 online databases (via ProQuest) housing scholarly literature.

Polysexual Experiences “Negotiating In/Visibility” (Daley, 2013)

Given the poor mental health previously detailed in data and theorizations, curiosity via research ought to be applied to how polysexual people experience mental healthcare if they attempt to access services. Moreover, Daley (2010) argues that queer people, “experience and interact with health care service providers in ways that are different from heterosexual [individuals] because they must consider the negotiation of self-disclosure/non-disclosures of their sexuality” (p. 336). However, there have been few studies that qualitatively inquire about

queer and/or polysexual peoples' experiences of mental healthcare (Eady et al., 2011; Flanders, Dobinson, et al., 2015).

A series of qualitative studies conducted by Daley (2010, 2012, 2013) – working from the field of social work – sought to research this topic by leading in-depth face-to-face individual interviews from a feminist framework. While she specifically studied experiences of womxn who self-identified as lesbian/queer and as having a mental health diagnosis, this research is conceptualized in a unique way that may lend itself well to experiences of polysexual people, and thus, is valuable to the current study.

Through this research, Daley developed a conceptual framework of “negotiating in/visibility” (2013) (see Figure 2). She explains the choice of the term “negotiating” due to the fluidity of exchanges that occur within such spaces. The term “in/visibility” recognizes the performance of queerness through physical attributes (e.g., hairstyle, clothes, mannerisms, etc.), being read as queer or heterosexual, and overt or covert disclosures (Daley, 2013). This framework depicts three intersecting surfaces and interacting elements that “drag upon queer women as they move through psychiatric and mental health services, and that allow them to delimit their performances of queer” (2013, p. 299): body space, intersubjective space, and “real” space.

Body space, “includes culturally located discursive meanings, which frame and inscribe [...] bodies” (Butler and Parr, 1999, as cited in Daley, 2013, p. 299). This suggests that queer womxn interact with mental health services/service providers as, “particularly inscribed bodies” (Daley, 2013, p. 302), based on their life experiences as a queer person, and within their additional subject positions. Intersubjective space includes sharing subjective states between service user and service provider, which may include, “[...] responses to [...] self-disclosures,

general practice skills and personal attributes, and facilitating the disclosure processes [...]" (Daley, 2013, p. 303). These interactions were found to heavily convey, "[...] recognition/non-recognition, acceptance/non-acceptance, and affirmation/non-affirmation [...]" (Daley, 2013, p. 303). "Real" space discusses the context of psychiatric and mental health services, which includes the model(s) of care utilized, the historical an ongoing legacy of psychiatric regulation and pathologizing, and shifting societal beliefs (Daley, 2013). In addition to these conceptual spaces, Daley (2013) acknowledges the social forces that impact experiences further (i.e., consumer-survivor movement, disability movement, mad movement, LGBTQ advocacy and activism, legislative gains, heteronormativity).

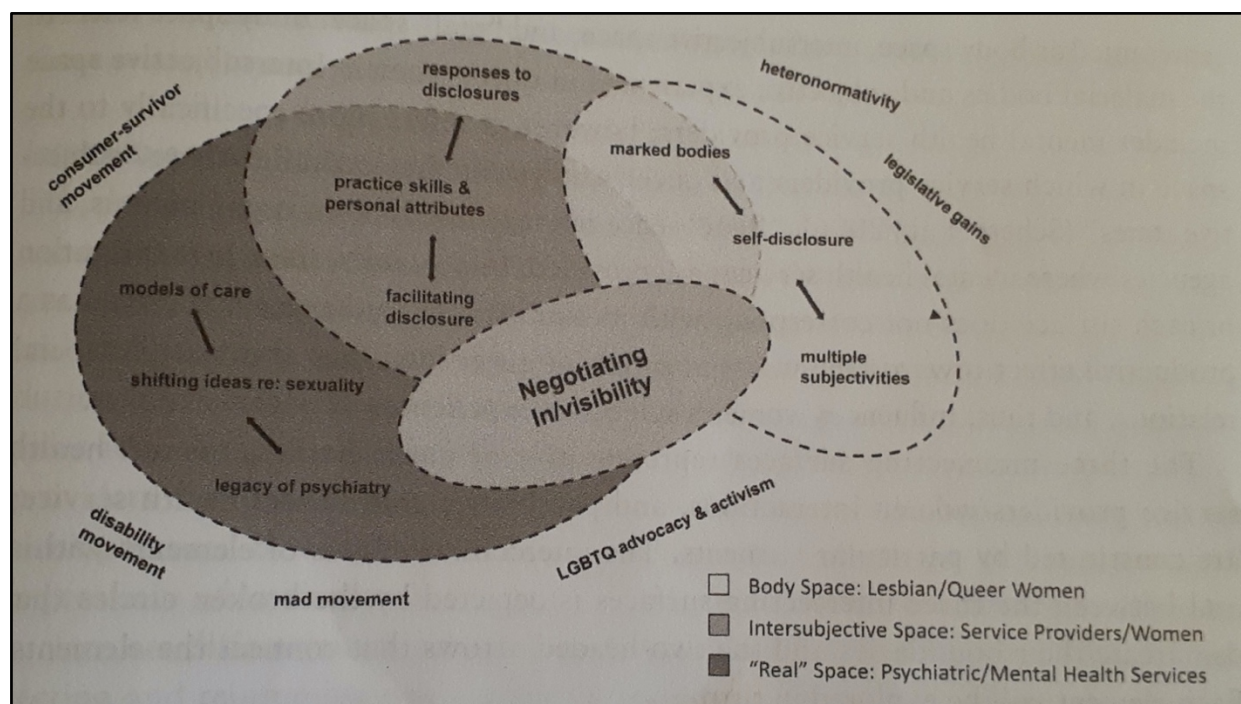


Figure 2. Negotiating in/visibility (Daley, 2013, p. 301).

Daley's (2013) conceptual framework will be utilized to structure the following review of literature on polysexual experiences of mental healthcare. By categorizing the relevant research findings through Daley's (2013) conceptualizations of body space, intersubjective space, "real"

space, and social forces, it may be possible to understand whether her framework derived from research with lesbian and queer womxn is sufficient when discussing polysexual people, or if additional concepts may be incorporated. However, it is worth noting that the author was only able to find three publications of such studies.

Body Space

Body space was outlined by Daley (2013) as including self-disclosure, marked bodies, and multiple subjectivities. Firstly, she argued that self-disclosures were an important process for the womxn in her study. Her research showed that self-disclosure in general was associated with, “[...] less anxiety, more positive affectivity, and higher self-esteem” (Daley, 2010, p. 338). However, she also found that, “[...] the assumption of heterosexuality often means that women are required to initiate discussions about sexual identity/orientation and the disclosure process during their interactions with service providers” (Daley, 2010, p. 337). Given the apparent importance of this process, she categorized the accounts from interviews into two phases of what she termed the “personal risking process: anticipatory and interactional phases” (Daley, 2012, p. 217). During the anticipatory phase, womxn engage in an internal contemplation to assess potential risks of self-disclosure (Daley, 2012). Then, during the interaction phase, the womxn developed a, “disclosure stance—passive disclosure, passive nondisclosure, active disclosure, or active nondisclosure—which they bring into their interaction with health care providers” (Hitchcock & Skodol Wilson, 1992, as cited by Daley, 2012, p. 217).

A qualitative study of young (aged 16 to 29) bisexual womxn in Toronto, Ontario (Flanders, Dobinson, et al., 2015) discussed several findings that related to body space. In relation to self-disclosures, Flanders and colleagues (2015) found that when polysexual womxn

came out to their service providers, they often had to explain labels and advocate for the legitimacy of their sexual orientation. Respondents stated that as a result they experienced feelings of dehumanization and exhaustion (Flanders, Dobinson, et al., 2015), which was then labeled as a deterrent from self-disclosing to subsequent service providers (Flanders, Dobinson, et al., 2015).

However, a related concept that was not explicitly outlined by Daley (2013) was experiences of internalized stigma. This notion was discussed by Flanders and colleagues, stating that it caused, “[...] hypervigilance about [ones] behavior in social situations, trying to communicate [their] identity to others while not fulfilling what [they] perceived as negative stereotypes about bisexual women” (2015, p. 474). This is certainly something that polysexual people may carry with them into a mental healthcare space, based on previous experiences of invalidation. Thus, internalized stigma may be an important contribution to the surface of body space for polysexual people.

Yet, a notion that was surprisingly missing from the literature on polysexual people was the concept of ‘marked bodies’ as defined by Daley (2013). Performativity of sexuality is constantly changing with societal trends. For example, the performance of queerness can sometimes be signaled through clothing and aesthetic (e.g., tattoos, coloured hair, piercings, activism pins, etc.). While this concept is largely based on stereotypes, it is something that queer people anecdotally take notice of in their own presentation and the presentation of others. Additional examples of performing queerness (or not) in a mental health service space could be behavioural, like arriving with a partner (e.g., holding hands, public displays of affection, etc.). Therefore, if a person can enter a space presenting more or less queer, this may be something polysexual people think of when attending therapeutic services. However, it is worth noting that

perceived sexual orientation based on physical or behavioural performance may perpetuate homonormativity – thinking there is a *right* and *wrong* way to be queer.

Lastly, the research with polysexual people similarly highlighted impacts of intersecting identities, communities, or subject positions (Flanders, Dobinson, et al., 2015) in the realm of body space. However, in-depth discussions of the complexities birthed by holding multiple subject positions have unfortunately not been found in the literature. Studies with the capacity to explore the intersection of polysexual identities with additional marginalized subject positions could bring about interesting and important discoveries.

Intersubjective Space

Next, intersubjective space was outlined by Daley (2013) as including clinician facilitation of disclosure, responses to disclosure, practice skills, and personal attributes. In regards to facilitating disclosure, Daley found that in many cases lesbian and queer womxn were being actively silenced through means of subtle omission, thus, requiring the womxn to, “[...] self-disclose in order to be fully seen” (Daley, 2010, p. 342). Then once they were left to self-disclose, some womxn experienced a dismissal of their sexuality, while others – more positively – experienced an “[...] understanding of sexuality as a potential source of stress and/or support [...]” (Daley, 2010, p. 342). Studies on polysexual individuals similarly discussed the implications of “coming out” to service providers.

In a qualitative study conducted in Ontario, Canada by Eady, Dobinson, and Ross (2011) from a psychological/determinants of health perspective, the authors discovered an array of both positive and negative experiences with mental health service providers. Some participants in their study reported negative responses to disclosures, revolved around expressing judgment,

dismissing bisexuality, pathologizing bisexuality, and asking intrusive or excessive questions. Judgment was said to be expressed through shock or outright disgust (Eady et al., 2011). Dismissal of bisexuality was exhibited through opinions that it was a “[...] transitional stage or not a valid sexual orientation,” telling service users that they, “would have to decide whether to identify as gay or straight” (Eady et al., 2011, p. 381). Furthermore, “[...] some of these providers explicitly associated [the service users’] mental health problems with their sexual identity” (Eady et al., 2011, p. 382), essentially pathologizing their sexual orientation.

Eady and colleagues stated that while some participants did wish to discuss issues related to their sexual identity, “[...] some found it frustrating when providers wanted to talk about their sexuality when they had come to talk about other things” (2011, p. 382). Finally, participants stated a negative component of intersubjective space was service providers who asked intrusive or excessive questions. Some individuals stated that they, “[...] felt pressured to disclose a sexual identity when [they were] not sure how [they] identified” (Eady et al., 2011, p. 382). Whereas other people stated that questions simply went, “[...] beyond what [they] felt was helpful or required in providing them with mental health care” (Eady et al., 2011, p. 382). Another interpretation was that service providers seemed to be, “[...] taking advantage of the opportunity to educate themselves at the patient/client’s expense” (Eady et al., 2011, p. 382).

On the other hand, some positive experiences with disclosure included expressing positive or neutral reactions, asking open ended questions, and seeking education outside of therapy. Many respondents stated that expressing positive or neutral reactions to disclosures was associated with perceptions of the service provider being “open-minded” (Eady et al., 2011, p. 383) and accepting, which correlates to their practice skills and personal attributes. Moreover, asking open ended and clarifying questions was appreciated by many polysexual people. By

doing so, participants perceived that service providers were allowing them to speak about whatever they wanted to raise or what was deemed important by themselves (Eady et al., 2011). Additionally, participants generally appreciated when their service provider sought education about polysexuality outside of their interactions (if needed), thus, not relying on the client to answer broad questions about sexuality that are not pertinent to the therapeutic relationship (Eady et al., 2011).

Lastly, the earliest study found in the literature utilized quantitative psychology-based methods to survey polysexual men and womxn (Page, 2004). Page found that, “Of [those] who disclosed their sexual orientation often or always to a mental health provider, most experienced acceptance [...]” (2004, p. 136). However, an interesting caveat was found when, “participants with more serious clinical issues, [reportedly] disclosed their bisexuality to clinicians less frequently than those with more moderate clinical issues, and they experienced less acceptance of their sexual orientation upon disclosure and more biased clinical interventions from providers” (Page, 2004, p. 136). Thus, there may perhaps be a correlation between real or anticipated acceptance of polysexual identity (versus monosexism) and non-stigmatizing views of mental illness (versus views based in sanism).

“Real” Space

The third surface of Daley’s (2013) framework – “real” space – was included models of care, shifting ideas regarding sexuality, and the legacy of psychiatry. She stated that many barriers to (meaningful) service were restrictive programs, medically based services, difficult to access services, and/or services with a limited number of sessions. Participants reported that these limitations had impact on their wellbeing, recovery, and “[...] not having the opportunity to

talk about sexual identity [...]” (Daley, 2010, p. 345). This space was unfortunately not much discussed in the literature on polysexual individuals. Although, research did make mention of oppression in service organizations, even within “[...] supposedly LGBT-friendly spaces” (Johnson, 2016, p. 380).

Social Forces

The final surface outlined by Daley (2013) – social forces – was described as including heteronormativity, the mad movement, the consumer-survivor movement, the disability movement, LGBTQ advocacy/activism, and legislative gains. These oppressions and activist movements vigorously compete against one another, slowly shifting our culture. While all queer people may experience heterosexism, monosexism is unique to polysexual people. Erroneous beliefs about bisexuality have been rampant throughout history. For example, Sigmund Freud wrote about bisexuality in the 1960s as a developmental phase that all individuals were born into, however, asserting that as an individual matured, they would become either a heterosexual or a homosexual (Callis, 2009). “Therefore, bisexuality was not a sexual identity, but rather an intermediate position based on an infant’s hermaphroditism in the womb” (Freud & Brill, 2008, as cited in Callis, 2009, p. 224). In modern society, it is still common to hear such dismissals of polysexuality, or even, myths that falsely denigrate the character of polysexual people or simply do not accurately represent polysexual people. Jorgensen (2012) details some of the most prevalent assumptions and stereotypes about polysexual individuals, which include:

[...] engaging in promiscuous sexual behaviors, having or desiring multiple sexual and romantic relationships concurrently, desiring relationships with men and women concurrently, being equally attracted to men 50% of the time and women 50% of the time, breaking up families by cheating with married persons, and transmitting HIV/AIDS between straight and gay communities. (pp. 22–23)

Additionally, Erikson-Schroth and Mitchell (2009) state that, “Contemporary culture paints [bisexual people] as promiscuous, greedy, indecisive, duplicitous, confused, fickle, attention-seeking and, ultimately, closeted gays (or straights)” (p. 298). These misrepresentations and outright denials lead to continued erasure of polysexuality and polysexual issues (Flanders, Dobinson, et al., 2015). The literature has unfortunately not detailed activist efforts – aimed to change these social forces – from the perspectives of polysexual people. Lastly, topics of sanism – or as Daley (2013) highlighted: the mad movement, the consumer-survivor movement, and the disability movement – were not discussed beyond the broad claims of pathologizing sexual orientation, as detailed by Eady and colleagues (2011) (previously discussed). Unfortunately, concrete examples were not provided or discussed throughout the literature. Future studies may consider seeking to gain a more nuanced understanding of the interaction between sanism and heterosexism and/or monosexism.

Implications for Social Work

Research reviewed in the former section subsequently made suggestions for clinical support of all kinds (e.g., psychotherapy, social work, etc.). These recommendations either came directly from participants, or were ascertained by researchers based on their participant interviews. The following remarks are not revolutionary by any means, and yet, the voices of polysexual research participants echo that they are not always being achieved.

Many recommendations have been made at the individual clinician level. Daley (2010) states that her study findings with lesbian/queer womxn suggest a need for service providers to, “create inviting relationships with lesbian/queer women that facilitate self-disclosure opportunities and foster recognition, acceptance, and affirmation of women’s sexual identities”

(p. 353). Given the research examined about polysexual peoples' experiences with coming out to service providers, this suggestion would likely be helpful when working with polysexual people as well. Moreover, Eady and colleagues (2011) discussed four tangible recommendations for practitioners working with polysexual people specifically:

(1) having knowledge of [polysexual identities, experiences,] communities and [...] resources for their clients, (2) not making an issue of sexual orientation when it was not relevant, (3) not being afraid to deal with issues around sexual orientation when they were relevant, and (4) helping clients feel good about themselves as [polysexual people]. [...] Although these changes do not address the broad systemic problems that impact the experiences of bisexual people who seek mental health care, they represent an important step in eliminating heterosexist and monosexist bias at the organizational level, and in so doing, improving experiences with mental health care for bisexual people. (pp. 385–386)

Thus, while focusing on what individual service providers can do, clinicians and social workers alike must remain critical of – unintentionally, or otherwise – reproducing systems of oppression within the healthcare setting and reinforcing assumptions, rather than holding the client as the expert of their own experience. At the organizational/systemic level, Salway and colleagues (2019) unearthed a particularly salient point through their systematic literature review. In concluding the review, researchers called for, “[...] structural supports to validate and honor diverse sexualities” (p. 107) through their policies, practices, and advocacy. This point is concise, and yet, its value cannot be underestimated.

Conclusion

In exploring polysexual experiences of mental healthcare, reviewing relevant scholarly literature has provided essential knowledge to enhance the utility of the current study. The themes discussed – how polysexual mental health may be different from that of heterosexual people or people with other queer identities, utilization of different frameworks to conceptualize such disparities, first hand reflections of polysexual people who have accessed mental healthcare,

and subsequent implications for clinical social work – have proven to be important points of inquiry into this topic. Furthermore, this literature review has aided in calling attention to apparent gaps in the literature, which may present opportunities for contribution. The research reviewed has lacked nuanced understandings of polysexual experiences of in/visibility in mental healthcare by either: (a) looking solely at other/monosexual queer identities (mainly experiences of lesbian womxn), (b) exclusively taking the psychology-based minority stress approach, or (c) conducting quantitative research that does not allow for the unfiltered voices of polysexual people. Thus, qualitative research on polysexual experiences of in/visibility in mental healthcare as explained by polysexual identified people who have accessed mental health services may lead to different conversations and understandings.

Chapter 3: Methodology and Research Design

Paradigm

This study was framed by a pragmatic paradigm. It therefore utilized mixed methods in order to operationalize the research process, exercising “all approaches available to understand the problem” (Creswell, 2009, p. 10), including constructivism and advocacy/participatory paradigms. The constructivist framework places value in understanding participant views in order to develop subjective meanings (Creswell, 2009). Thus, constructivism was applied in this research through the use a semi-structured interview with open-ended questions (see Appendix 4), allowing participants to voice their experiences and understandings. The research was extended through the use of an advocacy/participatory perspective, which is “[...] focused on bringing about change in practices” (Creswell, Hanson, Plano Clark, & Morales, 2007, p. 257). This paradigm allowed for dialogue about how mental healthcare services may be improved for polysexual people. These paradigms are both grounded in the ontological perspective of relativism, which states that truth is “[...] subjective and knowable only through embodied perception” (Starks & Brown Trinidad, 2007, p. 1374). Thus, the second method of reflexive photography was utilized in this research as a means of better understanding each participant’s embodied perceptions. Lastly, the epistemology aligning with these paradigms is that of co-created findings between researcher and participants through collaborative processes. Therefore, this research offered participants greater control over what information is relayed through the arts-based ‘take-home’ exercise, also allowing for greater reflection beyond the standard time-restricted interview.

Theoretical Frameworks

This research project was informed by several theoretical frameworks, each offering integral ways of understanding the experiences of polysexual people who access mental healthcare in Southern Ontario, Canada. The theories to be discussed in this section are queer theory, mad studies, intersectionality, and critical pedagogical theory. Queer theory was a central theoretical framing of this research project. As previously outlined in the literature review (Chapter 3), queer theory posits that, definitions of sexuality cannot honourably describe “[...] the specificity, materiality, and variety of sexual practices, among with their diverse meanings for individual lives [...]” (Sedgwick, 2008, p. xvi); thus inviting, “[...] a questioning of all sexuality and a critical unpacking of how we know what we think we know” (Mackinnon, 2011, para. 2). This theoretical approach was directly applied to the sample of participants relevant to this research: polysexual people. Mackinnon (2011) argues that queer theory rejects the, “[...] the tendency to minimize differences within queer communities [...]” (para. 8). Thus, by investigating polysexual peoples’ unique experiences, this research rejected the essentializing of queer people.

When discussing mental health and wellness, this study did not aim to, “[...] sell a sanitised and/or neurodiversity-infused knowledge, or praxis” (McWade, Milton, & Beresford, 2015, p. 307). Thus, mad studies was the second central theoretical framework utilized throughout this research project. “The contemporary mad movement came into being during the [...] 1960s and 1970s” (Menzies, Lefrançois, & Reaume, 2013, p. 3). Through this movement, the term ‘mad’ was reclaimed, “to represent a critical alternative to “mental illness” or “disorder” as a way of naming and responding to emotional, spiritual, and neuro-diversity” (Menzies et al., 2013, p. 10). The theoretical foundation – mad studies – is defined as a theory, which:

[...] incorporates all that is critical of psychiatry from a radical socially progressive foundation in which the medical model is dispensed with as biologically reductionist whilst alternative forms of helping people experiencing mental anguish are based on humanitarian, holistic perspectives where people are not reduced to symptoms but understood within the social and economic context of the society in which they live. (Menzies et al., 2013, p. 2)

As this study addresses issues related to mental healthcare, this framework was integral to the work. This research, therefore, provides a non-medicalized view of mental health and wellness, while respecting the language used by each participant to self-identify. For example, if a participant identified as having a ‘mental illness’ or ‘diagnosis,’ this researcher did not deny the use of such language and utilized their language when specifically referring to their psychiatric experience, however, the researcher continued to use non-medicalized language in all other instances. McWade and colleagues (2015) sum this up presciently by stating that, “It is ‘time to talk’, and not in the way the establishment wants us to [...]. Instead, let us build upon the rich histories of activism and bring our shared experiences of oppression and marginalisation together” (p. 308).

The third theory utilized was intersectionality – “[...] an analytical ambition to explore [subject positions] as complex, intertwined, and mutual reinforcing categories of oppression and social structures” (Mattsson, 2014, p. 9). Mattsson (2014) stated that, “in social work, intersectionality has been used as an analytical approach during recent years and it has been a way to understand both complex identities and how social structures affect people’s living conditions” (p. 10). This theoretical framework was employed through the focus on simultaneous experiences of oppressions that participants may face – namely heterosexism, monosexism (discussed via queer theory), and sanism (discussed via mad studies). Furthermore, attention was given to additional intersecting identities (e.g., racialized queer people, queer people with a disability, etc.). The aim in doing so was to gain a more complex understanding of participant

perspectives of systemic oppression and structural barriers, which is in line with relativism. This theoretical framing also spoke directly to advocacy/participatory research, as “[...] social justice has always been a core tenet of intersectionality theorizing” (Mehrotra, 2010, p. 427). Thus, intersectionality fit with the overarching objective of this research, to ground the experiences of polysexual people who access mental healthcare within larger systems of power, and to change these systems which oppress.

The final theoretical framework was Freire’s critical pedagogical theory. Critical pedagogy is “[...] concerned with issues concerning social difference, social justice and social transformation” (Mayo, 1990, as cited by Ledwith, 2001, p. 171). The foundation of critical thought is that, “critical thought leads to critical action” (Ledwith, 2001, p. 177). As previously discussed, one of the guiding paradigms of this research project – advocacy/participatory research – emphasizes creating positive social change. In this way, critical pedagogy got to the core of what this research was seeking to do. Furthermore, critical pedagogy in tandem with intersectionality elevated the analytical merit of the project. Ledwith (2001) argues that, “Focusing on the symptoms, rather than the causes, of oppression has falsely premised radical practice, leading to a dangerous illusion that we are making a difference” (p. 174). This framework was, thus, utilized by questioning societal assumptions about ‘queerness,’ mental health and wellness, and therapeutic intervention.

Methodological Framework

This research project employed the methodological framework of hermeneutic phenomenology. Phenomenological research offers a “[...] close examination of individual experiences” (Starks & Brown Trinidad, 2007, p. 1374). It is, “[...] an interpretive process in

which the researcher makes an interpretation (i.e., the researcher “mediates” between different meanings [...]) of the meaning of the lived experiences” (Creswell et al., 2007, p. 253). A hermeneutic approach, thus, acknowledges that the researcher is not able to simply set aside their own experiences and opinions in order to, “take a fresh perspective of the phenomenon under examination” (Creswell et al., 2007, p. 254). Instead, Kafle (2011) asserts that this school of phenomenology premises that, “[...] acceptance of endless interpretations [...] puts an effort to get beneath the subjective experience and find the genuine objective nature of the things as realized by an individual” (p. 186). In order to do so, researchers must recognize, “[...] implicit assumptions and attempt to make them explicit” (Kafle, 2011, p. 190).

Hermeneutic phenomenology was selected as the lens through which this research was conducted, analyzed and theorized because of its ability to produce rich data analysis and a deeper understanding of internal and external phenomena (Kafle, 2011). This methodological framework was informed by the fundamental ontological, epistemological, and theoretical underpinnings discussed in the preceding sections, as this research sought to give research participants a voice. Lastly, this framework informed the research design, which is discussed in full in the following section.

Research Design

This study applied a mixed modalities approach: utilizing qualitative and arts-based research methods. There were two points of researcher/participant interaction throughout the study. At the beginning of the initial face-to-face interaction, the researcher reviewed and explained the study consent form (see Appendix 3). Once the consent process was completed, each participant was asked to engage in a semi-structured interview with the researcher that

ranged from 30 to 90 minutes, depending on how detailed the participant chose to be. Interview questions were centered on the participant's experiences accessing mental health services.

Semi-structured interviews were thoughtfully chosen as one of the methods for this research project due to the paradigms and frameworks previously discussed. Interviews are one of the most common methods accompanying phenomenological research (Creswell et al., 2007), which provides opportunity for open dialogue. Additionally, critical pedagogy speaks to the importance of an open dialogue between researcher and participants. Ledwith (2001) states that, “through the process of dialogue, we listen from our hearts and minds, connecting with people through our common humanity” (p. 177).

The second part of the study was an arts-based ‘take-home’ exercise. After completion of the interview, participants were asked to partake in a reflexive photography practice (see Appendix 5). “Reflexive photography is an innovative qualitative research technique that examines participants’ interactions with their environment through their personal reflections on images that they captured [...],” which may also act as evidence of their perceptions (Amerson & Livingston, 2014, p. 202). Participants were tasked with taking (or selecting pre-existing) photographs that discuss a set of related themes. They were additionally asked to write a short description of each photo and explain how it reflects a certain theme.

The purpose of this reflexive photography activity was to offer an alternative way of conveying participants’ thoughts. Butterwick (2002) stated that arts-based inquiry was developed to “challenge the limitations and oppressive features of traditional scientific research, opening spaces for experimentation of alternative approaches” (p. 243). Amerson and Livingston (2014) posit that:

Using reflexive photography requires the researcher to relinquish control of the data collection to some degree. The photographer [...] decides what photograph to take and

how to express the meaning that is attached to the photograph. Usually in qualitative research, the researchers decide what data to collect, but in this case, the research participant chooses the photographs. Then, it is the role of the researchers to examine the underlying meanings and link them in a coherent manner to create themes. (p. 208)

This democratic process is parallel to this projects' epistemological underpinnings, which value the co-creation of knowledge between researcher and participants, thus allowing the researcher to impose less control over the study outcomes. Another key component of this method of inquiry is that it, "[...] it does not describe another's experience but rather recreates it for the reader/observer" (Hanauer, 2010, as cited by Finley, 2018, p. 572). This is in line with advocacy/participatory research, as photographs can offer a powerful means of conveying information and emotional experiences to the service providers who may subsequently read and view these research findings.

Ethical Considerations

Participation in this study was completely voluntary. Shoppers Drug Mart gift certificates (valued at \$15 CAD) were provided to all participants. Participants received the gift certificate after the consent process was completed, regardless of their length of their participation in the study and the information they provided. While this may have aided in incentivising people to participate, the gift certificate was not deemed large enough to impair one's capacity for non-coerced consent. Rather, the ultimate goal of providing the gift certificate was to offer a small token of thanks for each participants' time.

Due to the personal nature of this research, participants may have felt anxious prior to completing the study. This risk was managed by thoroughly reviewing the informed consent guidelines prior to beginning. There was also the potential for emotional discomfort during the interview. This risk, however, was mitigated through deliberate selection of interview questions

and prompts. If participants did experience discomfort during the study, they were offered the opportunities to talk it over, take a break, not answer any question(s), or end the session.

Participants were assured (prior to starting the study) that if they chose to end the study, for any reason, it would not affect their relationship with the researchers, York University, or any other group associated with this project. In that case, all associated data collected was promised to be immediately destroyed wherever possible. These risks and options were detailed in the consent form. Lastly, queer friendly resources were provided to all participants, in case they wanted support after completing the study.

All data gathered during the research project was assured to be held in confidence. However, limits to confidentiality included ongoing child abuse and potential harm to the participant or others. Participants were informed that in these scenarios, the researcher may have a duty to report this information to local child protective services or crisis services, respectively. This stipulation was explicitly indicated in the consent form to ensure that all participants could make informed decisions about what they wanted to share throughout the interview and reflexive photography processes.

No identifying information (e.g., names, service agencies, etc.) has been included in this current publication (or future publications) of study results. Participants were provided the option to have interview quotations and submitted photographs reproduced in the final publication, which have been held to this standard of confidentiality. Though, participants who consent to having their photographs reproduced in the final publication were then provided the opportunity for artistic acknowledgement, which would breach their confidentiality, as it would identify them as a study participant. While their name was assured to not be associated with specific interview responses, this option may not have been desired by participants for a multitude of reasons

related to both privacy and safety. This optional consequence was explicitly detailed in the consent form.

Lastly, the study methods chosen must be examined as a potential source of ethical transgression. While inquiring about participants lived experiences may be difficult for some, it can also be an empowering process, as participants are provided with the opportunity to be valued as experts. Furthermore, the incorporation of reflexive photography may have offered participants “[...] increased insight [into their experiences] through their engagement” (Amerson & Livingston, 2014, p. 203). In analyzing the subsequent data, the researcher aimed to stay as close to participants verbal and written narratives, rather than interpreting and theorizing meanings. However, as the primary researcher, I grappled with the fact that I am not able to fully put aside my worldview and biases. Despite efforts to minimize my biases, my experiences have undoubtedly informed my interpretation of the data. Thus, I must acknowledge the massive amount of power I have as the person compiling people’s experiences and thoughts. The same data (interview responses and photographs) may produce vastly different findings if analyzed by another person with different frameworks. Thus, through this research, I strived to honestly and authentically portray the lived experiences of participants, despite barriers inherent to the process.

Data Collection

The six interviews were held in a private study room at the participants choice of public library in Southern Ontario. If allowed by the participant, the interviews were audio recorded on two recording devices (one laptop and one cell phone) in case of malfunction. If not allowed, the researcher was prepared to take detailed notes during the course of the interview. Notes or

‘memos’ were made during and “[...] after each interview regarding the topics talked about [...]” and “[...] about ways of categorising the data” (Burnard, 1991, p. 462). Interviews were then transcribed by the researcher, omitting or anonymizing any identifying information. Secondly, the reflective photography exercise was asked to be submitted to the researcher within one week of completing the initial interview. Photographs could be submitted through email or at a second in-person meeting with the researcher, which may have been preferred if photos were in a physical format, or if participants wanted to debrief this experience. The reflexive photography exercise was completed by four of the six participants.

Participants

Participants were recruited through a process of general invitations via online advertisement and printed posters (see Appendix 2). Additionally, recruitment employed a snowball sampling strategy by encouraging potential participants to share the study information with other people who may be interested. Six participants were recruited from Southern Ontario who were 18 years of age or older, identified within the ‘polysexual umbrella’ (as per the definition provided in Chapter 1), and who have accessed mental healthcare (including inpatient, outpatient, community based, residential, and/or private services). In describing their sexual orientation, three participants identified primarily as pansexual, one as queer, one as fluid, and one as asexual. Though, several participants described using alternative labels such as bisexual or queer depending on the context. Furthermore, one participant identified as aromantic, while another participant identified as panromantic. In describing their gender identity, three participants identified as cis-females, two as nonbinary or gender nonconforming, and one as a cis-male.

Data Analysis

First, interviews were transcribed by the researcher in preparation of analysis. Barbour (2014) stated that, “[...] valuable insights may be derived from paying attention to the odd intriguing comment or use of vocabulary by participants” (p. 264). Additionally, “[...] it is important to pay attention to emphasis and tone, which can also significantly alter the meaning of an utterance” (Barbour, 2014, p. 257). Thus, these potential nuances were taken into consideration when transcribing all interviews. Reflexive photography submissions (including the photo and accompanied text) were not altered in any way, though the researcher wrote rich descriptions of each photo for accessibility purposes.

The data gathered during the collection process of this project – including the transcribed interviews, submitted photographs, and accompanied text – was analyzed and interpreted through a process of thematic analysis in order to draw out common themes within different participants' stories. “Thematic analysis focuses on identifiable themes and patterns” (Aronson, 1994, p. 1) in verbal, textual and visual data; and was thus, a fitting method of analysis. A review of related literature aided in finding already classified patterns (Aronson, 1994; Tuckett, 2005) (see uncoloured and green codes in Appendix 6). Potential themes were also able to be identified as the interviews were taking place; “[...] allowing direct feedback from the participant and immediate confirmation (or rejection) of the central importance of the idea” (Tuckett, 2005, p. 78) (see yellow codes in Appendix 6). Finally, themes were further considered upon review and coding of the transcripts and reflexive photography submissions as a whole (Aronson, 1994; Tuckett, 2005).

Both a-priori and in-vivo codes were utilized in the coding of transcripts. A-priori codes are early coding categories that, “[...] reflected closely the questions included in interviews”

(Barbour, 2014, p. 262). Examples of a-priori codes that were directly discussed in interviews were ‘disclosure’ of sexual orientation to service providers, and the ‘intersectionality’ of participants subject positions. Alternatively, in-vivo codes “[...] may sum up complex and intriguing ideas,” which may take “analysis down unanticipated but interesting routes” (Barbour, 2014, p. 264). A couple of in-vivo codes that emerged from the data were ‘capitalism’ to refer to constraints on public mental health services, and ‘signage’ to refer to queer friendly indicators made visible by mental health services. These codes could then be utilized to construct categories and themes. Similar and unique “themes that emerge[d] from [participant data were then] pieced together to form a comprehensive picture of their collective experience” (Aronson, 1994, p. 2) (see Appendix 6).

Thus, the “[...] process’ of coding, writing, theorising, and reading [took] place simultaneously” (Tuckett, 2005, p. 77) throughout this research project. Though, it is relevant to note Tuckett’s (2005) caution that, “[...] a review of literature performed [prior to conducting interviews] may expose the research to criticism of influence (bias) and a shutting down of the author’s openness to themes emergent from the data” (pp. 78–79); however, this strategy conversely offers, “[...] the researcher an opportunity to challenge and add to the literature” (p. 79). Therefore, taking critiques into consideration, this analysis was chosen as it allowed for influence from existing literature as well as the addition of themes that emerged throughout data collection. This is aligned with hermeneutic phenomenology as the “hermeneutic cycle” of qualitative research analysis includes continuous, “[...] reading, reflective writing and interpretation [...]” (Kafle, 2011, p. 195), throughout every stage of the research project. This process is demonstrated in Figure 3.

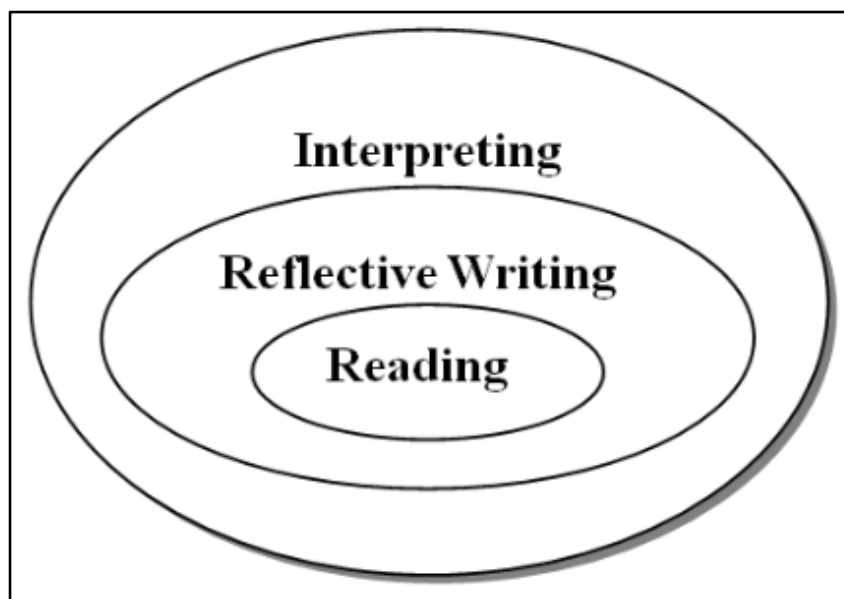


Figure 3. Hermeneutic phenomenology data analysis process (Kafle, 2011, p. 195).

Limitations

The restricted study size was a definite limitation of this study. If this researcher had the ability to recruit more participants with diverse experiences and subject positions the generalizability of findings could have been expanded. However, this limitation was sought to be minimized through the use of “[...] information-rich cases – cases from which one can learn a great deal about the focus of inquiry and therefore are worthy of in-depth study” (Patton, 2015, p. 308). Thus, through semi-structured interviews in tandem with reflexive photography, a great deal of rich data was obtained.

Another limitation was the lack of participation in the reflexive photography exercise. This was certainly a risk in choosing a method of data collection with little researcher control, however, it was a learning experience for this researcher nonetheless. If this exercise were to be approached differently in future research, more thorough instructions would be recommended. Lack of structure was intentional to provide participants with creative freedom, however, some

participants provided feedback that they would have preferred to have more instruction. Additionally, it may have been beneficial to provide participants with more time to take and submit the photos. This was not feasible in the current study due to the restricted timeline. Lastly, a second incentive may be considered upon submission of photos in order to specifically thank participants for their time and effort in this portion of the study.

Summary

In conclusion, this study has been heavily guided by its ontological, epistemological and theoretical underpinnings. The framework of pragmatism was operationalized utilizing mixed methods including constructivism and advocacy/participatory paradigms. This project was also informed by several theoretical frameworks, including queer theory, mad studies, intersectionality and critical pedagogical theory. Lastly, this research project employed the methodological framework of hermeneutic phenomenology. This all worked in tandem to form the current mixed modality study from start (planning of the research design and considering ethical implications) to finish (analyzing and interpreting the data).

Chapter 4: Findings and Discussion

Introduction

This chapter details the current study findings. These findings serve as an extension of Daley's (2013) research with lesbian womxn to polysexual people. As such, the findings have been organized in themes based in her theory of "negotiating in/visibility" (Daley, 2013), which depicts intersecting surfaces of body space, intersubjective space, "real" space and social forces. To review, body space, "[...] includes culturally located discursive meanings, which frame and inscribe [...] bodies" (Butler and Parr, 1999, as cited in Daley, 2013, p. 299). The results of this study will contribute to the discussion on intersecting subject positions, alongside a polysexual orientation. Intersubjective space includes sharing subjective states between service user and service provider, which may include, "[...] responses to [...] self-disclosures, general practice skills and personal attributes, and facilitating the disclosure processes [...]" (Daley, 2013, p. 303). This study further discusses the relevance of polysexual orientation to mental healthcare, as perceived by service users. "Real" space discusses the context of psychiatric and mental health services, which includes the model(s) of care utilized, the historical and ongoing legacy of psychiatric regulation and pathologizing, and shifting societal beliefs (Daley, 2013). Participants shed light on a phenomenon related to "real" space that was missing in the literature reviewed – physical, online and community presence. Lastly, social forces were additionally argued to impact service user experiences, which were described by Daley (2013) as including the consumer-survivor movement, the disability movement, the mad movement, LGBTQ advocacy and activism, legislative gains, and heteronormativity. The literature review suggested that the relation between the themes of monosexism and sanism should be researched further. While the current study participants certainly discussed this topic, a larger theme of resistance emerged

from the data. Thus, the following chapter will outline the themes of intersectionality; relevance; physical, online and community presence; and resistance.

Body Space: Intersectionality

Scholarship focused on polysexual experiences and negotiating body space have found that in-depth discussions about the complexities of intersecting polysexual identities with additional marginalized subject positions are needed (Flanders, Dobinson, et al., 2015). Although this was not explicitly the focus of this study given its scope, the research process aimed to allow space for all parts of participants to be present. As a result, the theme of intersectionality resonated throughout. Thus, this section outlines the study findings related to intersectional needs of polysexual people, based on the unique subject positions embodied by participants. This is by no means a comprehensive look at intersectionality, though, it remains an important conversation.

A few participants discussed how gender impacts their experiences with mental health services. Much of the previous research on lesbian, gay, and polysexual people incorporated a large focus on disclosing/‘coming out’ to service providers (Daley, 2010, 2013; Eady et al., 2011; Page, 2004). This was mirrored by many participants in the current study who discussed when and how they have chosen to tell service providers about their sexual orientation. However, a nonbinary participant stated that disclosing their sexual orientation is sometimes not a decision they were able to make:

“Because I'm nonbinary, there's no deciding factor of coming out and so... as soon as you [say your pronouns are] they/them, then it's like okay, bam. Yeah. There's no... you can't possibly be straight.”

Thus, they are often unable to negotiate the visibility of their gender and sexual identity. On the other hand, a male participant shared a negative experience of coming out to a therapist who he thought would be affirming, but instead did not ‘believe’ in male bisexuality. He stated: “She said men are fixed. And if you are attracted to men, then you're gay, and you're in denial.” Thus, this piece of these participants subject positions hugely intersected with how their sexuality was perceived in service settings.

Furthermore, three of the study participants identified as BIPOC (Black and Indigenous People/Person(s) of Colour) and discussed this in relation to their sexuality and accessing mental health services. One person stated that they were unsure if it affected the service they received, while the other two people stated that it did. One participant discussed how being a racialized queer womxn at times brought up feelings of shame and anticipated rejection that impacted her mental healthcare. She stated:

[...] even when I see a [service provider] that looks quite similar to me in terms of cultural backgrounds, or are from the same country as I am... and I feel a sense of judgment there. Just because my culture... it's not supposed to be queer.

Thus, well representation in service providers is largely seen to be a positive thing, this participant vulnerably stated that it caused worry – stemmed in internalized oppression – without actually knowing what the service providers views were. This fear then led to not disclosing her sexual orientation, which she would have otherwise liked to discuss. Another participant discussed her personal experiences being queer and Indigenous. She shared feeling misunderstood due to a lack of queer and Indigenous representation beyond two-spirit peoples. She stated, “[...] a lot of people think that the only thing Indigenous peoples can be in the queer community is two-spirit.” This, therefore, led to non-affirming conversations with service providers.

Participants who identified as older adults discussed how ageism has interacted with their sexuality and experiences with mental health services. One participant shared his frustration with the lack of representation of older polysexual or queer people in group-based mental health or wellbeing programming, as much of the queer programming he had access to was seemingly geared towards younger people. Another participant similarly stated that a service provider did not consider her sexuality to be important to her therapy due to her age and relationship history:

I think there's an assumption that at this age, people... so I think by being a married person, and then not... there was an assumption that my sexuality must have somewhat stabilized if I was in a married monogamous relationship, which I don't think it ever did. That was a way of sort of stabilizing one relationship not my identity.

Thus, an assumed 'resolution' or 'stabilization' of sexual identity as one ages may at times point to the lack of queer specific services for older adults (whether individual and/or group based services).

Additionally, participants who described being low-income discussed many barriers to accessing mental health services in general. Some consequences shared were not having access to transportation to larger cities where queer specific resources are located; programming running during the day when people are not able to take off work; experiencing long wait times for free services; feeling restricted by the limits of free services (e.g., short-term, specific to one 'issue,' etc.); and not being able to afford private services where you can be more selective about your therapist. However, one participant reported attending a walk-in style counselling service that did have a cost associated, though stated it was "relieving" to find out that the service had funding for people who self-identified as part of the 2SLGBTQIA community, so their service was free. Thus, participants stated that a lack of access to services due to finances impacted the quality of care they received, if any at all.

Lastly, participants described physical health needs that were important to their mental health care, whether related to sexuality or otherwise. One participant offered a photographic representation of positive experiences accessing both physical and mental health services, seen in Figure 4. They stated:

These tools help my body to stretch beyond the postures and positions that it is usually in. While accessing mental health services, I learned about different tools and methods that helped my mind to exercise and stretch beyond [the] thinking patterns that it was used to. These tools and devices help me to continuously improve my physical and mental health on a long-term basis.

Thus, this person emphasised their need for both physical and mental health care for their overall wellbeing. They additionally shared that their sexuality was not relevant to the work they were doing in therapeutic spaces, which shows through the lack of connection to sexuality in this photographic submission. This subject will be further discussed in the subsequent section on relevance.



Figure 4. Reflexive Photography: Intersectionality (Daisy Hu) [Photograph Description: Brightly coloured physical therapy devices.] Image Used with Permission.

Overall, it is clear that participants wished to be seen and understood in mental healthcare spaces through an intersectional lens; allowing them to take all or many of their parts (subject positions) into account as they deemed appropriate and beneficial. This was emotionally conveyed by a participant who highlighted the complexities of holding multiple marginalized subject positions:

And I'm just like, well, I'm not status Indian. I don't have enough blood quota, so I'm not Indigenous enough. And I'm not queer enough. And I'm not disabled enough, but I'm not healthy enough. Like, I'm not enough of anything, but at the same time, I am just a mess. I am a bunch of little things all put together in a little ball that is screaming and ready to explode.

Thus, feeling affirmed in the unique ways her marginalized identities intersect was important to this person's sense of self, sense of belonging to communities (including the queer community), and their general wellbeing. Another participant submitted a photograph that touched upon the affirming work service providers have done with her, and how it is impacted by the many identities she embodies (see Figure 5):

It's one of those days where I feel content with myself. Lots of therapists have tried doing positive affirmation with me... I've never been a fan of positive affirmations... but I feel okay with myself. I feel okay with however I identify [...], as long as the sun is hitting me.

This highlights that for many people this is not an overnight journey that comes from a single conversation, but through continuous work, which can certainly be explored and bolstered through mental healthcare services, if wanted by service providers. This comes with a gentle reminder that not all polysexual experiences look alike. As Dean (2001) stated, “[...] groups [should not be] treated as if they are static and monolithic with defining characteristics that endure over time and in different contexts” (p. 625). Therefore, an important takeaway from this section may be to give space in mental health services for the multitude of subject positions people hold, whenever possible.



Figure 5. Reflexive Photography: Intersectionality 2 (Varda) [Photograph Description: Light shining into a dark room, with a person's shadow as they take the photograph. The photo is directed partially at a wall. From what is seen of the space, there is a mini-fridge with miscellaneous belongings on top.] Image Used with Permission.

Intersubjective Space: Relevance

As previously discussed in Chapter two, Eady and colleagues (2011) considered dissonance between service user and provider about the relevance of sexual orientation to mental healthcare to be a common issue. They stated that many clinicians were either, “[...] making an issue of sexual orientation when it was not relevant [...]” or were “[...] afraid to deal with issues around sexual orientation when they were relevant [...]” (Eady et al., 2011, p. 385). This issue was similarly discussed by participants in the current study. Participants depicted both of the two

aforementioned situations, and conversely, also detailed times when their sexuality has been appropriately discussed by their service providers. While this issue has already been covered in part by extant research, this researcher thought it was important to give voice to the stories and struggles that participants shared.

Firstly, some participants discussed times when service providers erroneously linked their sexuality as a cause or contributor to their mental health and/or relational issues (either in part or fully), or vice versa. A participant explained how such situations occur, in her experience:

A lot of mental health professionals will also say things like: “Maybe you just haven't found the right person.” “Maybe you're just confused.” “Maybe your childhood trauma is affecting you.” And yes, I have [experienced] trauma. Yes, I am confused. Not about my sexuality. [...] When it is an inclusive space, they tend not to touch on the meaning behind your sexuality because they understand that it just ‘is.’ You don't choose to be gay. You just are.

Such rhetoric is rooted in heterosexism and monosexism, as it subtly (or sometimes overtly) deems queer identities to be unnatural, and thus, in need of explanation.

Additionally, many participants described times when they have accessed mental health services and their sexuality was discussed at length, though it was not relevant to the care they were seeking. This was likely often based in assumptions about queer people. For example, a participant shared her experience of meeting with a service provider who seemed to have a very narrow understanding of queer issues – limited to ‘coming out’ – which led to incorrect assumptions about the issues she was facing:

“So tell me about your coming out... that must have been difficult in [omitted], assuming that that's a conservative province. What were your parents like?” And I'm like, I'm not actually here at all because of those sort of tried and true ways of thinking, about like... that coming out must be traumatic. Well, for me, it wasn't. It's more sort of like the anxiety of how to operationalize my experience and communicate it now that I'm no longer partnered. The anxiety around going through divorce and being in a new city. So her focus was on what I had considered work that I'd already done whether or not in therapy.

Thus, for this person, her sexuality was relevant to a certain degree, just not in the ways assumed by the service provider. Other participants stated that their sexuality was not at all relevant to their mental health needs. One person explored this through a reflexive photography submission (see Figure 6), in which she stated:

I know I need help, and I've tried multiple times. With therapy and medication... I always end up leaving because it never seems to work for me. I've been offered to go with queer [...] based counseling multiple times and that's frustrating. There's more to me than just my sexuality.

This particular participant was offered queer specific services, which she found disheartening as that was not what she felt she needed support in. Therefore, assumptions about relevance can have greatly negative impacts.



Figure 6. Reflexive Photography: Intersubjective Space (Varda) [Photograph Description: A white board with writing erased, though there is some writing around of that is out of focus.]

Image Used with Permission.

Such assumptions about relevance may be based in a minority stress model and anti-oppressive practices, which can essentialize groups and reinforce normative binaries (Badwall, 2016; Brown, 2012; de Montigny, 2011; Mackinnon, 2011). Brown (2012) argues that when using such discourses of anti-oppression:

We have begun with the masters tools - these dominant foundational social categories are organized within dominant discourses and dominant social relations. We keep them alive in part by living them as they were constructed, thereby naturalizing them, making them inevitable. The subsequent subjectivism and essentialism, is ironic, inadvertent, not the intent. (p. 27)

Therefore, while this type of response is perhaps well intended, it is problematic as it leaves out the wide range of impacts on queer people's lives - positive ones in particular. This was conveyed by a participant's sarcastic mimicking of the response they often encounter when 'coming out' to service providers: "[...] oh my gosh, you're gay? You must be so sad all the time. [...] Oh, this queer person... Yes, of course... Mentally ill." They additionally provided an explanation of how they handled a similar situation, by stating: "That's the least of my problems. There's no... they're not even connected at all for me. I think the healthiest thing about me is that I'm queer. That's the thing I'm most sure about." Thus, while Eady and colleagues (2011) offered similar issues nearly a decade ago, an overemphasis on relevance of sexuality to mental healthcare is still being reported by this study's participants.

On the other hand, some participants shared experiences of service providers brushing a disclosures "under the rug" by not providing space to discuss their sexuality when service users did want to talk about related issues. A participant described an experience of disclosure being met with the rhetoric of "everyone is gay" (reference to lyrics of Nirvana's song All Apologies, released in 1993):

Okay, I get that. Yes, we don't fit tightly into... like, even straight people don't fit tightly into that category. There are really variable human experience of sexuality. But I'm

saying this is important to me personally and it's having effects on my personal life. And it's giving me anxiety. And it just felt too kumbaya, like I wasn't taken seriously. And part of that was, I think, her own lack of understanding about bisexuality. In particular, that you could be bi[sexual] in a relationship that outwardly presents as straight.

Thus, a minimization of sexual identity was understandably upsetting to this participant. While this may be seen as in direct opposition to the aforementioned situations where service providers were felt to overemphasize the importance of disclosures (at times to the point of pathologizing), this presents an important finding – the importance of checking in with participants to understand how relevant they perceived their sexuality to be.

Furthermore, participants discussed positive experiences where their sexuality was discussed as relevant to the topic at hand, or when they wanted to talk about it – if at all. Many noted times when service providers “[...] didn’t really make a big deal out of it [...]” when it wasn’t relevant as positive. Another participant shared her recollection of how this issue was appropriately assessed by a particular service provider:

She made sure to ask, “Okay, are what are we comfortable to talk about? What do you not want to discuss? If there's ever anything that you're not comfortable about just let me know.” [...] Which is honestly, one of the first experiences I've had with that.

Thus, participants conveyed a desire for their sexuality to be discussed only when relevant to their mental healthcare, as determined by them. This could simply be done by asking service users about their perceived relevance, rather than making assumptions. While this is not a ground-breaking recommendation, it is quite shocking to hear about the numerous stories when service providers did not offer this minimal intervention, even with existing decade old research that this study echoes.

“Real” Space: Physical, Online and Community Presence

Daley (2013) described “real” space as the context of psychiatric and mental health services, which include the model(s) of care utilized, the historical and ongoing legacy of psychiatric regulation and pathologizing, and shifting societal beliefs. While these topics were certainly discussed by participants in the current study, there was a unique emphasis on the real space – no quotations. This importantly includes the physical service space (e.g., waiting room, service provider offices, diversity seen in the people providing and accessing services, etc.), online presence (e.g., organization website, social media, etc.), and community involvement (e.g., actively speaking out against oppression, offering priority to people who belong to marginalized groups, etc.). This conversation was deemed to be included under the heading “real” space, because, while it was not explicitly discussed by Daley, these mediums work to further detail the “philosophies and practices” (2013, p. 303) of the service, as was originally suggested.

Many participants discussed the presence of “safe/r space” declarations and rainbow flag stickers covering mental health service provider doorways, windows, and office walls. To some, these “safe/r space” assertions were seen as efforts to signal 2SLGBTQIA acceptance and pride. For example, this was discussed by a participant who greatly appreciated a particular decoration in a service providers office that gave a nod to the pride flag, as depicted in Figure 7. She stated, “The rainbow neon sign is above my therapists desk, and helps to affirm that I am welcome in this space. It gives a welcoming glow to the room.” Another participant discussing ‘queer-friendly’ signs stated: “I’m always like, “phew” *exhales*... Like I always stop and I always notice it. So even small things [are] very impactful overtime. Those are... those really

work away at the bricks that you've put up.” However, this phenomenon was interestingly given mixed reviews by participants as a whole.



Figure 7. Reflexive Photography: “Real” Space (Charlotte Knight) [Photograph Description: A neon sign of a rainbow in front of a cloud that is hung on a white office wall alongside a clock and other decorations that are out of sight.] Image Used with Permission.

While the “safe/r space” rhetoric is not new, it has certainly changed throughout the past few decades. Harris (2015) stated that:

[...] Moira Kenney trace[d] the beginning of the “safe space” idea to gay and lesbian bars in the mid-60s. With anti-sodomy laws still in effect, a safe space meant somewhere you could be out and in good company—at least until the cops showed up. Gay bars were not “safe” in the sense of being free from risk, nor were they “safe” as in reserved. A safe place was where people could find practical resistance to political and social repression. (para. 4)

Several participants indicated that since its inception, the idea of “safe/er spaces” has been co-opted by liberalism and has, thus, become somewhat of a ‘buzzword’ lacking any concrete

meaning. One person stated: “I see the little rainbow stickers that they have. But that doesn't necessarily mean they actually do provide support [to the queer] community.” Such signs were said to be “patronizing” unless organizations and/or service providers were seen to be actively taking a more political stance. A political stance was said to be signaled by signage that spoke to the acceptance of otherwise subjugated groups, discussions about oppressive actions and behaviour not being tolerated in the space, and/or being social justice advocates in their community. This is in comparison to the frequently perceived scenario of organizations and/or service providers simply putting up a flag or sign and thinking that their job ends there. As a result, a commitment to social justice that spans across and beyond queer issues was deemed imperative by participants. Thus, such signs were perceived as an empty promise unless action had clearly been taken by organizations and/or service providers to make their programming queer friendly and accessible.

This was clearly depicted in two contrasting reflexive photography submissions from a single participant (see Figure 8). The participant offered one photograph of a rainbow flag sticker in a mental health service provider doorway. They secondly presented a photograph of a poster in the doorway of a different mental health service provider (within the settlement sector) that stated:

“You are a part of our community. This is an LGBTQ+ & newcomer Positive Space. We invite you to a positive space... A comfortable, welcoming environment. Access to culturally inclusive services with dignity and respect. A place where we challenge homophobia and transphobia. That believes you - staff, volunteers, newcomers, friends, families, spiritual leaders, and community leaders - can help to make our space a Positive Space.”

The latter sign is much more active and political in comparison to the rainbow flag. The language seemed to offer a direct link to how this framework impacts their practice; embodying a critical perspective in that “critical thought leads to critical action” (Ledwith, 2001, p. 177).

The participant commented on this poster, stating that it, “[...] has been up in that window for years and years, and every time I've read it and walked past it it's made me feel good, and it's a representation of sustained/long standing inclusion.” Thus, signs of active engagement in service spaces that participants had accessed were meaningful in that they acted as representations of organization and/or service provider values.



Figure 8. Reflexive Photography: “Real” Space 2 [Photograph Description: The left side showcases the first photo mentioned of the pride flag, while the panel to the right showcases the second photo of the poster.] Image Used with Permission.

As existing literature has revealed and this study has confirmed, there is much room for heterosexism, heteronormativity, homonormativity, monosexism, sanism, and other forms of oppression within mental healthcare and therapeutic spaces (Eady et al., 2011; Flanders, Gos, et al., 2015; Page, 2004). Therefore, there is much merit in gaining some insight into how inclusive,

accepting, knowledgeable and safe an organization and/or service provider may be before accessing services – especially from a distance. Looking at organizations and/or service providers online presence was said to help with this. For example, in discussing a particular counselling service that a participant was hoping to soon access, they stated, “I follow them on all the socials and they do events and everything.” Knowing that the organization was involved in the queer community was comforting to this participant, as it was a sign that they would likely be affirmed when accessing their services. Another participant discussed finding private therapists through online advertisements:

“[...] anyone can throw a rainbow up on their page and it doesn't actually... There's no process that says, “oh, this is actually an interest of hers.” But she had things on her profile like she was kink-positive and was involved in [...] polyamory and that told me [...] she at least has an understanding [to] some extent that human sexuality is fairly complex.”

This took the meaning of the rainbow flag beyond the “everyone is welcome” rhetoric by showcasing knowledge and acceptance of sexual diversity. Furthermore, these discussions were extended to the other people they might see present in particular mental health service spaces – including staff/service providers and fellow service users.

A racialized participant stated: “[...] if you walk in and absolutely everyone is white, even the posters are white people, the brochures are white people.... there's absolutely no diversity. There's something going on there.” That ‘something’ is white supremacy which causes barriers to BIPOC getting jobs in mental healthcare and/or accessing services. This touches on the importance of organizations to not only prioritize hiring and serving people from oppressed groups, but also holding themselves accountable to doing the tough work of critically discussing how to make these spaces safer for BIPOC and otherwise marginalized people. Additionally, although you may not be able to visibly tell when someone is queer, having queer identified

service providers were seen as vital to representation within mental health services. All participants described this as positive, no matter if they would purposefully seek out a queer identified service provider or not. Although, it is worth reviewing research from Wong and colleagues (2003), who asserted that service provider “knowledge and experience did not necessarily guarantee cultural competence” (p. 149), even within one’s own same cultural group. Thus, this does not mean that queer identified service providers do not also have critical reflection and work to do.

While this section has not been very specific to polysexual identities – but rather queer and other marginalized identities as a whole – it nevertheless speaks to the previously posed research question: “How do polysexual identified individuals wish to be seen, understood, and/or engaged within the specific context of mental healthcare?” Participants clearly conveyed that they would like mental health services and service providers to engage in queer politics publicly, whether through signs in physical office spaces, online (via their websites, social media, etc.), community involvement, and/or activism. A participant succinctly asserted: “If you're going to put the rainbow sticker on your door, be willing to do the research.” Another participant added: “Empty words mean nothing. If there's not action, don't even bother with the words.” These are both true, because without research and action, services and service providers are falsely advertising a space as ‘safe’ and are, thus, likely to cause harm.

Social Factors: Resistance

Unfortunately, there was much discussion throughout this study about the presence of oppression in therapeutic spaces. Examples of this (some of which have been described in full elsewhere throughout this chapter) include – but are not limited to – assumptions about sexuality

based in heteronormativity or monosexism (e.g., straight, gay, or lesbian based on current partnership), denial of polysexuality, sanism based on sexuality, and so on. The impact of this was conveyed through a particularly vulnerable reflexive photography submission (see Figure 9), which stated: “Sometimes it’s hard to get out of bed. It’s hard because the weight of my identity – what makes me myself – is overwhelming. It’s tiring to advocate for myself constantly. I am tired.” Thus, it makes sense why polysexual people report poorer mental health when compared to monosexual people (Arnett et al., 2019; Bostwick et al., 2010; Brennan et al., 2010; Flanders, Gos, et al., 2015; Steele et al., 2009) and also report unmet healthcare needs (Tjepkema, 2008). It can be demoralising for people to face oppression generally, never mind in the spaces where they attempt to seek support.



Figure 9. Reflexive Photography: Social Factors (Varda) [Photograph Description: Unmade bed with pillows, a stuffed animal, and blankets.] Image Used with Permission.

Despite this, participants explored ways of resisting oppressive ideals, which took on a wide range of forms. Many participants questioned the purpose of accessing services that perpetuated oppression and/or were not knowledgeable about queer identities and ‘issues.’ Therefore, some people cared for themselves by ceasing to access certain services or meeting with particular service providers. Other participants challenged the lack of knowledge providers had about sexual and gender identity by seeing opportunities to educate them. This was done by providing suggestion to change wording on intake forms, thoroughly explaining their identities beyond a label, defying the gender binary, and affirming their own identities in conversations with providers (e.g., “I think the healthiest thing about me is that I'm queer. That's the thing I'm most sure about”). Some people found this practice to be helpful, while others questioned its effectiveness. However, both disengagement and engagement with such services and providers, as described previously, are valid responses and neither is above the other. This decision may be based on safety, power, privilege, (dis)ability to switch providers, energy, mood, or otherwise. Though, each is an act of resistance in their own way.

Chapter 5: Conclusions

Implications for Critical Social Work

While this study did shed light on unique experiences and hardships that polysexual people face, it mostly pointed to an overarching experience of oppression – including and beyond heterosexism, monosexism and sanism – within mental health service spaces. Therefore, the results may have much bearing on critical social workers, especially those who work in frontline and management positions. This section will review the relevance for critical social work based on the themes presented in the previous chapter.

The research findings related to body space showcased a need for service users to be seen and understood in mental healthcare spaces through an intersectional lens; allowing them to take all or many of their parts (subject positions) into account as they deemed appropriate and beneficial. Thus, it is imperative that social workers have an understanding of intersectionality. However, intersectionality has long been incorporated in social work pedagogy (Mattsson, 2014). This may point to a disconnect between pedagogy and how services are run. Space for intersectional bodies and discussions may prove difficult in siloed, short-term services. Therefore, social workers must remain critical of their systems of service delivery and cognizant of the need for seeing people as whole, rather than in parts.

Findings related to intersubjective space revealed that service users want their sexuality to be discussed only when relevant to their mental healthcare, as determined by them. Thus, social work pedagogy must be rooted in mad studies to avoid the pathologizing potential of medical models. Furthermore, it is important for service providers to be educated in queer identities and ‘issues.’ Though, as previously mentioned, Dean (2001) proposed that, “[...] we distrust the experience of “competence” and replace it with a state of mind in which we are

interested, and open but always tentative about what we understand” (p. 629). Thus, when intervening in the lives of others, social workers must acknowledge and embrace their perpetual, “lack of competence” (Dean, 2001, p. 624), while continuously striving to learn more about the unique individuals they are working with. Ultimately, it is important for service providers to check in with service users to better understand how relevant they perceive their sexuality to be to the work they are doing.

The research findings related to “real” space showed that mental health services and social workers need to be engaging in queer politics publicly, whether through signs in physical office spaces, online (via their websites, social media, etc.), community involvement, and/or activism. Thus, just saying you ‘accept everyone’ is not enough. Having a social work degree is not enough. Personally being part of the 2SLGBTQIA community or from an otherwise marginalized group is not enough (Wong et al., 2003). Social workers must continue critical reflection through their policies, practices, and advocacy.

Lastly, findings related to social forces unfortunately confirmed the ongoing presence of oppression in therapeutic spaces. It can be demoralising for people to face oppression generally, never mind in the spaces where they attempt to seek support. Thus, social workers must remain critical of – unintentionally, or otherwise – reproducing systems of oppression within healthcare settings and otherwise.

Future Research

Due to the limited size of this study, it may be worthwhile for this research to be extended by a larger scale study with the ability to engage with diverse participants and gain more rich understanding of intersectionality within mental healthcare. Additionally, it may be

beneficial to construct the same research on negotiating in/visibility within mental healthcare (based on extant research by Daley 2010, 2012, 2013) with other queer identities or otherwise marginalized groups. Such research may provide further insight into how oppression is perpetuated and/or resisted by service providers in mental health spaces.

Conclusion

In summation, this study was an extension of Daley's (2013) research on lesbian womxn's experiences negotiating (in)visibility in psychiatric services, to polysexual people (who are sexually and/or romantically attracted to multiple genders). It posed the question: "How do polysexual identified individuals wish to be seen, understood, and/or engaged within the specific context of mental healthcare?" This research approached this question through both semi-structured interviews and reflexive photography, in an attempt to gain a more thorough and intimate understanding of polysexual peoples' experiences. Findings revealed that polysexual people wish to be seen as intersectional bodies, for their sexuality to be understood through their own perspectives as it relates (or not) to mental healthcare, to be engaged with through queer politics, and for therapeutic services to not be yet another space where they must resist oppression. While these results are not revolutionary by any means, they convey – often unmet – needs of polysexual people, from which service providers can reflect upon their own practice.

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Appendices

Appendix 1: PRP Ethics Protocol

		<div style="font-size: small;"> Office of Research Ethics York University 4700 Keele Street Toronto, Ontario, Canada, M3J 1P3 </div>	<div style="font-size: small;"> ore@yorku.ca researchinfo@yorku.ca </div>
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MRP PROTOCOL:

RESEARCH INVOLVING HUMAN PARTICIPANTS

INSTRUCTIONS:

A. Who should complete this Protocol Form?

This form should be completed by Graduate Students conducting research involving human participants for the purposes of a Major Research Paper (MRP). Research activities generally include – but are not limited to – experiments, interviews, surveys, focus groups and participant observation. Copies of approved protocols should be kept on file by the student researcher for a period of 2 years.

B. Who Should NOT complete this form?

1. **Graduate or Undergraduate Students conducting research for a course in which everyone in the class is conducting the same research should NOT complete this form:**

For courses in which all students are conducting the same/similar studies, Course Instructors only should complete the:
Generic Protocol: Course Related Research Involving Human Participants

Please consult your Course Instructor for further information.
2. **Graduate or Undergraduate students conducting individual projects as part of a course assignment should NOT complete this form:**

For courses in which graduate or undergraduate students are completing individualized research studies as part of a course assignment; or for the purposes of an undergraduate theses or individual projects, students should complete the:
Individualized Protocol – Course Related Research Involving Human Participants
3. **Students conducting research that must be reviewed by the HPRC should NOT complete this form. To determine whether your research must be reviewed by the HPRC, please answer the following questions:**
 - a. **Is your research funded?** ☒ N ☐ Y
(Funded research refers to stand alone research funding and excludes student awards such as bursaries and scholarships.)
 - b. **Is your research more than minimal risk?** ☒ N ☐ Y
(What is minimal risk research? If potential participants can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the participant in those aspects of his or her everyday life that relate to the research then the research can be regarded as within the range of minimal risk)
 - c. **Does your research involve Aboriginal/Indigenous/Indigenous Peoples?**
☒ N ☐ Y

The following questions may assist in determining whether your research involves Aboriginal/Indigenous/Indigenous peoples:

Delegated Ethics Review: MRP Research Ethics Protocol
July 2017 | 1

research
ethicsOffice of Research Ethics
York UniversityKeele Tower, Fifth Floor – 4700 Keele Street,
Toronto, Ontario, Canada, M3J 1P3ore@yorku.ca
researchinfo.yorku.ca

(i) Will the research be conducted on Aboriginal/Indigenous land (Canada; international) for which permission and/or approval from an authority (such as a band council, First Nations Research Ethics Board etc.) may be required?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
(ii) Will recruitment criteria include Aboriginal/Indigenous identity as either a factor for the entire study or for a subgroup of the study?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
(iii) Will the research seek input from participants regarding an Aboriginal/Indigenous peoples' cultural heritage, artefacts, or traditional knowledge?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
(iv) Will research in which Aboriginal/Indigenous identity or membership in an Aboriginal/Indigenous community be used as a variable for the purpose of analysis of the research data?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
(v) Will interpretation of research** results refer to Aboriginal/Indigenous communities, peoples, language, history or culture?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y

(NOTE: "Research" does not include literary criticism and/or history (excluding oral history) and/or primarily textual activities). If you have answered "Yes" to any of the above noted questions, then your research involves Aboriginal/Indigenous/indigenous peoples and must be reviewed and approved by the HPRC.

d. Does your research involve Clinical Trial(s)?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
e. Does your research involve Animals?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
f. Does your research involve Biological Agents?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
g. Does your research involve Invasive procedures?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
h. Does your research involve collection of human bodily fluids?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
i. Does your research involved radioactive material?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y

NOTE: If you have answered "yes" to any of the questions noted above, then this is NOT the correct form. You are required to complete the HPRC protocol form and submit to the HPRC for review. Please contact the Office of Research Ethics (ore@yorku.ca) or 416-736-2100 ext 55201 for further assistance.

C. Does this research require any other approvals?

Research involving another institution (such as a school, university, business, government agency) may require additional ethics review and approval or permissions if using institutional resources (such as internal listservs, or conducting interviews on the premises of the institution).

a) Does the research involve another institution or site? If Yes: Specify the institution(s)/site(s): St. Joseph's Healthcare Hamilton	<input type="checkbox"/> N	<input checked="" type="checkbox"/> Y
b) Do any of the institution(s)/site(s) require administrative permission?	<input type="checkbox"/> N	<input checked="" type="checkbox"/> Y
c) Has any other REB cleared this project? If Yes, please submit the original application and provide a copy of the clearance letter.	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y

NOTE: If the research is to be conducted at a site requiring ethics approval or administrative permission, please include all draft informed consent forms/administrative permission requests. It is the responsibility of the researcher to determine what other means of clearance are required, and to obtain clearance prior to starting the project.

D. Who do I contact and where do I submit the MRP Protocol - Research Involving Human Participants?

To find the appropriate contact within your Department, Graduate Program and/or



Office of Research Ethics
York University

Kennell Tower, Fifth Floor – 4700 Keele Street,
Toronto, Ontario, Canada, M3J 1P3

ore@yorku.ca
researchinfo@yorku.ca

Faculty/School/College to submit the protocol, Researchers (Course Instructors or Students) must consult the "[Chart of Contacts – Delegated Ethics Review Committees](#)".

Faculty and students conducting course-related research requiring ethics review in any of the units not listed in the chart should contact the Office of Research Ethics (ore@yorku.ca) or 55201 for further information.

E. How long will the review process take?

The average time to process minimal risk protocols is approximately twenty working days from the date of receipt by the Delegated Research Ethics Review Committee.

NOTE: INCOMPLETE OR ILLEGIBLE PROTOCOLS WILL BE RETURNED TO THE RESEARCHER, WHICH WILL DELAY THE ETHICS REVIEW PROCESS.

F. Research Ethics Guidelines:

Researchers are encouraged to review the various Research Ethics Guidelines to address any research specific questions they may have. Please visit the Research Ethics website to review [Research Ethics Guidelines](#) that may be relevant to your research.

MRP PROTOCOL FORM:

PART A – COURSE INFORMATION

Student Name:	Alyssa Nicole Appolonia DeAngelis		
Student Number:	216101388		
Program:	MSW 2-Year, 2 nd Year		
Email:	a2deangelis@gmail.com		
Phone Number:	289-795-9550		
Faculty Advisor	Shamette Hepburn		
Email:	hepburns@yorku.ca		
Office:	Ross S810		
Phone Number:	416-736-2100 x 66324		
Title of Research Project*:	Polysexual Experiences with Mental Healthcare		
Start date:	January 1, 2020	End Date:	December 31, 2020

PRIVACY: Personal information in connection with this form is collected under the authority of The York University Act, 1965 and will be used for educational, administrative and statistical purposes. If you have any questions about the collection, use and disclosure of personal information by York University, please contact: Office of Research Ethics, Kanell Tower, Fifth Floor, 416 736 5201

PART B – EDUCATIONAL ELEMENT

In order to conduct research involving human participants, you are required to:

- Familiarize yourself with York University's "[Senate Policy Research Involving Human Participants](#)" as well as the basic principles by which ethical research involving human participants is conducted. (E.g. lecture, case study, test etc.).
- Review the "[Student Researcher Responsibility Document](#)"
- Complete the [TCPS 2 Tutorial – Course on Research Ethics \(CORE\)](#)

Please confirm the following:

- ☒ I have reviewed and am familiar with the "[Senate Policy Research Involving Human Participants](#)"
- ☒ I have reviewed and am familiar with the "[Student Researchers Responsibility Document](#)"
- ☒ I have completed the [TCPS tutorial](#). TCPS Tutorial Certificate is attached

PART C - PROTOCOL DOCUMENT CHECKLIST

Please attach the following items, if applicable, to the **MRP Protocol: Research Involving Human Participants** application.

NOTE: Please ensure ALL fields in this application are filled out. For sections that apply please mark with an "x"; for sections that do not apply, please mark as "n/a".

Incomplete forms will not be accepted for review.

1. ALL protocol forms must have the following documents attached:

- An informed consent form (or multiple consent forms and/or assent forms if relevant)
- Certificate of completion of the CORE (TCPS) ethics tutorial

2. Consent documents (check all that are applicable):

x	Written Informed Consent form
n/a	Substitute Consent form (Parental/Guardian consent) — required if your research participants are under 16 years of age or without capacity to consent.
n/a	Assent Form — required if your research involves substitute consent
n/a	Verbal Consent Script — required if you plan to seek verbal consent for any of the research participants
n/a	On-line Consent Script — required if participants are asked to consent online
x	Consent for Audio/Visual/ Taping Form — required if you plan to use audio recording or photographs of participants. This may be included in the regular consent form as an additional check box.

3. External permissions and approvals (if applicable):

n/a	Decisions Needed From Other REB Boards — required if your research requires ethics approval from an institution other than York University
n/a	External REB approval required – certificate attached
x	External Institutional permission required – documentation provided
n/a	Internal institutional permission/approval required (e.g., OIPA) – documentation provided
n/a	Medical Directive
n/a	Research Agreement(s) – append all copies
n/a	Data Use Agreements (for use in secondary data analysis)

4. Test Instruments (if applicable):

n/a	Questionnaires and Test Instruments
x	Draft interview questions, focus group questions

5. Recruitment (if applicable):

x	Recruitment Materials: Posters, Letters, Participant Pool Advertisement, etc.
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6. Debriefing (if applicable):

n/a	Debriefing Letter – required if your research involves deception (see section 10, Informed Consent form for details)
n/a	Debriefing Consent Document – required following administration of debriefing statement (if your research involves deception)

7. OTHER (if applicable):

n/a	Reviewed: Clinical Trial Research Guidelines
n/a	Provenance of Anonymous data
n/a	Research Team Member Confidentiality Agreement
x	Participant Images Informed Consent Addendum

PART D – RESEARCH INFORMATION

1. PROJECT DESCRIPTION

In layperson's terms, please provide a general and brief description of the research (e.g., hypotheses, goals and objectives, etc.).

The term polysexual is an "umbrella term" to define a person who is sexually and/or romantically attracted to multiple genders, which can encompass several sexual orientation identities including – but not limited to – bisexual, pansexual, omnisexual, ambisexual, queer, fluid, or no label at all. Research has found that polysexual people report poorer mental health when compared to monosexual people – including heterosexual, gay and lesbian individuals (Arnett, Frantell, Miles, & Fry, 2019; Bostwick, Boyd, Hughes, & McCabe, 2010; Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Flanders, Gos, Dobinson, & Logie, 2015; Steele, Ross, Dobinson, Veldhuizen, & Timmouh, 2009). Furthermore, data has found that, "Bisexuals were more likely to report unmet [physical and mental] health care needs, compared with heterosexual Canadians" (Tjepkema, 2008, p. 62). As a response to this data, the proposed research project seeks to explore the research question: "How do polysexual identified individuals wish to be seen, understood, and/or engaged within the specific context of mental healthcare?"

Face-to-face interviews will be conducted with 4-6 participants age 18 and older, which will offer participants the opportunity to share their experiences of mental healthcare as a polysexual person, and perceptions of how mental health services can be improved.

The study will also utilize an arts-based framework - reflexive photography. Participants will be given the option of taking or selecting pre-existing photographs that discuss a set of related themes. They will be asked to write a short description of each photo and explain how it reflects a certain theme. The purpose of this exercise is to provide an alternative way of expressing one's experiences, thoughts, and emotions of the topic.

This research project will employ the methodological framework of hermeneutic phenomenology. Phenomenological research offers a, "[...] close examination of individual experiences" (Starks & Brown Trinidad, 2007, p. 1374). A hermeneutic approach acknowledges that the researcher is not able to simply set aside their own experiences and opinions in order to, "take a fresh perspective of the phenomenon under examination" (Creswell et al., 2007, p. 254). Instead, this school of phenomenology premises that, "[...] acceptance of endless interpretations [...] puts an effort to get beneath the subjective experience and find the genuine objective nature of the things as realized by an individual" (Kafle, 2011, p. 186).

The rationale for the proposed study is to begin to explore the impact of heterosexism and monosexism when receiving mental health supports. The results will be used to suggest changes to practices in mental healthcare.

2. PARTICIPANTS

a.) **State who the participant(s) will be:** *Describe the participants that will be recruited and about whom personal information will be collected (i.e., numbers, age, special characteristics, etc.). Describe the size of the group from which participants will be recruited and the estimated number needed for the research (minimum/maximum). Where active recruitment is required, please describe inclusion and exclusion criteria. Where the research involves extraction or collection of personal information, please describe from whom the information will be obtained and what it will include (include permission letters).*

This research project will involve 4-6 participants who identify as polysexual and have accessed mental healthcare.

Inclusion: 18 years of age or older, able to provide written informed consent and communicate in English, identifies as polysexual, have ever (historically and/or currently) accessed mental health services (including inpatient, outpatient, community based, residential, and/or private).

Exclusion: Identifies as two-spirit, as this identity is grounded in Indigenous spirituality and goes beyond the Western understanding of polysexual sexual identity/orientation.

No personal health information will be collected.

b.) Please indicate if this study will be using a participant pool ☒ N ☐ Y

If 'Yes', please indicate which pool(s):

- ☐ URPP
☐ Schulich Marketing pool
☐ School of Administrative Studies participant pool
☐ KURE
☐ Glendon Participant Pool
☐ Other:

3. RECRUITMENT

- a) **How will participants be recruited (e.g., snowball technique, random sampling, previously known to interviewer, telephone solicitation, etc.)?** Participants will be recruited through a process of general invitations. Invitations will be used via two mediums: online advertisement and printed posters. Printed posters will be affixed throughout areas frequented by students at York University Keele Campus. Posters may also be affixed at St. Joseph's Healthcare Hamilton West 5th Campus pending ethics approval and site manager approval (see proposed email). Additionally, recruitment will employ a snowball technique by encouraging potential participants to share the study information with other people who may be interested.

- b) **Will you be using any advertisements, flyers, posters, email scripts, social media postings, etc. for recruitment purpose?**

☐ N
☒ Y - If 'Yes,' please attach a copy of each with your application.

4. INDUCEMENTS:

- a) **Will you be offering inducements to participate (e.g., money, gift certificates, academic credit, etc.)?**

☐ N
☒ Y - If 'Yes,' please check all that apply:
☒ Financial
☐ In-kind
☐ Draw
☐ Participant Pool Bonus Points
☐ Other:

- b) **If compensation is provided, please provide the source of funding for the compensation/incentive:**

\$15 Shoppers Drug Mart gift certificate from personal funds

5. METHODS:

- a) **Please indicate all the research methods that apply:**

<input type="checkbox"/> Action Research	<input type="checkbox"/> Ethnography
<input type="checkbox"/> Observation	<input type="checkbox"/> Survey
<input type="checkbox"/> Documentary/Filmmaking	<input type="checkbox"/> Focus Group
<input type="checkbox"/> Experimental Lab Study	<input checked="" type="checkbox"/> Interview
<input type="checkbox"/> Oral/Life History	<input type="checkbox"/> Human Tissues
<input type="checkbox"/> Experimental Behavioural Study	<input type="checkbox"/> Online Research
<input checked="" type="checkbox"/> Other: Reflexive photography	

- b) **Do any of the methods involve:**

Audio Recording	<input type="checkbox"/> N	<input checked="" type="checkbox"/> Y
Still Recording	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y



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Video Recording ☒ N ☐ Y

NOTE: Explicit consent is required to use these methods of recording. Please see Section 10, "Informed Consent" for details.

- i) If you are using recordings, please account for how they will be safely stored, eventually destroyed or archived, and how, if used in research dissemination, confidentiality will be maintained: Audio will be recorded from two devices (one laptop and one cell phone) in case of malfunction. Both sets of audio recordings will be secured digitally on my (the researchers) personal computer upon completion of each interview. Files will be encrypted. All audio files will be deleted upon completion of research.

- c) **What will be required of the participant(s).** Clearly specify in a step-by-step outline exactly what the participant(s) will be asked to do in each methodology. A separate outline is required for each methodology. Include the settings, types of information to be involved, and how data will be analyzed. Include details about identifying participants, recruitment, procedures participants will undertake, etc. Include copies of study instruments. Please also include the estimated time commitment required of participants for each method.

There will be two points of researcher/participant interaction throughout the study.

At the initial interaction, the researcher will review and explain the consent form. The gift certificate will be provided at completion of consent to ensure them that they will receive compensation no matter the information they provide, or if they choose to end the interview at any time.

Each participant will be asked to participate in a semi-structured interview with the researcher that will range from 30-90 minutes, depending on how detailed the participant chooses to be. This interview will be centered about the participant's experiences accessing mental health services. Participants will be asked to respond to questions which are related to heterosexism, heteronormativity monosexism, and sanism (see interview guide attached). The responses to these questions will be transcribed, and then analyzed using thematic analysis in order to draw out common themes within different participants' stories.

The interviews will be held in a private work/study room at the participants choice of location: York University Keele Campus, or a public library in the Greater Toronto and Hamilton Area. These sessions will be recorded on two recording devices (one laptop and one cell phone) in case of malfunction. Recording is for the purpose of transcription, which will be completed by me (the researcher) after each interview.

The second part of the study will include an arts-based at-home assignment. After completion of the interview, participants will be asked to complete a reflexive photography exercise, by taking (or selecting pre-existing) photographs that discuss a set of related themes. They will be asked to write a short description of each photo and explain how it reflects a certain theme (some of which are predetermined and others may be offered by participants based on what was discussed during their interview) (see the guide attached). This task is asked to be submitted to the researcher within one week of completing the initial interview. Photographs can be submitted through email, or at a second in-person meeting with the researcher (which may be preferred if photos are in a physical format, or if participants would like to debrief this experience).

- d) **What is the experience of the researcher/research team with this kind of research?**

Please provide a description of the individual team members' experience with the proposed methods, participant population, etc.

The researcher has experience working in both research and social service positions within the field of mental health care. Additionally, the researcher is currently enrolled in a graduate research seminar SOWK 5250 and will be supported through SOWK 5450 during recruitment and data collection.

6. RISK:

Please indicate potential risks that the participants as individuals or as part of an identifiable group or



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community might experience by being part of this research project (**NOTE:** Checking 'Minimal' indicates that the risk associated with the method meets the definition of minimal risk as set out in the TCPS-2):

☐ No known/anticipated risks

☒ Y – If 'Yes,' please complete the following:

a) Physical risks (including any bodily contact; administration of any substance)?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
b) Psychological/emotional risks (feeling uncomfortable, embarrassed, anxious, upset)?	<input type="checkbox"/> N	<input checked="" type="checkbox"/> Y
c) Social risks (including possible loss of status, privacy and/or reputation)?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
d) Data security (i.e., risk to participant from data exposure)?	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
e) Tied to deception involved in the study? (See DEBRIEFING section below)	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
f) OTHER:		

Please describe how each of the potential risks described above will be managed and/or minimized: Despite providing detailed information ahead of time, participants may still feel anxious prior to or during the interviews. This risk will be managed by going over the informed consent form guidelines with the participants prior to beginning, as well as outlining the options participants have during the sessions without any repercussions (i.e.: taking a break, not answering any questions, leaving the discussion). There is also the potential for a participant to become emotional during an interview. This risk will be mitigated beforehand by carefully considering and piloting interview questions within research seminar SOWK 5450. During the session, if a participant does become emotional, they will be offered an opportunity to talk it over afterwards. All participants will be given a list of queer friendly services that can be called upon if they feel emotional or unsafe at a later time.

7. BENEFITS

What, if any, are the benefits to the participants?

Or, ☐ No benefits

- a) Discuss any potential direct benefits to the participants from their involvement in the project; these might include education about research methods, useful knowledge gained about self, etc. Potential benefits to participating in research may include a positive feeling from having contributed, opportunity to share their own stories and personal narratives, feelings of empowerment as participants are provided with the opportunity to be valued as experts, and knowledge gained about self.
- b) Comment on the (potential) benefits to the scientific/scholarly community or society that would justify involvement of participants in this study.
The research aims to fill a gap in the existing research. Much of the literature lacks a nuanced understandings of polysexual experiences of in/visibility in mental healthcare by either: (a) looking solely at other/monosexual queer identities (mainly experiences of lesbian women), (b) exclusively taking a psychology-based minority stress approach, or (c) conducting quantitative research that does not allow for the unfiltered voices of polysexual people. Thus, qualitative research on polysexual experiences of in/visibility in mental healthcare as explained by polysexual identified people who have accessed mental health services may lead to different conversations and understandings.

8. SECONDARY ANALYSIS OF DATA:

NOTE: Secondary Data Analysis is described as the analysis of data collected for a purpose other than that for which it was originally collected in order to pursue a research interest which is distinct from that of the original work. Researchers are advised to review the "[Secondary Data Analysis](#)"



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Guidelines for further information on requirements related to use of secondary data for research purposes.

a.) Are you conducting secondary data analysis?

- ☒ **N – If 'No,' please go to Question 9**
☐ **Y**

If 'Yes,' please answer the following questions:

- i) Are you using **Anonymous Data?** (data which never included personal identifiers)
☐ **N**
☐ **Y – If 'Yes,' please provide a description of the provenance of the data set:**

NOTE: Research that relies *solely* on secondary analysis of anonymous data is exempt from ethics review.

- ii) Are you using **Anonymized data?** (Data which has been stripped of personal identifiers; no potential for data linkage.)
☐ **N**
☐ **Y – If 'Yes,' please provide a description of the provenance of the data set:**

- iii) Are you using **Identifiable data?**
☐ **N**
☐ **Y – If 'Yes,' please provide a description of the provenance of the data set:**

b.) If you are conducting secondary analysis using IDENTIFIABLE DATA, please address the following:

- i) Do you plan to link this identifiable data to other data sets?
☐ **N**
☐ **Y – If 'Yes,' please describe:**
- ii) What type of identifiable data from this data set are you planning to access and use?
☐ Student records (please specify in the space below)
☐ Health records/clinic/office files (please specify in the space below):
☐ Other personal records. Please specify:
- iii) What personally identifiable data (e.g., name, student number, telephone number, date of birth, etc.) from this data set do you plan on using in your research? Also, please explain why you need to collect this identifiable data and justify why each item is required to conduct your research.
- iv) Describe the details of any agreement you have, or will have, in place with the owner of this data to allow you to use these data for your research. (***You must submit a copy of any data use/access agreements.***)
- v) When participants first contributed their data to this data set, were there any known preferences expressed by participants at that time about how their information would be used in the future?
☐ **N**
☐ **Y – If 'Yes,' please explain:**
- vi) How will you obtain consent from the participants whose identifiable data you will be



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accessing? Please explain:

NOTE: Consent of participants is required for research involving secondary analysis of data that includes personal identifiers. Waiver of consent may only be considered if researchers meet the additional criteria. Please consult the [Secondary Data Analysis guidelines](#) for further information.

vii) If you do **not** intend to seek consent of participants for use of identifiable data for secondary analysis, please provide a rationale as to why:

9. CONFLICT OF INTEREST:

- a) Is there a possibility of an apparent, actual or potential conflict of interest on the part of researchers, the University or sponsors? (e.g. commercialization of research findings; self-funded research)
- ☒ N
☐ Y - If 'Yes,' please elaborate and outline how the potential or real conflict of interest will be addressed:
- b) Do any members of the research team have multiple roles with potential participants (such as researcher and therapist, researcher and teacher, student/supervisor, etc.)
- ☒ N
☐ Y - If 'Yes,' please review [Research Involving Investigators' Students](#)
- i) Describe the nature of the multiple roles between researcher(s) and any participants:
- ii) Describe how the potential conflict of interest that will emerge as a result of the dual roles will be minimized or managed:
- c) Are there any restrictions regarding access to or disclosure of information/results/data at any point during the study including completion that the funder/sponsor has placed on the researchers? (These include controls placed by sponsors, funding sources, advisory or steering committees.) If 'Yes,' please describe:

10. INFORMED CONSENT

- a) Is there a relationship between participants and either of the following:

Person obtaining consent: ☒ N ☐ Y
Investigator(s): ☒ N ☐ Y

If 'Yes,' what steps will be taken to avoid the perception of undue influence in obtaining free and informed consent:

- b) Ongoing consent is required if the research occurs over multiple occasions or over an extended period of time. Does the research occur over multiple occasions and/or over an extended period of time?

☐ N
☒ Y

If 'Yes,' please describe the process of how you intend to obtain ongoing consent:

Participants will be reminded of the voluntary nature of this study and of their option to stop



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participating at any time, for any reason (see assignment guide attached). The gift certificate will be provided at the beginning of the initial meeting to reinforce that their compensation is not dependant on the information they provide.

- c) Is substitute consent involved (e.g., children, youths under 16, those without capacity to consent)?

☒ N
☐ Y

If 'Yes,' please elaborate on how consent and assent will be obtained (an assent form/ script must also be provided):

- d) Is Deception involved? Specifically, do you intend to withhold any information from and/or intentionally mislead the research participants?

☒ N – Please go to Question E
☐ Y

If 'Yes:'

- i) Please provide a description of the nature of the deception and whether it is full or partial:

Please provide a rationale as to why deception (in whole or part) is required:

- ii) Please append a copy of the debriefing statement.

The debriefing statement needs to explain three elements:

- (i) Why the experiment was developed and why the deception was necessary.
- (ii) What the current research says about the topic, which includes providing two references (text, article, on-line reference) that the participants can reasonably access and understand (if you have an academic and non-academic population, you may need to provide more than one version of the debriefing statement or make sure that the references can be accessed by the least educated of the population).
- (iii) Any additional resources that would be useful for the participant. Resources need to be appropriate and accessible for the participants. For example, if you are conducting a study on parenting, you could include community resources for parenting classes or recommendations for parenting guides. (Source: Univ. Virginia, IRB).

Researchers must re-obtain consent from the participants once the debriefing statement has been provided. Participants shall be provided with and sign the "Debriefing Consent Form."

- iii) If a debriefing statement will not be provided to the participants, please provide a rationale as to why a statement will not be provided:

- iv) For studies that are not deceptive, briefly describe the process and nature of any immediate post-study information that will be provided to participants and the rationale for providing this information (e.g., counseling or trauma resources, information links, etc.):

- e) How will informed consent be obtained? (Please check all that are applicable):

☒ Informed Consent Form (please attach draft version) (and assent form if relevant)



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☐ Verbally* (please attach draft approximation of what participants will be verbally told)

☐ Online Consent Form** (please attach draft version)

***If informed consent is being obtained verbally, please provide a rationale regarding why a written informed consent form is not being used:**

****If online consent is being obtained, please indicate the website where the questionnaire/survey will be hosted:**

11. DATA SECURITY:

Privacy refers to an individual's right to be free from intrusion or interference by others. It is a fundamental right in a free and democratic society. The ethical duty of confidentiality refers to the obligation of an individual or organization to safeguard entrusted information. Security refers to measures used to protect information. It includes physical, administrative and technical safeguards.

For a fuller description of researcher obligations surrounding confidentiality, privacy and data security issues, please consult the [Data Security Guidelines for Research Involving Human Participants](#).

In light of the above, please address the following questions:

- a) **Will the data be treated as confidential?** ☐ N ☒ Y
If 'No,' please provide a rationale as to why not:
- b) **Will the participant(s) be anonymous?** ☐ N ☒ Y
If 'No,' please provide a rationale:
- c) **Describe the procedures to be used to ensure anonymity/confidentiality of participants or informants (where applicable) -or- the confidentiality of data during the conduct of research and dissemination of results.**
The interview audio-recordings are to be transcribed for thematic analysis. Transcripts will be anonymized by the researcher, prior to being analyzed. All identifying information will be removed or anonymized (e.g., changing name of a specific mental health program to a generic definition like "a mental health service organization"). The interview audio-recordings will be destroyed upon verification of the data by the researcher.
Additional data containing personal details that might lead to the identification of participants (i.e., email addresses, name, consent form) will be destroyed upon completion of the study.
- For the reflexive photography portion of the study, participants are provided the option to have their submitted photographs reproduced in the final study report. However, in the assignment instructions, participants are informed that photographs which may risk exposing any person's identity (i.e., depicting faces, names, etc.) will not be reproduced in the publication(s) of this research (regardless if they provided consent to do so), and will instead rely on the description only. This precaution is included to ensure the confidentiality and safety of participants. Lastly, if participants would like artistic credit in the final report, they are provided the option to detail how they would like to be identified, which will only be attached to photographs, not interview responses.
- d) **Explain how written records, video/audio recordings, artefacts, and questionnaires will be secured, how long they will be retained, and provide details of their final disposal or storage. Describe the standard data security procedures for your discipline and provide a justification if you intend to store your data for a longer period of time. If the data may have archival value, discuss this and whether participants will be informed of this possibility during the consent process.**



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Access to records and data will be limited to the researcher and faculty advisor. The collected written data will be secured in a locked location. All electronic files will be saved on an encrypted USB key, which will be kept under lock and key in my home at all times. The data will then be stored until research outputs are complete. A password protected master linking log with identifiers will be kept and stored separately from the data and will be destroyed at the end of the study (by December 31, 2020 at the absolute latest).

- e) **Please describe how you plan to store hard copy data, i.e., consent forms and other written records.**
☒ Locked filing cabinet
☐ Other:
- f) **Please describe how you plan to store electronic data (such as video/audio recordings and document files)**
☒ Encrypted and/or password-protected USB keys, laptops and/or other portable electronic data devices
☐ Secure Server
☐ Other:
- g) **Please describe how you plan to store other formats of data (if applicable):**
 N/A
- h) **If you plan to destroy research data:**
 a. Please provide a firm date by which the data will be destroyed:
 December 31, 2020
 b. Provide details of their final disposal:
 i. for hard copy data (e.g., cross-cut shredder, etc.):
 Cross cut shredder
 ii. for electronic data (e.g., deletion and overwriting of drives; destruction of drives; etc.):
 Deletion and overwriting of data stored on USB key
- i) **If you plan to retain data indefinitely, please provide a justification (e.g., data use for future research):**
 N/A
- j) **Describe any limitations to protecting the confidentiality of participants whether due to the law, the methods used, the nature of the sample population, or other reasons (e.g., duty to report).**
 If participants share information about an ongoing child abuse situation or disclose information that suggests potential harm to themselves or others the researcher has a duty to report. This is explicitly noted in the consent form.
- k) **Identify all parties who will have access to the data.**
☒ Primary Investigator/student
☐ Supervisor
☒ Other (please specify): Faculty advisor
- l) **Uses of the data: Please describe all forms of output that are anticipated to result from this research (e.g., presentations, written papers, placing data in an archive, creative works, documentary films, etc.). Describe how any potentially identifying information will be handled in each form of output.**
 There will be a final report (PRP) written and kept on file through the Social Work department at York. All personal information within this report will be anonymized and thus there will be no potentially identifying information which exists within the output. Any other outputs which might subsequently be produced (e.g., a conference presentation, a paper submitted to a scholarly



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journal, an information sheet provided to clinicians) will be based on the final PRP and thus will also not include any potentially identifying information.

- m) **Subsequent use of data:** Will the data potentially be used for other purposes in the future (e.g., teaching, future analysis, publishing of dataset, archiving in an institutional repository, etc.)?

☒ N ☐ Y

If 'No,' the data will be solely used for the purposes describe in this application and will not be used for other purposes in the future.

If 'Yes,' participants must be informed of this possibility during the consent process. Subsequent use of the data for new purposes may require additional review by the REB.

- n) **Please describe how the data will be prepared to make it suitable for future use (e.g., anonymization, storage, archiving, etc.). Please describe what future uses might occur (e.g., use within the PI's research group, transmission to other researchers, publication of the dataset, etc.). Please identify any known repositories to which data may be submitted. (The REB recognizes that all potential future uses cannot be anticipated; but does expect that data will be prepared in a manner for future uses that respects the conditions under which the data were originally collected).**

N/A





STUDENT RESEARCHER DECLARATION

I have reviewed and am familiar with the guidelines and principles detailed by the HPRC, the Delegated Ethics Review – Student Researcher Responsibilities Information Sheet and with the Senate Policy on Research Involving Human Participants, and affirm that, to the best of my knowledge this research conforms thereto.





I hereby certify that the course-based research involving human participants is unfunded and minimal risk research, does not involve Aboriginal/Indigenous/Indigenous Peoples or Clinical Trials and that all information on this form and all statements in the attached documentation are correct and complete. I affirm that I am aware of my responsibilities as a researcher as it speaks to the conduct of research involving human participants and as outlined in Senate Policy on Research Involving Human Participants. I am aware that all human participants in the research must have signed a written consent form or have provided oral consent for their participation in the research. I am aware that the approved protocol and signed consent forms have to be retained for two years following the completion of the research.





I hereby undertake to notify the Delegated Ethics Review Committee to which I am submitting this protocol in the event that I make any changes to the approved MRP Protocol – Research Involving Human Participants. I am aware that a further ethics review may be required as a result of such changes and that research shall be suspended pending clarification and/or resolution. I will also notify the Delegated Ethics Review Committee if any unforeseen risks not specified in the research proposal appear. In such a case, the study will be suspended pending clarification.

Wm

   Alyssa DeAngelis 

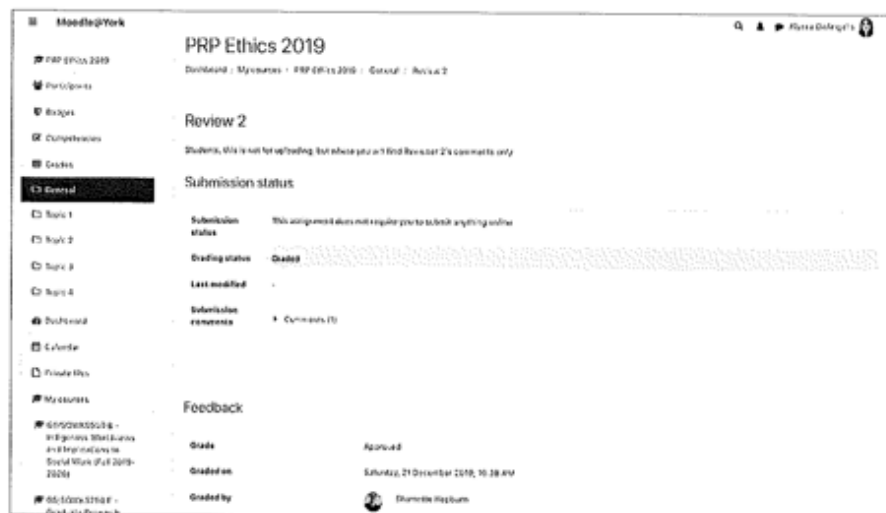
Feedback

Grade	Approved
Graded on	Friday, 13 December 2019, 12:24 PM
Graded by	 Teresa Macias
Feedback files	<div> ADIAngResearch Poster (Print).pdf 13 December 2019, 12:24 PM</div> <div> ADIAngPRP-ethics-form_sovk SIGNED.pdf13 December 2019, 12:24 PM</div> <div> ADIAngRecruitment Posters - Email.pdf13 December 2019, 12:24 PM</div>


   Alyssa DeAngelis 

Submission status

Submission status	This assignment does not require you to submit anything online
Grading status	Graded
Last modified	-
Submission comments	<div>▶ Comments (1)</div> <div><div>Luan M Seed Gneglich · Fri, 10 Dec 2019, 2:35 PM</div><div>This is an interesting and important study. Please see my comments throughout. My main suggestions have to do with your interview guide. First, a semi-structured interview guide would provide much more opportunity for the participant to lead the conversation. Your interview guide, as it is, reads more like a questionnaire. Besides its validity due to researcher bias, I feel, I note that many of your questions are closed-ended, requiring only a "yes" or "no" response. This will give you very little data to work with. Would you not want to begin with an open question about their experience of mental health services? Second, rather than providing a lesson on the meanings of your key theoretical terms, I suggest you let participants use their own words to describe their experiences, and then you use those concepts in your analysis of the data. I note that the live-hoop "assignment" which sounds a little daunting indicates that they will be "required" to receive a gift that they have already received. Please make the necessary revisions and resubmit to your instructor. I do not need to see your application again provided your instructor signs off on it.</div></div> <div><div>Add a comment...</div><div>Save comment Cancel</div></div>
Feedback	
Grade	Approved with changes



Appendix 2: Recruitment


18+ 

ARE YOU BISEXUAL, PANSEXUAL,
QUEER (OR ANY IDENTITY WITHIN
THE POLYSEXUAL UMBRELLA)?

HAVE YOU EVER ACCESSED
MENTAL HEALTH SERVICES?

WE WANT YOUR OPINIONS ON
HOW TO BETTER SERVE
POLYSEXUAL PEOPLE.

EMAIL ALYSSA AT
ADEANGEL@YORKU.CA TO LEARN
MORE ABOUT THIS STUDY!

 *RECEIVE A \$15
SHOPPERS DRUG MART
GIFT CERTIFICATE FOR
YOUR PARTICIPATION*

Appendix 3: Informed Consent

Exploring Polysexual Experiences with Mental Healthcare – Informed Consent

Researcher

Alyssa DeAngelis, MSW Candidate, York University, Social Work Department, Ross Building 8th Floor, 4700 Keele Street Toronto, ON, Canada, M3J 1P3; Email: adeangel@yorku.ca

Purpose of the Research

The term *polysexual* is an “umbrella term” to define a person who is sexually and/or romantically attracted to multiple genders, which can encompass several sexual orientation identities including – but not limited to – bisexual, pansexual, omnisexual, ambisexual, queer, fluid, or no label at all. Research has found that polysexual people report poorer mental health when compared to monosexual people – including heterosexual, gay and lesbian individuals (Arnett, Frantell, Miles, & Fry, 2019; Bostwick, Boyd, Hughes, & McCabe, 2010; Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Flanders, Gos, Dobinson, & Logie, 2015; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). Furthermore, Canadian research has found that polysexual people were more likely to report unmet physical and mental health care needs, compared with heterosexual people (Tjepkema, 2008). As a response to this data, the proposed research project seeks to explore to the research question of: “How do polysexual identified individuals wish to be seen, understood, and/or engaged within the specific context of mental healthcare?” This research project is part of a Masters of Social Work program, which may also be presented in scholarly journals and at conferences. The ultimate goal of this research project is to suggest changes to practices in mental healthcare.

What You Will Be Asked to Do in the Research

You will be asked to participate in a 30-90 minute semi-structured interview with the researcher. This interview will be centered around your experiences accessing mental health services. If allowed, this will be audio recorded for the purpose of transcription by the researcher. If not allowed, the researcher will take notes during the interview. After completion of the interview, you will be asked to participate in a reflexive photography exercise, by taking (or selecting pre-existing) photographs that discuss a set of related themes. You will be asked to write a short description of each photo and explain how it reflects a certain theme. This task is asked to be submitted to the researcher within one week of completing the initial interview. Photographs can be submitted through email, or at a second in-person meeting with the researcher (which may be preferred if photos are in a physical format, or if you would like to debrief this experience). You will be granted a \$15 Shoppers Drug Mart gift certificate as a token of thanks for participating in this study.

Risks and Discomforts

Due to the nature of this research, you may feel anxious prior to or during the study. This risk will be managed by reviewing the informed consent guidelines thoroughly prior to beginning. There is also the potential for emotional discomfort during the interview. This risk, however, has been mitigated through deliberate selection of interview questions and prompts. If you do experience discomfort during the session, you will be offered the opportunity to talk it over, take a break, not

answer any question(s), or end the session. Queer friendly resources are provided to all participants, should you be in need of support after completion of the study.

Benefits of the Research and Benefits to You

You will have the opportunity to provide your input as an expert on your own experiences, contribute to the development of knowledge in this growing field, and potentially gain knowledge about yourself.

Voluntary Participation

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer would not influence the nature of your relationship with the researchers or staff of York University either now or in the future.

Withdrawal from the Study

You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. If you decide to stop participating, you will still be eligible to receive the promised gift certificate.

Confidentiality

All information you supply during the research will be held in confidence. Unless you specifically indicate your consent, your name, speech, and/or photographs will not appear in any report or publication of the research. The data requested consists of this paper consent form, handwritten notes, audio recording of initial interview, and photographs submitted (either electronically or physically). Your data will be safely stored in a locked location and all electronic files will be encrypted. Only the researcher and faculty advisor will have access to this information. This data will be destroyed upon completion of the study via shredding of paper documents and deletion of electronic files. Confidentiality will be provided to the fullest extent possible by law.

Limits to Confidentiality

If you share information about ongoing child abuse or disclose information that suggests potential harm to yourself or others the researcher has a duty to report.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact the researcher Alyssa DeAngelis by e-mail (adeangel@yorku.ca) or the faculty advisor Shamette Hepburn by email (hepburns@yorku.ca). You may also contact the Graduate Program in Social Work at gradsowk@yorku.ca and/or 416-736-2100 ext. 55226.

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor

for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures

I, _____, consent to participate in **Exploring Polysexual Experiences with Mental Healthcare** conducted by Alyssa DeAngelis. I have understood the nature of the this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

_____ I agree to allow audio recording of the initial interview. I am aware that I may withdraw this consent at any time without penalty.

_____ I agree to allow anonymized quotes in the final publication of this research. I am aware that I may withdraw this consent at any time without penalty.

_____ I wish to have my submitted photographs reproduced in the final publication(s) of this research. I am aware that I may withdraw this consent at any time without penalty.

If my submitted photographs are reproduced in the final publication(s) of this research, I wish to receive artistic credit under the following name: _____.
I understand that while the name provided above will not be linked with specific interview responses, this will implicate me as a study participant.

☐ I require a disposable camera for the reflexive photography portion of this study.

Signature: _____
Participant

Date: _____

Signature: _____
Researcher

Date: _____

Appendix 4: Interview Questions

Demographics

Please feel free to describe yourself however you're most comfortable (e.g., use or avoid labels, include additional descriptors/subject positions that you feel impact these answers, etc.).

- How would you describe your gender identity?
- What are your pronouns?
- How would you describe your sexual orientation?

Opening Questions

- Can you tell me about your experiences with mental health services?
- How have your experiences with mental health services been impacted as a *[insert persons sexual identity]* person – if at all?

“Coming Out” / Disclosure

- Can you tell me about a time that you have had to disclose your sexual orientation to service providers?
 - Can you describe what that was like for you?
 - *If yes:* How has the response been?
 - *If no:* Why not? Do you wish you had/could?
 - Is this decision to disclose (or not) dependent on certain factors?
(e.g., presence or lack of queer friendly signs or programming, “vibe” of a mental health service provider or space, etc.)

Body Space (i.e., the Individual)

- Have you ever considered minimizing/concealing or emphasizing physical attributes that may make you more/less likely to be read as *[insert persons sexual identity]* when attending mental health services?
 - *If yes:* Please provide an example of this.

Intersubjective Space (i.e., Service Providers)

- Do you feel as though your previous and/or current mental health service providers fully understood your sexuality? Please explain.
- Has there ever been a time when you felt as though your service providers have perpetuated a ‘right and wrong’ way to be *[insert persons sexual identity]* (i.e., homonormativity)?
 - *If yes:* Please provide an example of this.
- Can you tell me about a time when you had a positive experience of mental healthcare related to sexuality.

(e.g., a time your sexual orientation was affirmed/ discussed neutrally or positively, etc.)

- How do you think this impacted the overall mental health care you received at that time, if at all?
- Can you tell me about a time when you had a negative experience of mental healthcare related to sexuality.

(e.g., pathologizing sexuality by framing it as problematic or related to a mental health concern when you felt it was not related, assumed to be straight or gay/lesbian depending on current partner, morally judged, etc.)

- How do you think this impacted the overall mental health care you received at that time, if at all?

“Real” Space (i.e., Service Programs/Organizations)

- How have the mental health services you have used been inclusive or exclusive of *[insert persons sexual identity]* people?
(e.g., programming that has mandate or flexibility to include discussion around sexuality, programming that is restrictive to a certain therapy modality that is not inclusive of sexuality, medicalized services that are not cognizant of the history of queer sexual pathology, etc.)

Social Forces

- Are there additional factors that you feel impact your sexual orientation and/or how you are treated and perceived by mental healthcare providers?
(e.g., race, ethnicity, disabilities, etc.)

Recommendations

- Are there any gaps in the mental health services that you need as a *[insert persons sexual identity]* person?
 - *If yes:* What are they?
- In your opinion, what would make mental health services better for *[insert persons sexual identity]* people (i.e., from both organizations and individual service providers)?

Reflexive Photography

**Researcher will review the reflexive photography process on the handout.*

**Researcher and participants will brainstorm additional themes collaboratively, based on the completed interview (e.g., performativity, heterosexism, heteronormativity, homonormativity, monosexism, sanism, etc.).*

Closing

- Do you have any questions for me about this research?

**Researcher will provide all participants with the resource of queer friendly crisis supports that are accessible in Ontario.*

Appendix 5: Reflexive Photography Exercise

Reminder: Your participation in the study is completely voluntary and you may choose to stop participating at any time, for any reason.

Guidelines:

- Submit 1-5 photographs on any of the themes listed below.
- Please note that photographs submitted cannot be the artistic property of another person.
- With each photo, please include a short description of the photo and an explanation of how it reflects a particular theme. This may be 2-6+ sentences total for each picture. Please feel free to be as descriptive as you feel necessary.
- Please gain verbal consent if planning to take or use a photo of another person.
- Please note that photographs that may risk exposing any person's identity (i.e., depicting faces, names, etc.) will not be reproduced in the publication(s) of this research (regardless if you provided consent to do so), and will instead rely on the description only.

Themes:

- Positive experiences as a polysexual person accessing mental health services
- Negative experiences as a polysexual person accessing mental health services
- Any additional themes that stood out to you through this interview:
 -
 -
 -

Please submit photographs and accompanying descriptions by _____
at the latest.

Photographs are to be submitted: ☐ Via email to adeangel@yorku.ca

☐ In person – Scheduled: _____

Appendix 6: Coding Matrix**COLOUR CODE**

	Based on Daley's theory of “negotiating in/visibility” (for lesbian womxn)
	Emerged through literature review (on polysexual people specifically)
	Emerged through data (i.e., interviews and/or reflexive photography)

Theme	Definition	Code	Explanation
Body Space	Culturally located discursive meanings, which frame and inscribe bodies.	Queer Performativity	Actions that one does/makes consciously or unconsciously to be read as queer. Butler argues that “the act that one does, the act that one performs is, in a sense, an act that's been going on before one arrived on the scene” (Gender Trouble).
		Intersectionality	Additional subject positions that impact sexual orientation and accessing mental healthcare.
		Internalized Oppression	When a member of a marginalized group has an oppressive view of their own group, or affirm negative self-stereotypes. Internalized oppression may manifest on an individual or group level, and may result in conflict or discrimination within the group.
Intersubjective Space	Subjective states between service user and service provider, which may include, responses to self-disclosures, general practice skills and personal attributes, and facilitating the disclosure processes.	Disclosure	The action of making ones sexual orientation known (or "coming out").
		Acceptance	The feeling, action or process of being received as adequate or suitable.
		Rejection	The experience of not being included, being dismissed/denied, or not feeling/being safe.
		Safety	Sense of being safe (not at risk of rejection or harm) with a particular service provider or within a particular organization.
		Knowledge	Service provider knowledge (or lack thereof) about 2SLGBTQIA identities and issues.

		Relevance	The congruence or dissonance between service provider and service user, pertaining to perceived relevance of sexual orientation on mental health needs.
		Hiding	Intentional hiding or concealing one's sexuality or aspects of sexuality.
		Service Provider Identity	Knowing a service provider is part of the 2SLGBTQIA community, or an otherwise marginalized community.
		Relationship	Discussion about the relationship between service user/provider, and how it may be impacted positively or negatively by the aspects of intersubjective space.
"Real" Space	The context of psychiatric and mental health services, which includes the model(s) of care utilized, the historical an ongoing legacy of psychiatric regulation and pathologizing, and shifting societal beliefs.	Programming	Discussion about the type of programs/services that are offered at a particular mental health organization.
		Medical Model	The medical model is a model of health which suggests that disease is detected and identified through a systematic process of observation, description, and differentiation, in accordance with standard accepted procedures, such as medical examinations, tests, or a set of symptom descriptions.
		Signage	The presence of (or lack thereof) queer friendly and/or political activism signage.
		Political	Organizations that take a politically oriented stance/activism (or do not).
		Efficacy	The effectiveness of services and treatment, based on the experience (whether positive, negative, or neutral).
		Access	Impact to accessibility of services due to cost, location, transportation, or otherwise.
		Community	Having access to a queer community/peers as a mental health aid.

Social Forces	Oppressions and activist movements (e.g., heterosexism, monosexism, heteronormativity, mad movement, consumer-survivor movement, disability movement, LGBTQ advocacy/activism, and legislative gains).	Heterosexism	A system of attitudes, bias, and discrimination in favor of opposite-sex sexuality and relationships.
		Heteronormativity	The presumption that other people are heterosexual or that opposite-sex attractions and relationships are the only norm.
		Sanism	Discrimination and oppression against a mental trait or condition a person has, or is judged to have. This discrimination may or may not be characterized in terms of mental disorder or cognitive impairment. This is resisted by the mad movement, consumer-survivor movement, and disability movement.
		Resistance	The refusal to accept or comply with something; the attempt to prevent something by action or argument.
		Homonormativity	The privileging of heteronormative ideals and constructs onto LGBT culture and identity. It is predicated on the assumption that the norms and values of heterosexuality should be replicated and performed in the homosexual community.
		Monosexism	A belief that monosexuality (either exclusive heterosexuality and/or homosexuality) is superior to or more legitimate than a polysexual (i.e., non-monosexual) orientation.
		Capitalism	An economic and political system in which a country's trade and industry are controlled by private owners for profit, rather than by the state. Reference may be made to cost of services.