2023-09-18

Psychologists' Practices in Supporting LGBTI Clients' Self-Advocacy Skills

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Psychologists' Practices in Supporting LGBTI Clients' Self-Advocacy Skills

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SCIENCE

GRADUATE PROGRAM IN EDUCATIONAL PSYCHOLOGY

CALGARY, ALBERTA

SEPTEMBER, 2023

Abstract

Globally, Canada has been a leading country incorporating the social justice framework in psychological theory and practice, which includes supporting sexual minorities. In the past decades, researchers and clinicians have focused on addressing systemic barriers by advocating for their clients. More recently, the concept of self-advocacy has been included in ethical guidelines, encouraging professionals to promote in their practice empowering clients to speak on their own behalf. The present study explored how Canadian psychologists promote client self-advocacy skills development using the enhanced critical incident technique (ECIT), an exploratory qualitative research method. Specifically, this study explored the factors that facilitate and hinder psychologists in supporting clients in developing self-advocacy and what factors they wish had been present as they engaged in this work. The sample consisted of 9 psychologists located in Alberta, British Columbia, Saskatchewan, New Brunswick, and Nova Scotia. Data analysis conducted using established ECIT protocols yielded 373 critical incidents (CIs) and Wish List items (WL) that were organized into the following categories: (1) 13 helping CIs; (2) 8 hindering CIs; and (3) 6 WL. Findings suggest that self-advocacy can be developed in one-on-one counselling settings and through the therapeutical process. Additionally, the findings suggest that creating safe spaces within the counselling settings and outside communities influences the ability of LGBTI clients to speak on their own behalf. Implications for researchers, psychologists and other mental health professionals are provided.

Keywords: self-advocacy, social justice, LGBTI[1], counselling practice, social action

[1] Lesbian, Gay, Bisexual, Transgender, Intersex. This is the acronym internationally recognized, as of August 08, 2023. https://women-gender-equality.canada.ca/en/free-to-be-me/2slgbtqi-plus-glossary.html#

Preface

This thesis is original, unpublished, independent work by the author, L. G. Ibarra-Alexanderson, which received ethics approval from the University of Calgary Conjoint Faculties Research Ethics Board (CFREB) on September 08, 2022 (Ethics application #: REB22-0782). The following study was not funded by any external sources, thus there are no conflicts of interest to state.

Acknowledgments

I want to thank my supervisor, Dr. José Domene, for all the guidance, countless hours of unconditional support, and for always encouraging me. I am truly grateful for having crossed paths. I appreciate all your wisdom and amazing conversations. Above all, thank you for inspiring me to be a better professional and human being. Your contribution to my life has been invaluable.

I wish to extend my heartfelt gratitude to Ashlee Kitchenham, an extraordinary mentor whose guidance and support have been invaluable to me. Thank you for all the inspiration and support, for believing in me and for cheering me up in difficult times. Our philosophical conversations, which I hold dear to my heart, have been both enriching and meaningful, and I eagerly anticipate many more to come.

Thank you to all the remarkable participants who graciously opened their hearts and invited me into a sacred space by sharing their experiences and incredible talents, thus making this project possible. Your willingness and commitment to making the world a better place are deeply appreciated. Thank you for your invaluable contributions.

I would also like to express my gratitude to the committee members, Dr. Callaghan and Dr. Lacerda-Vandenborn, who provided essential support for this project. I greatly admire your work and career paths, and I was truly honoured when you agreed to collaborate on this endeavour. Additionally, I want to express my gratitude to Dr. Bedi for his significant contributions and insightful suggestions that enhanced this project. I would also like to acknowledge Becky Como for her unwavering support and crucial collaboration throughout this journey.

This journey would not have been as amazing as it was without my cohort, my small Canadian family. Thank you for being so inspiring and amazing; you taught me what books cannot. I really appreciate all the uncontrollable laughs, and I cherish every moment we spend together.

Thank you to all my instructors for all the wisdom they shared with me. Especially Dr. Mudry for supporting me in shaping the proposal of this project and in many ways in becoming a researcher, and Dr. Maroney for lighting a spark that accompanied me throughout this journey.

Gracias a mi familia, mis abuelos y mis padres por todos los esfuerzos que derivaron en quien soy; cada paso que doy, lo hago honrando todos los regalos que me han dado. Gracias a mis padres y sus maravillosas parejas por todo su apoyo incondicional y cariño. Um abraço a tuda a familia no Brasil, obrigado pelo carinho.

Gracias a todos mis amigos, que me han demostrado que el amor, el cariño, el apoyo y la compañía va mucho más allá de los conceptos de tiempo y espacio. Un especial agradecimiento a Edith y Marisol, sin su apoyo incondicional este sueño no hubiera sido posible.

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Dedications

Aos amores da minha vida: Diogo, Milanesa & Milka

Obrigado por me acompanhar na construção da vida dos meus sonhos. Eu não sabia que essa felicidade existia. Por todas as vezes que vocês estiveram ao meu lado, por todas as montanhas que movemos e por tudo que tivemos que deixar para trás. Um viva a toda a magia que fazemos!

Eu realmente tenho *the time of my life* com vocês.

Amo vocês com todo meu ser.

A mis hermanos, por toda la inspiración y el amor incondicional

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Chapter One: Introduction

This qualitative study explored the experiences and practices of Canadian psychologists using the enhanced critical incident technique (ECIT) method. More specifically, this research described helpful, hindering, and wished-for factors that influenced supporting LGBTI clients in developing self-advocacy skills. The methodology and findings take a social justice perspective and are located within a post-positivist and critical realist paradigm. This chapter introduces the present study by describing the context of the problem and articulating the purpose, objectives, research questions and assumptions. Following this, I describe my interest in this topic, my social location, and the significance of the study.

Context of the Problem

In the past decades, social justice has become an essential ethical duty for many Canadian psychologists, generally interpreted as acknowledging, appreciating, and responding to clients' sociocultural context within and beyond the counselling process (Collins, 2018). In applied psychology, social justice principles urge professionals to commit to changing public policies and laws and creating an equal society, aiming to abolish unfair treatments or inequities resulting from marginalization, discrimination, and oppression (Chung & Bemak, 2012; Kozan & Blustein, 2018). Furthermore, for some scholars, social justice has become the fifth force of psychology (Collins, 2018; Fleuridas & Krafcik, 2019).

Despite numerous attempts to promote social justice within psychology and related fields, professionals still face many challenges to practice (Toporek et al., 2006). One challenge is the lack of accessible training about how to appropriately and ethically advocate on behalf of clients (Toporek et al., 2006, 2009). For example, advocating on a client's behalf could lead to a breach of confidentiality and privacy. Another example is the potential risks associated with acting in a

different role than those the psychologist was contracted for (i.e., multiple relationships), which are strongly discouraged by many provincial standards of psychology practice (see: CPBC, 2014; CAP, 2022; SCP, 2019). This conflicting position sets the professional in a double bind; the boundaries of what could be done and what needs to be avoided need to be clarified.

Test et al. (2005) stated that the lack of consistency among various definitions of advocacy and the roles of mental health professionals might lead to confusion. For instance, some authors assert that participation in systemic changes should be approached outside of mental health professionals' counselling work (i.e., actively participating in politics and with lawmakers) (Sánchez-Corral, 2018). Other authors suggest that supporting clients in developing self-determination and self-advocacy skills would still create systemic changes (Dong et al., 2015).

Self-advocacy is a construct that refers to the abilities or set of skills that enable individuals to act on their own behalf (Field, 1996). Test et al. (2005) stated that self-advocacy originated in the United States after the civil right movements of the 1950s and 1960s. Self-advocacy emerged internationally after the United Nations General Assembly adopted the International Covenant on Economic, Social and Cultural Rights in 1966. According to Test et al. (2005), the concept of self-advocacy developed widely in the developmental disabilities community because community members often interpreted advocacy as outsiders perceiving them as incapable of making their own decisions. Authorities were overprotective, fostered dependence and negatively impacted people's autonomy living under those conditions. In other words, the self-advocacy movement within the developmental disabilities community was founded on the belief that individuals with disabilities should have the autonomy to form their own social organizations and advocate for their rights.

In recent years, the American Psychological Association has adopted the concept of self-advocacy, particularly in the LGBTI community guidelines of practice (see: APA, 2015, 2021; Hailes et al., 2020). The term self-advocacy has begun to appear more frequently in the psychology literature as a strategy within the social justice framework (see: Courtland, 2019; Goodrich, 2015). However, the existing literature provides little guidance about which methods psychologists should use to implement principles of self-advocacy in their work.

Purpose, Objectives and Research Questions

To expand understanding of how psychologists promote self-advocacy with clients who belong to the LGBTI community, this research study explored how psychologists implement social justice principles in this aspect of their practice. Using the enhanced critical incident technique (ECIT; Butterfield et al., 2009), this study was designed to reveal helping and hindering factors that influence psychologists' practices in supporting LGBTI clients to develop self-advocacy skills.

It will become evident from the literature review in Chapter 2 that concepts of social justice and advocacy have become increasingly important within Canadian counselling psychology. Although there is less focus within the profession on self-advocacy, this skill has been mentioned more frequently in practice guidelines from other countries. For example, self-advocacy was introduced in the American Psychological Association's Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (TGNP) (APA, 2015), Guidelines for Psychological Practice with Sexual Minorities Persons (SMP) (APA, 2021) and Hailes and colleagues' (2020) article, "Ethical Guidelines for Social Justice in Psychology." In the TGNP guidelines 1, 5 and 7, self-advocacy is mentioned in the rationale and application of the guidelines (APA, 2015). In the SM guidelines, self-advocacy appears as part of

the rationale of the first guideline (APA, 2021). Moreover, Hailes et al. (2020, p. 4) state that there is a need to promote "strengths-based approaches in psychology [to] empower clients to develop their *self-advocacy* skills, strategies, and resources to be agents of change in their own lives."

The importance of promoting self-advocacy skills within all branches of professional psychology, combined with the lack of research exploring what actions counselling psychologists take to implement self-advocacy in general and with clients from the LGBTI community in particular, lead directly to the central research question that will guide this proposed study: *What factors helped, hindered, and would have helped psychologists to support clients from the LGBTI community in developing self-advocacy.* Consistent with the ECIT method that was used, this central research question was addressed through three specific sub-questions focused on what has helped, what has hindered, and what additional factors participants believe would have been helpful for promoting client self-advocacy.

Research Assumptions

From the onset of the study to the discussion of its findings, several assumptions influenced the questions, the intended use of the data, and the approaches taken at each stage. Butterfield et al. (2009) asserted the importance of researchers stating assumptions underlying the study, which guided the theoretical agreement (Chapter 5).

A post-positivist epistemology directed the present research report, which entails that there is a reality that can be approached by creating imperfect and incomplete models. See Chapter 3 for additional information. Four other main assumptions were made concerning the participants and the research process. Firstly, I assumed self-advocacy is a skill that can be developed and promoted. Secondly, I assumed that promoting client self-advocacy is an

intervention that counselling psychologists already practice, whether they have explicitly used the label or not. Thirdly, I assumed understanding how professionals addressed promoting self-advocacy would provide information about the LGBTI community, its needs, and ways to facilitate self-advocacy that would serve other professionals working with this group of clients. Finally, I assumed it is possible to fight systemic disparities through individual interventions by supporting the autonomy and agency of vulnerable populations.

Personal Background

It is important that I offer a thoughtful reflection on my epistemic and personal reflexivity. I am Mexican and decided to study as an international student in Canada due to this country's undeniable progress and leadership in human rights practice. As a professional, I wanted to explore the intersection of mental health and social justice. I am also a member of the LGBTI community. I identify as gay and am a privileged white Latino who has never consciously experienced homophobia. I was fortunate to be born and raised in Mexico City, a progressive large Latin American city with a very open-minded family that always accepted and supported my sexual orientation. Nevertheless, many close friends have suffered discrimination, stigma, and violence due to their sexual orientation and gender identity. For as long as I can remember, I have wanted to support marginalized and vulnerable populations and aspire to build an equal society.

The first time I was called to act was when I learned that the life expectancy of trans women in Latin America is 35 years, mainly because of violence (Inter-American Comission on Human Rights, 2015). Transgender people are also subject to violence in close relationships. This information was a crucial turning point for me, as I wanted to become an advocate for the community.

As a researcher and academic, I am interested in studying evidence-based and empirically supported practices (e.g., interventions and techniques). While I find enormous value in postmodern research studies, I am more comfortable aspiring to be as objective and precise as possible. My understanding of being objective and accurate is that knowledge should, to a certain extent, apply to many people within the population I am studying. I recognize that reality's complexity does not allow us to articulate the "Truth." Therefore, knowledge is always a work in progress. However, we can still aim for an imperfect partial representation of reality. This blueprint allows us to review findings with the falsifiability criterion and reflect on the scope, limitations, and conditions under what we state is likely to happen. Antithesis, for me, is a healthy virtue when conducting research. This mindset may explain my preference for post-positivism and critical realism.

I perceive a tug-of-war in academia within the human services disciplines, including counselling psychology, having to choose between the social or the medical model; however, in our practice, both can intersect. Psychologists could benefit from each model's virtues and reflect on their drawbacks.

Structure of this Study

Chapter 2 provides a summary of the literature review and theoretical context that framed the basis of this research. This summary is followed by a detailed rationale of the research methodology in Chapter and by a description of the findings in Chapter 4. Finally, Chapter 5 concludes with a comprehensive discussion of the findings, highlighting the strengths and limitations of the study, exploring the implications for the practice of counselling psychology, and proposing directions for future research.

Chapter Two: Literature Review

This chapter provides an overview of the literature that informed the foundations of the current study. Many countries, including Canada, have become increasingly multicultural and tolerant of diverse sexuality, including efforts to socially include members of the LGBTI community (Sinacore et al., 2011). Nonetheless, many sexual minorities still experience depression, anxiety, stress and direct exposure to stigma and prejudice (Latifoğlu, & Khdir, 2021; Moradi et al., 2009; Nadal et al., 2010). The primary focus of this thesis research was to examine the factors that contribute to psychologists' actions and factors in assisting clients with their self-advocacy development; In other words, at its core, the object of study was the relationship between psychologist and client.

To begin this chapter, I summarize the existing literature on relationships between the mental health professions and the LGBTI community. Then, the theoretical framework that guided this study is described: the causal agency theory (CAT) of development. Lastly, the concepts of advocacy and self-advocacy within the LGBTI community are contextualized.

Mental Health Professionals and the LGBTI Community

Bedi et al. (2011) define Canadian counselling psychology as a broad specialization to promote the well-being and mental health of individuals, which has transdisciplinary characteristics and overlaps with other professions. These authors suggest that. in some cases, counselling psychologists in Canada maintain “a scope of practice that is virtually indistinguishable from clinical psychologists” (p. 133). Moreover, there is a lack of consensus on the definition of counselling psychology between Canada and other countries (i.e., the United States and the United Kingdom). Therefore, conducting a literature review exclusively dedicated to counselling psychology was not achievable. Consequently, it is necessary to rely not just on

counselling psychology research but also on counselling-related literature from other fields such as clinical psychology, clinical social work, psychiatry and psychotherapy. This research includes counselling psychologists as authors, researchers, or participants but also includes therapists with other professional or educational backgrounds. Mental health professionals, including counselling psychologists, also face challenges when conducting research in the LGBTI community. As Moradi et al. (2009) described, the difficulties related to studying sexual minority issues, such as being inclusive in a sample, the lack of clear definitions, conceptualization, and measurement, and the overlap with other mental-health-related issues (e.g., grief, identity, systemic barriers). The existing counselling research that has overcome these difficulties with studying the LGBTI population has mainly focused on understanding the clients' experiences (see: Gruson-Wood, 2022; Nadal, 2010, 2012). However, there are some studies that focus on mental health professionals' abilities to work with this population.

Earley et al. (2020) reported in the UK that extensive research revealed that a considerable portion of mental health professionals within Western societies were ill-equipped to cater to the specific needs of LGBTI clients. This deficiency can be attributed to the fact that these practitioners have received little to no specialized training (Alderson, 2004). This lack of training may be associated with the challenge researchers and practitioners face with the complexity of conceptualizing human sexuality.

Furthermore, Godfrey et al. (2006) conducted a Delphi method study to explore and determine the knowledge, experiences and values required to work with LGBTI clients effectively. The sample consisted of 15 experts in the fields of family therapy, social work or psychology in the United States, who had experience working with clients from the LGBTI community. Three main themes resulted from the data analysis. The first theme included

categories such as values and qualities (e.g., being open-minded), theoretical orientation, issues common to LGBTI clients and diversity, and ethical or legal issues. The second theme stressed, "the importance of getting to know LGB persons as opposed to LGB places or products" (p. 498). Finally, the third theme recommended materials such as books, articles, and professional journals for therapists working with this population.

In the United States, Nadal et al. (2012) conducted a qualitative study exploring how nine transgender people experienced microaggressions, the different types of microaggressions and how participants reacted. Participants were aged 29 on average. The researchers analyzed their data using directed content analysis, which revealed twelve categories of microaggressions that transgender people experience. The researchers described the implications for counsellors when working with this population (e.g., psycho-educational workshops that promote safe spaces, acknowledge and reprimand microaggressions and sexual harassment).

In a qualitative literature review conducted by members of the Department of Psychiatry of the Massachusetts General Hospital, Boroughs et al. (2015) aimed to understand, conceptualize and acquire LGBTI cultural competency as mental health professionals. They provided 28 recommendations to achieve competency with evidence-based practice. These recommendations were categorized into themes according to different levels of training/expertise (i.e., basic skills to postdoctoral skills). The authors included eight recommendations as part of the basic skills required to develop competence to support LGBTI clients. These basic skills include the recognition and constant reflection of the changing environmental factors of LGBTI people and the impacts on their mental health, self-awareness of the psychologists' biases, and the ability to recognize if clients' sexuality is central to the presenting concern and treatment, or

whether it is only a differential factor in the case conceptualization but not specific. Boroughs et al. stated that the essential recommendation is:

> To be best equipped to therapeutically address the unique and changing contextual conditions experienced by LGBT people, psychologists need to be aware of the historical context and remain informed about these sociocultural changes, both positive and negative. Training programs should therefore develop a plan for apprising trainees of environmental changes (e.g., legal, educational, societal) and their impact on the healthy functioning of LGBT individuals and communities. (p.155).

Israel et al. (2008) conducted a qualitative study with 42 LGBTI participants in the United States. Through semi-structured interviews, participants described what they considered helpful and unhelpful in their therapeutic experiences with psychologists and social workers. Researchers used the ethnographic content analysis method to describe mainly overarching counselling skills that are not specifically related to LGBT competence (e.g., listening, warmth, reframing), except affirming in dealing with clients' sexual orientation or gender identity. They also reported situations where clients perceived their therapist to be distant or lacking in empathy and where the therapist used ineffective or harmful interventions.

In summary, existing research related to counselling LGBTI individuals primarily focuses on understanding the experiences and challenges faced by mental health professionals in providing appropriate care. Studies have shown that mental health professionals, including counselling psychologists, often lack the specialized training needed to effectively address the specific needs of LGBTI clients. The existing body of research that has examined mental health professionals and the LGBTI community emphasizes the need for professionals, including

counselling psychologists, to receive specialized training and develop cultural competency when working with the LGBTI community to provide effective and sensitive care.

Theoretical Frameworks

According to Grand and Osanloo (2014), a theoretical framework is a research guide based on existing theory that associates or reflects the assumptions of the study and should be clearly stated and explicitly mentioned in the early stages of the research. The present study aligns with two theoretical frameworks: the first one is social justice, which is one of the core values of Canadian counselling psychology (Bedi et al., 2011; Sinacore, 2011). The second one is the causal action theory, a human development theory, which supports to clarify how individuals develop *ideally* (i.e., epistemic subject of the study) and support the theoretical agreement of the findings.

Social Justice, Advocacy and Psychology

Social justice within counselling psychology can be traced back to its inception in the early 20th century (Toporek et al., 2006; Bedi et al., 2011; Kennedy & Arthur, 2014). In the 1970s, there was a more obvious turning point in applied human services disciplines (e.g., counselling, counselling psychology, social work and special education) with the human rights movement. Human services, including counselling psychology, shifted from the medical toward the social model as an approach to mental health (Sonpal-Valias, 2019). Beyond the profession of counselling psychology, social workers have widely contributed to understanding the importance of engaging in advocacy and self-advocacy in therapy (Stuntzner & Hartley, 2015).

Counselling psychology in Canada was established as a specialization within psychology by the Canadian Psychological Association in 1986 (Sinacore, 2019). Watkins (1994) identified that attention to diversity issues and vulnerable populations (i.e., ethnic and non-ethnic

minorities) distinguishes counselling psychology from other specializations within the field of psychology. Kennedy and Arthur (2014) identified that, in Canadian counselling psychology, mental health concerns are situated in social contexts, and more recently, professionals have been engaged in addressing issues of power, social injustice, and oppression. Nevertheless, only in recent years advocacy and other social justice interventions have been accepted as part of the psychologists' professional identity (Sinacore, 2019).

Organizations such as the American Psychological Association (APA) have introduced various guidelines and standards to support psychologists working with the LGBTI community in the United States. For instance, the Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients, the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, and Guidelines for Psychological Practice with Sexual Minority Persons (APA, 2012, 2015, 2021). In Canada, in the past decade, there has been an increasing requirement in academia and professional associations, such as the Canadian Psychological Association (CPA), to incorporate this advocacy effort as part of psychological practice and accreditation (CPA, 2023; Thrift & Sugarman, 2018; Sinacore et al., 2011).

Counselling psychologists are encouraged to develop competencies to work with diverse clients and advocate for them to address disparities and discrimination (Toporek et al., 2006; Kennedy & Arthur, 2014). Advocacy is also one of the core elements of psychologists' practices (Beatch et al., 2009; Bedi et al., 2011; CPA, 2023; Courtland, 2019). Advocacy can encompass a range of proactive interventions aimed at supporting marginalized individuals. These interventions may involve assuming leadership roles, fostering collaborations within school systems and communities, and actively participating in political discussions and engagement with legislators (Courland, 2007; Kennedy & Arthur, 2014).

Toporek and Williams (2006) recognized six significant themes that express the complexity and ethical issues that arise from the infusion of social justice and advocacy into counselling practice: (1) competence, (2) assumptions and worldview, (3) politics, (4) roles and boundaries, (5) informed consent, and (6) “do no harm.” The term "competence" consists of the ongoing responsibility that counselling psychologists hold in continuously assessing and adapting their professional practices and self-care, particularly when the well-being of their clients or themselves, or the political environment they operate in, might lead to negative impacts in their work. "Assumptions and worldviews" underscore the significance of engaging in self-reflection regarding the right approaches to problem-solving and professional actions. In relation to working with minority populations, "dual roles and professional boundaries" indicate that certain counselling psychologists may adopt diverse roles that deviate from conventional counselling practice, highlighting the necessity of reflecting on boundary definitions in each context and the capacity to recognize potential concerns that may arise. The aspect of "politicizing of social justice" urges counselling psychologists to examine their worldviews and beliefs to avoid displaying moral and political superiority over their clients or groups. To facilitate informed decision-making, "consent" is emphasized in training and practice to assist clients and counselling psychologists in contemplating the consequences of interventions. Lastly, "Do no harm" serves as an invitation to reflect on how specific interventions may affect particular populations and the potential impact on clients' sense of self-determination.

Despite these efforts, psychologists still struggle to practice advocacy due to the tensions that exist at the intersection of psychology and social justice; in other words, the conflict created by integrating the frameworks of psychological theory with the social justice vision (Arfken & Yen, 2014; Hailes et al., 2020). For instance, Evans and Russell-Mayhew (2020, p.688) observed

from the lived experiences of a working group at the 2018 Canadian Counselling Psychology Conference that, while social justice is stated as a core value in the Canadian Code of Ethics for Psychologists, "social justice is often understood academically, but the implementation of the action-oriented process of social justice remains unclear to many." To confuse the matter further, social justice, advocacy, and self-advocacy are terms used in daily language without having a clear or consistent definition (Tyler, 2015).

Nadal (2017, p. 938) identifies five ethical dilemmas related to the lack of motivation of psychologists to participate in social justice activism:

> (a) ethical concerns and professional boundaries, (b) the belief in political neutrality in psychology, (c) a desire to maintain personal balance and self-care, (d) the lack of psychology training on social justice activism, and (e) the belief that social justice advocacy is unnecessary in psychology.

The first dilemma, "ethical concerns and professional boundaries," refers to the situations in which psychologists have to engage in political activities. For some psychologists remaining neutral is necessary to maintain ethical boundaries because of potential negative consequences (e.g., misrepresentation of their opinions, impacts on the therapeutic alliance). Other psychologists argue that it is acceptable to engage in political activities as long as it is conducted in their personal capacities and supported by professional knowledge, which includes having conversations with clients about sensitive topics that could strengthen the therapeutic relationship. The second dilemma, "the belief in political neutrality in psychology," addresses the conflict of compromising psychology as a science by engaging in political views (i.e., remaining neutral). In contrast, contemporary psychologists have questioned the effectiveness of 'neutrality.' The third dilemma, "a desire to maintain personal balance and self-care," highlights

the concern that engaging in extracurricular advocacy can become an additional stressor and contribute to burnout. Psychologists' burnout is an ethical concern. The fourth dilemma, "the lack of psychology training on social justice activism," refers to the lack of specialized training in incorporating social justice in psychology, which results in psychologists being unfamiliar with the skills to engage in social justice in their work environments. The fifth dilemma, "the belief that social justice advocacy is unnecessary in psychology," addresses some psychologists' lack of interest to engage in progressive movements due to personal or religious beliefs, often related to conservative policies. This dilemma also includes the need to self-reflect on the ethical implications of maintaining certain views.

In the United States, Baluch et al. (2004) identified barriers to psychologists participating in advocacy efforts. Their description included the sacrifice and additional responsibility that social justice requires, a lack of understanding of the social justice definition, the long-term nature of change in this regard, and the incompatibility of some psychological approaches to address social justice issues. This master's thesis explored what Kennedy and Arthur (2014) have suggested as an important direction for research using the social justice framework: Understanding what social action has been taken counselling psychologists in their practice and how they have engaged with improving marginalized people in Canadian society.

In summary, counselling psychologists are encouraged to develop competencies to work with diverse clients and advocate for them to address disparities and discrimination. However, integrating social justice principles into practice remains challenging due to tensions between psychological professional practice and social justice frameworks. The lack of clear definitions and understanding of social justice terms contributes to the complexity of advocacy in psychology.

Advocacy and Social Justice in Counselling Psychology. In Canada, counselling psychology is defined as a research and practice specialization that involves efforts to "ameliorate distress, facilitate well-being, and maximize effective life functioning" (Bedi et al., 2011, p. 130). Advocacy is considered a core activity within the specialization, which has been addressing social inclusion and disparities before it became widely popular (Sinacore, 2019; Evans & Russell-Mayhew, 2020). Furthermore, the Canadian Code of Ethics for Psychologists (4th edition) includes advocacy in multiple places. The second guiding principle of the code, "Responsible Caring," includes the standard of maximizing benefits, in which psychologists are encouraged to advocate on behalf of a primary client as part of providing responsible care for them. Similarly, the fourth principle of the code, "Responsibility to Society," includes the need for psychologists to "advocate for appropriate change to occur" in any social structures or policies that oppose any principles of the code (CPA, 2017, p. 31).

Social justice advocacy in counselling psychology requires the use of interventions that go beyond traditional helping roles (Kozan, 2015; Ratts, 2009). One approach that might intersect traditional helping roles and social justice advocacy is the ability to help people speak for themselves (i.e., self-advocacy). Theoretically, focusing on self-advocacy will allow counselling psychologists to increase clients' welfare and avoid ethical dilemmas while producing systemic change.

Social Action from the Social Justice Perspective. Sopal-Valias (2019) identified that, within the developmental disabilities community, many health professionals operated from the medical model to understand well-being and mental health, while professionals who align with the social justice paradigm operate from a civil rights approach. Goodman et al. (2004, p.795) analyzed social justice work from an ecological model of social analysis and proposed that

interventions occur on three different levels: “the micro level, including individuals and families; the meso level, including communities and organizations; and the macro level, including social structures, ideologies, and policies” (Collins, 2018). Furthermore, Dong et al. (2015) identified that rehabilitation counsellors operating from a social justice perspective would use peer mentoring, self-help, political advocacy, and self-determination interventions. I consider that self-determination and self-help are highly associated with LGBTI self-advocacy.

How we understand our profession will shape how we approach and understand clients’ habits and concerns, our interventions and assessments and this understanding -or lack of it- will impact the training of future mental health professionals. The present research focused on psychologists’ practices using the social justice paradigm at the micro-level of intervention (i.e., within individual counselling/psychotherapy settings), as Binger and Wetchler (2012, p. 285) mentioned:

> At the micro level, practitioners are working specifically with clients on empowerment issues that may be done with the specific client or on behalf of the client. For instance, with diverse LGBTQQ couples and families, psychotherapists may work with these clients on developing specific self-advocacy skills related to understanding how to effectively access needed resources.

Causal Agency Theory

In addition to using a social justice framework, this study aligns with the Causal Agency Theory (CAT) of how human beings develop and thrive. CAT was initially introduced by Wehmeyer in 1992 as a functional model of self-determination that served the population with intellectual and developmental disabilities (Shogren et al., 2015). Wehmeyer (2014) proposed that people can be the *causal agent* of their own lives, implying that we have certain authority to

act and provoke change. In other words, people can *self-determine* their lives -to a certain extent- and have the right to self-governance. Wehmeyer also emphasized that this theory did not attempt to analyze and predict all kinds of human behaviour in all types of contexts, but rather understand contextually what motivated people and which factors supported agency in some individuals.

CAT assumes that enhanced outcomes would result from developing interventions and definitional frameworks to promote self-determination (Wehmeyer et al., 2017). The earliest philosophical roots of the construct lie in Locke's determinism in the seventeenth century. According to Shogren et al. (2019), this doctrine proposed that events result from preceding causes; in other words, human beings have the freedom to act and are, therefore, self-determined in nature. CAT was formulated to provide a deeper understanding of the process of people becoming self-determined and what that encompasses.

The primary focus of the present study did not entail delimiting the concept of self-advocacy. However, it is important to highlight that, in the existing literature, there is no clear distinction between the concepts of self-advocacy and self-determination. In fact, many clinicians use them interchangeably, and some researchers have established a causal relationship between them (Hagiwara et al., 2019). CAT does not explicitly elaborate on self-advocacy. However, self-advocacy overlaps with the CAT concepts of self-determination and agency. The understanding that people can be the causal agents of their lives is a core human development assumption of self-advocacy. In other words, if humans are not causal agents who are free to act and self-determine, self-advocacy would not have a place in individuals' lifespans.

Self-Advocacy

The term self-advocacy emerged out of the civil rights movement for people with disabilities in the United States in the 1950s and 1960s, including advocacy groups for African American women, parents, and clients living with a developmental disability. This movement emerged partially due to the overprotection provided by authority figures, impacting the autonomy of individuals living with a disability. At the time, people with disabilities had others articulate their needs, as they were seen as incapable of making their own decisions (Test et al., 2005). In the special education field in the 1990s, self-advocacy was defined as acting on one's behalf (Field, 1996).

Test et al. (2005) conducted a systematic literature review of articles published or in press between 1972 and 2003, as well as more than 150 papers, program evaluations, books and non-intervention studies to elaborate the concept of self-advocacy for people with disabilities. One of their findings was that most academics associated self-advocacy with a subset of self-determination skills. However, the University of Syracuse's Center on Human Policy defined self-determination as a subset of self-advocacy skills. Furthermore, some authors, like Field (1996), suggest that both concepts can be used interchangeably.

Test et al. (2005) also developed a self-advocacy framework from their extensive literature review. This framework describes the main components of self-advocacy: knowledge of self, understanding of one's rights, communication, and leadership. Furthermore, in the developmental disability community, the conceptualization and practical use of self-advocacy has been a positive predictor of helping students transition to different stages of education and employment (Mazzotti et al., 2014; Tedla, 2017; Test et al., 2009).

Self-Advocacy and the LGBTI Community

In the United States, Savage et al. (2005) conceptualize using empowerment strategies as tools for promoting self-advocacy with LGBTI clients. Using the Social Empowerment Model, they elaborated a theoretical model which associated self-determination and self-advocacy. The Social Empowerment Model is based on a conflict theory that presupposes a society that separates groups due to power disparity. Savage et al. highlighted how language, homophobia and heterosexism oppress the LGBTI community. To address these issues, the researchers proposed using empowerment strategies. They defined empowerment as an ongoing process involving, "extensive reflection relating issues of control, critical awareness and participation of people lacking an equal share of valued resources" (p.133). Moreover, they highlighted that empowerment is a goal of self-advocacy and that community empowerment is one way for LGBTI clients to deal with distress and support each other collectively.

The researchers suggested promoting empowerment to increase self-advocacy (i.e., applying the SEM), which is achieved in five steps. The first consists of creating an affirmative foundation with clients and deconstructing LGBTI-associated stereotypes. The second step involves defining clients' goals for empowerment. The third comprises the implementation of strategies for clients' self-acceptance and validation. The fourth consists of socially and politically incorporating the three components of Zimmerman and Warschausky's (1998) psychological empowerment. These components are intrapersonal, interactional, and behavioural. Finally, Savage et al. argue that the fifth and final step to promoting empowerment is to actualize society's behaviours and actions. This model suggests that empowering clients is a way of systemically combatting homophobia and heterosexism.

Although the term emerged in disability learning studies, self-advocacy has been adopted within the profession of psychology and encouraged to support clients from the LGBTI community (see: APA, 2015, 2021; Hailes et al. 2020). For example, affirmative therapy encourages self-advocacy practices (Bigner & Wetchler, 2012). Other studies have used the term self-advocacy as part of their suggested interventions for counselling psychologists working with LGBTI community members (Courtland, 2019). Research in applied psychology has shown that self-advocacy has been beneficial for gender-fluid clients (Knutson & Koch, 2021) and the LGBTI elderly (Ye et al., 2015).

Li et al. (2017) conducted a study with 21 gay and bisexual men with Latino backgrounds, specifically of Mexican or mixed-Mexican origin in the United States. The aim of the study was to delve into the firsthand experiences of family microaggressions and resilience strategies of the participants. The researchers used semi-structured interviews and direct content analysis to reveal three common strategies of resilience. One of these strategies was self-advocacy, which was described as "empowering behaviours used to represent one's self and values, such as by challenging harmful norms or educating others" (Li et al., 2017, p. 115). Li et al. also identified self-advocacy strategies within participants' narratives; these strategies encompassed actions such as coming out, authentically living their lives despite their families' disapproval of their sexual orientation, and challenging family members' worldview.

In the United States, Kuhlemeier et al. (2021) researched 96 school professionals from a socio-anthropological perspective. They investigated how these participants perceived LGBTI students' needs and the actions that school professionals took to address these needs. Utilizing a grounded theory research method, the researchers concluded that one of the strategies that supported making LGBTI students visible is self-advocacy:

> Participants who gauged the relative size of the school's LGBTQ population on seeing students advocate for their civil rights were often those responsible for addressing students' requests. In some instances, participants could identify a number of transgender students but had difficulty recalling any lesbian, gay, or bisexual students. (p.562)

According to their findings, transgender people demonstrated a higher level of engagement in self-advocacy compared to students who had not disclosed their sexual orientation (e.g., asking to use their correct pronouns or having bathroom access).

Luceno (2019) conducted similar research about the role of teachers, teaching assistants, school counsellors, school psychologists, administrators, and administrative personnel in Alberta in creating and sustaining safe and inclusive spaces for LGBTI youth. Luceno found that self-advocacy was one of the most important skills that should be taught to youth, specially the LGBTI youth. Similarly, San and Breen-Franklin (2019) studied the experiences of three LGBTI college students in the United States and found that occupational therapists have an important role in promoting self-advocacy.

In Ontario, Gruson-Wood et al. (2022) carried out a qualitative study focusing on LGBTI parents' experiences with social and institutional inclusion/exclusion. In the first phase, the researchers analyzed 30 LGBTI participants' interviews. In a next phase, the researchers invited 13 participants from the first phase sample to attend story-making workshops, which led to the creation of five story-telling videos. This multimedia data was also analyzed by the researchers. The authors arrived at the conclusion that utilizing these videos represented an act of self-advocacy, serving as a means to resist precarious inclusion.

In summary, the body of research that has examined self-advocacy suggests that, although the term initially developed in the community with disabilities, it has been adopted to

support LGBTI clients as well. Affirmative therapy and other interventions encourage self-advocacy practices in the LGBTI community. Studies have shown the positive effects of self-advocacy on gender-fluid clients, LGBTI elderly, and LGBTI youth in educational settings. Research also suggests self-advocacy helps make LGBTI individuals more visible and promotes social and institutional inclusion. However, despite these indications in the literature that promoting self-advocacy may be helpful when working with LGBTI clients, to my knowledge, no published studies have described what actions are taken by psychologists to help clients develop this set of skills (e.g., Courtland, 2007, 2009; Bigner & Wetchler, 2012).

The Present Study

As described in this chapter, advocacy is considered a core activity in Canadian counselling psychology. While there clearly have been efforts to train psychologists to work effectively with diverse and marginalized clients, there are still deficiencies in the research and training on how to navigate ethical dilemmas and professional boundaries. Additionally, several studies described in this literature review have revealed the positive effects of self-advocacy on various LGBTI populations. However, the research on specific actions taken by psychologists to develop self-advocacy skills for LGBTI clients remains limited. The literature review highlights the importance of understanding and promoting self-advocacy in the context of counselling psychology and the LGBTI community to enhance clients' well-being and support social inclusion. Therefore, the present research study was guided by the following research question: *What factors helped, hindered, and would have helped psychologists to support clients from the LGBTI community in developing self-advocacy*

Chapter Three: Methodology

This chapter provides an overview of the methodology used to address the research question identified in the previous chapter. Chapter 3 begins with an overview of the enhanced critical incident technique (ECIT), a qualitative method that evolved from the critical incident technique (CIT) (Butterfield et al., 2009). This is followed by the description of participant recruitment and selection, data collection and analysis procedures and the steps taken by the researchers to ensure the trustworthiness of the data. Finally, this chapter concludes by discussing the ethical measures taken to protect the well-being and rights of participants.

ECIT Overview and Appropriateness

ECIT is a qualitative method designed to explore critical incidents (i.e., events) and factors representing discrete knowledge or experiences that individuals possess. The method presupposes that information can be extracted through self-reflection on past events. Butterfield and colleagues (2009) adapted the five general steps of Flanagan's (1954) CIT to develop the enhanced version (ECIT). They also added three main enhancements to the original CIT procedures: (1) the inclusion of contextual questions at the start of the interview to provide background information; (2) nine credibility checks; (3) a list of questions regarding incidents and factors (e.g., "people, supports, information, programs," p.267) that did not occur but that the participant believes would have helped in the past or could be helpful in the future.

ECIT is an appropriate exploratory method for researching phenomena in psychology where little is known (Butterfield et al., 2005; Sander, 2019). The present research began with the assumption that Canadian psychologists are currently using self-advocacy in the therapeutic processes with their clients. It also presupposed that self-advocacy can be promoted (i.e., learned) and that information about self-advocacy promotion can be elicited through participant

self-reflection. As mentioned in preceding chapters, within the context of clients from the LGBTI community, there was no previously published information regarding self-advocacy strategies used by clinicians and psychotherapists. Therefore, ECIT was an appropriate method in this research context, as the researchers sought knowledge particular to a set of individuals (i.e., psychologists) who had experience in a particular area (i.e., working with sexually diverse clients) where little is known.

Research Paradigm

Guba and Lincoln (1994) highlighted the importance of reflecting on the paradigm behind a research method to understand better the context in which a study is conducted. These authors describe a research paradigm as a belief system that guides the entire process from conception to conclusion. This belief system is built upon ontological, epistemological, axiological and methodological assumptions (Duffy & Chenail, 2008; Poterotto, 2005). Ontology refers to assumptions about the form and nature of reality: how things, including developing self-advocacy, are and how they work. Epistemology refers to observing the relationship between the researcher and what we can know from participants and their practices (Guba & Lincoln, 1994). The concept of axiology describes the role that researchers and participants play in conducting research by considering their values, assumptions, ethics and beliefs (Mertens, 2010; Ponterotto, 2005). ECIT's paradigm assumptions align with the ontological approach of critical realism and the epistemological and axiological approach of post-positivism (McDaniel et al., 2020).

Critical realism, which evolved from realism, is the ontological approach that aligns with this study (McDaniel et al., 2020). Researchers working within the realist tradition assume that there is a reality and that their position is analogous to a "detective" attempting to uncover social and psychological processes (Braun & Clark, 2022; Harper & Thompson, 2012). Realist research

aims to discover valid and reliable knowledge about psychosocial phenomena independent of the researcher's awareness. In other words, data reflects reality for realists. However, as opposed to direct realists, critical realists recognize that information researchers can access from reality does not mirror reality exactly but only a fraction of it. Harper and Thompson (2012) explain that, when interviewing participants, they might not be fully aware of all the factors influencing their perception. Therefore, research can only elicit imperfect models of reality. In other words, we acknowledge that we are not expecting to obtain verifiable information, but we aim to obtain - under certain conditions- reliable and accurate information.

The ECIT interviewing techniques and the credibility checks described in later sections place this study in the post-positivist epistemology (McDaniel et al., 2020). ECIT credibility checks are designed to produce accurate knowledge but, more importantly, to identify and control for researcher bias, which can distort the researcher's understanding of the objective reality of the phenomenon being studied. This trustworthiness process aims to increase the likelihood of findings' transferability across contexts and similar populations to the LGBTI (e.g., other marginalized populations) (Kain, 2004). The post-positivist epistemology of ECIT aligns well with Braun and Clarke's (2022) description of critical realism.

This study aligns with Duffy and Chenail's (2008) description of the post-positivist axiological approach:

> Reduce research bias as much as possible. Disclose researcher assumptions and conflicts of interest. Make decisions very carefully based on evidence from the research. Best practices are evidence-based. Must be willing to subject methods and findings to peer review. Findings [are] always subject to change based on new evidence (p. 27).

Additionally, this research coincides with the nature of ethical behaviour expected from all researchers working from virtually every research paradigm, highlighted by Mertens (2010, p.59), "respect privacy; informed consent; minimize harm (benefice); justice/equal opportunity)."

Regarding the axiological approach in this study, it is presupposed that my beliefs, values, assumptions, and experiences influenced my ability to perceive and understand an objective reality. However, the ECIT method is designed to involve other researchers at various stages of the process, in order to limit the influence of these personal biases. In the present study, they reviewed the analysis process and the content of the findings. Additional information on the strategies used within ECIT research to mitigate researcher biases and provide evidence-based findings are described in the "credibility checks" section of this chapter. Furthermore, Duffy and Chenails (2008) emphasized that, in any post-positivist research, a key element is to disclose the researcher's assumptions and conflicts of interest, as I outlined in Chapter One. This transparency also provides the reader with a comprehensive understanding of the potential influences on my interpretations, which are disclosed in Chapter Five. Finally, the ethical dimensions of this study are discussed in the "ethical considerations" section of this chapter.

Participants

Sampling Procedures and Sample Size

Purposive and snowball sampling were used for the current study, as these techniques effectively identify individuals with expertise in a particular area (Becks, 2017; Denzin & Lincoln, 2011). The decision-making process regarding the sampling was conducted considering feasibility and ethical implications. Specifically, feasibility shaped the profile of professionals who would be able to provide information to answer the research question and who had time to

participate in the study. In relation to the ethical implications, it was established that some psychologists would not be able to participate due to potential conflicts of interest or dual role relationships with the research team.

Determining a sample size before data collection is challenging when using ECIT. Butterfield et al. (2009) and Flannagan (1954) advise that participant interviews should continue until data saturation is reached. Exhaustiveness (i.e., data saturation) of themes occurs when no new information arises from new participants. When exhaustiveness is reached, this suggests that an adequate number of participants have been interviewed and are part of a trustworthiness evaluation.

Recruitment.

Recruitment was conducted in two rounds, one in September and the other in October 2022. An electronic poster/invitation (See Appendix A) was emailed to: (1) LGBTI agencies across Canada, such as Egale Canada, Pflag, and Pride Counselling; (2) psychology instructors from the University of Calgary and other universities; (3) organizations and individual psychologists who publicly reported having worked or specialized in diverse sexuality and had contact information on their websites; and (4) regional and national professional associations such as the Psychologists' Association of Alberta (PAA) and the Canadian Psychological Association (CPA).

All individuals interested in participating in the study were screened to review their eligibility. The following eligibility criteria determined the participation of people who expressed interest in being part of the study. There were three inclusion criteria: (1) English-speaking, (2) registered, licensed, or registered provisional psychologists who had practiced in the past year of the interview in Canada, and (3) self-reported as having experience supporting members of the

LGBTI community in developing self-advocacy skills. Psychologists identifying with all gender identities were eligible to participate in the study.

There were also three exclusion criteria. First, participants were provided with a definition of self-advocacy and were asked to evaluate on a 4-point Likert scale (completely agree, partially agree, partially disagree, completely disagree) whether this definition reflects their own experiences with LGBTI clients (See Appendix B). Participants who responded "completely disagree" would have been excluded from the study, although nobody who completed the screening question responded in this way. Secondly, participants must have been willing to commit to the initial interview (approximately 90 minutes) and the cross-checking interviews (approximately 45 minutes). Thirdly, psychologists who were also students from the counselling psychology program at the University of Calgary were excluded due to potential conflicts of interest. All participants who met the inclusion and exclusion criteria were scheduled for the interview and emailed the consent form (Appendix C) and interview guide (see Appendix F).

This recruitment and screening process resulted in nine psychologists being invited to participate in the study. All participants were given a small traditional folk art sculpture (an *alebrije*) from Mexican artisans in appreciation of their time and participation. These handmade pieces also support the Mexican indigenous and artisans' community.

ECIT Procedures

The following sections detail the five major steps of conducting an ECIT study, which includes procedures for conceptualizing the study, collecting and analyzing data, and interpreting the findings. In addition, the nine credibility checks suggested by Butterfield et al. (2009) in the present study are discussed.

Step 1: Ascertaining the General Aims of the Activity to be Studied.

Butterfield et al. (2009) suggest as a first step to ascertain the general aims of the activity being studied by reflecting on the objective of the activity and the desired outcome when a person engages in this activity. This study focused on the factors, incidents and approaches (e.g., techniques, interventions, features of settings, external resources, and psychological constructs) of psychologists who self-identified as having promoted self-advocacy with LGBTI community clients. Additionally, it was important to ensure that participants and I had a common understanding of what self-advocacy means, for which a broad definition of self-advocacy was created by my supervisor and myself: Clients learning how to advocate on their own behalf rather than letting others advocate for them. All participants reported their clinical experiences with LGBTI clients related to this definition. The object of study was the relationship between the psychologist and the client. The main objective was to elicit discrete strategies psychologists use to support LGBTI clients in developing their self-advocacy skills. More specifically, to understand what strategies psychologists perceived as helping, hindering, and those they thought would have been helpful.

Step 2: Making Plans and Setting Specifications

According to Butterfield et al. (2009, p. 269), the second step in an ECIT study involves "(a) defining the types of situations to be observed, (b) determining the situation's relevance to the general aim, (c) understanding the extent of the effect the incident has on the general aim, and (d) deciding who will make the observations." The authors also explain that this step involves decision-making about who will make the observations, creating an interview guide or set of protocols for interviewers to follow, and training all people involved in the study on the purpose and the intent of questions.

For the present study, I, the principal investigator, adapted an ECIT semi-structured interview guide that was carefully reviewed by my thesis supervisor as part of the rigorousness and trustworthiness of this study (see Appendix F). The interview guide was adapted from the example provided by Butterfield et al. (2009). Because I was the only person conducting interviews, it was not necessary to train others on the interview procedures. Overall, this guide supported the goals of having a detailed interview record, maintaining the interviewer's focus on the participant's story, and ensuring that all questions have been asked, responded to, and adequately explored (Becks, 2017).

Step 3: Data Collection

Data collection is the third major step of ECIT. Participants were given the option to meet in person or through a video-conference interview. All participants preferred to be interviewed online, accommodating and being mindful of their schedule and availability. Specifically, I conducted the online interviews on Zoom, a software approved by the University of Calgary's Conjoint Faculties Research Ethics Board (CFREB). All interviews were video and audio-recorded. I collected data using the semi-structured interview guide found in Appendix F. As Butterfield et al. (2009) suggest, the first interview within the ECIT research protocol is essential because it:

> (a) allows the participant to tell their story and feel heard and understood, (b) provides the background information against which the CIs and WL items can be understood, (c) elicits the CIT data, and (d) gathers the demographic data that describe the sample. (p. 270).

Butterfield et al. (2009) also recommend gathering as much information as needed from each participant's experiences. Therefore, follow-up questions were posed to clarify and expand on a particular factor throughout the interviews.

In the present study, the first interview was divided into three sections. The first part of the interview included an explanation and purpose of the study and open-ended contextual questions to understand the participants' backgrounds (e.g., their personal and professional relation to the LGBTI community). This part of the interview also explored the participating psychologists' definitions of self-advocacy and if there were events that precipitated their need or desire to promote self-advocacy among their LGBTI clients. I also built rapport and gathered contextual information using in the first part of the first interview.

The second part involved asking participants about their critical incidents relevant to the research question, starting with helpful and followed by the hindering factors, and finally asking about wish list items. Participants were asked to provide specific examples of these factors. Exploration of these incidents and items included asking participants about the importance, the context and the personal meaning of the incident or item. Finally, participants were asked to provide demographic information, which included seven aspects: years working as a psychologist, age, gender pronouns, sexual orientation, cultural background, language spoken at home and education level. Participants were reminded that the demographic questions were not a part of the research question but were included only to provide context in the demographic section of the findings. Butterfield et al. (2009) recommend gathering as much information as needed from each of the participants' experiences. Therefore, follow-up questions were posed to clarify and expand on a particular factor in all parts of the first interview. Participants were also

asked whether they thought they had another element to add to their story, and all the elements were covered.

The average length of the first interviews, including the demographics component, was 99 minutes (*SD* = 12.29). Additionally, while only some of the first interviews with all participants were conducted in the same order, I explored the same content areas at the same level of detail with all participants. At the end of each interview, participants were asked if they would be willing participate in a second interview and if they wished to receive a copy of their findings. All participants chose to provide feedback electronically instead of in a second interview and all nine participants stated they wished to receive a copy of their findings. I wrote several notes highlighting the important factors while conducting the interview, transcribing and re-reading the transcripts.

Step 4: Data Analysis

The fourth step is the analysis of the data, which was conducted using established ECIT protocols. In ECIT, the general data analysis process consisted of determining the frame of reference, then formulating the categories derived by similar grouping incidents, and finally determining the level of specificity or generality. The latter means to what extent general behaviours will be useful to compare others (Butterfield et al., 2005, 2009).

Organizing raw data. The first step of the data analysis consisted of generating a transcript of each interview. All interviews were audio-recorded by Zoom and computer-transcribed using a supporting software called Temi. Then, I reviewed all the transcripts for accuracy and removed or altered all participants' identifiable information.

For the frame of reference, my supervisor and I created a framework with a taxonomy to classify the information. This included codes (CI/WI), categories, themes, and class. The codes

and categories are detailed in Chapter 4, accompanied by quotes and examples of the incidents and factors separated by class (helping, hindering and wish list). However, in I discuss the broader themes regarding self-advocacy with LGBTI clients that the categories clustered into, in Chapter 5.

Identifying the CI and WL items. The second phase of data analysis involved identifying the critical incidents by examining transcripts and reviewing the interviews. All transcripts were read at least three times in a period of five months and then imported to NVivo 12, a software program to conduct qualitative data analysis. Each participant's data was analyzed independently, but I also checked for exhaustiveness after each group of three participants.

I began by analyzing each interview independently, looking for critical incidents to discern patterns and contrasting their similarities and differences. The critical incidents (CI) and the wish items (WI) were coded using descriptive coding to name the incident and the operational definition (in the "description" of each of NVivo's nodes). As suggested by Butterfield et al. (2009), I provided self-explanatory names for each incident. The operational description also clearly referred to the example and the subjective importance of that incident as reported by each participant.

After each participant's interview was coded, the codes were contrasted with the notes I created in Step 3 to verify that no important factors were missing. Helping factors, hindering factors and wishlist items were separated into different files in the "Codes" section of NVivo, as Butterfield et al. (2009) advised that helping, hindering and wishlist items should be analyzed separately. The CIs and WI were also classified in the Nodes section of NVivo by each participant, which allowed me to export a codebook to cross-check with each participant and

corroborate statistically the participation rate of each category. The latter will be described in more depth in the "Credibility Checks and Trustworthiness" section of this chapter.

Creating categories. Once important factors or incidents were identified, categories were created to group various CIs and WLs. After coding the first three transcripts, I grouped all the helpful factors of the three participants and created categories based on similarities, patterns, and differences. Categories shifted as I gathered information from additional participants, sometimes changing the name (e.g., expanding it) or separating CI from a certain category and adding it to a different one.

Each category was then described, and the level of specificity was determined by reflecting on the research question and the purpose of the study (Butterfield et al., 2009). Choosing the name of each category involved reflecting on the specificity and generalizability and responding accurately to the research question. After coding and grouping all CIs and WLs into categories, those that did not meet a criterion of 25% participation (i.e., at least three out of the nine participants had similar incidents or factors) were eliminated. According to the standards established by Borgen and Amundson (1984), a minimum participation of 25% is required to form a viable category in ECIT research.

Step 5: Interpreting the Data

Data interpretation and reporting findings are the final steps in the ECIT method. Reporting should include not only a discussion of the findings but also the implications and limitations of the study and a detailed explanation of the credibility (Butterfield, 2009). Information about the findings is presented in Chapter 4, information about implications and limitations is discussed is in Chapter 5, and the credibility process is discussed next.

Credibility Checks and Trustworthiness

Butterfield et al. (2009, p.274-278) have developed nine credibility checks to enhance the trustworthiness of ECIT research:

(1) **Audiotaping interviews.** All transcripts and participant statements were audio-recorded (video-recorded during online meetings) and I checked all transcripts for accuracy, promoting descriptive validity.

(2) **Interview fidelity.** An interview guide (see Appendix F) was used to ensure that the method is being followed accurately for interview fidelity. My supervisor and I discussed some of the clarifying follow-up questions and methods and determined how to maintain objectivity in further steps (e.g., cross-checking with participants and other researchers).

(3) **Independent extraction of CIs** A research assistant, who is a counselling psychology graduate student, was provided with 25% of the transcripts (n = 3). She signed a confidentiality agreement and used NVivo to conduct her own extraction of CIs. Specifically, this researcher independently identified the CIs and WL, after which her findings were contrasted with my analysis. There was a high level of agreement (96% agreement rate): only five out of 139 CIs and WL did not match because they were missed by one of the researchers. After discussion between the researcher and research assistant, all five were added to the list of the CIs.

(4) **Exhaustiveness.** All nine interviews were conducted before starting to analyze the data. Data was analyzed in sets of three participants, and no new categories emerged between the third and the sixth interview. However, we decided to continue the analysis of the remaining three interviews for two reasons. Firstly, the interviews had already been completed and nothing within ECIT precludes adding more data even after

exhaustiveness is reached (Butterfield et al, 2009). Second, including data from all interviews honoured the time and effort participants had provided to the study. Finally, including all nine interviews increased the robustness of the participation rate and the fidelity of independent extractions of CIs by supporting categories with more participants and examples.

(5) **Participation rate.** This refers to the number of participants who provide data for each category, divided by the whole sample. Consistent with Butterfield and colleagues (2009) recommendations, categories need to meet a 25% participation rate to demonstrate robustness (i.e., at least three participants). Concerning the helping incidents, all 13 categories had more than 25% participation. Only one category out of eight hindering incidents had less than 25% participation. Finally, in one out of seven categories of Wishlist items, one category had less than 25% participation. The two categories that failed to meet the 25% participation rate are named but not elaborated upon in this thesis.

(6) **Independent placement of incidents into categories.** I provided the research assistant with a total of 25% of the incidents and asked to categorize them independently. It has been suggested by Andersson and Nilsson (1964) as cited in Butterfield et al. (2009) that an 80% matching rate or higher is a good rate for this credibility check. There was a high level of agreement between the research assistant's analysis and my analysis on all categories: helpful (86%), hindering (83%), and Wishlist items (85%). The research assistant and I discussed the distinctions between two CIs and the self-explanatory names of the CIs (i.e., preparing and practicing). After this discussion, we reached a consensus decision about the final interpretation of the data for all the differences in analyses. There

were only differences in the names of three of the helping categories and the distribution. Additionally, these changes would not have impacted the participation rate.

(7) **Participant cross-checking.** Once the data were analyzed, a description of the findings was emailed to the participants to cross-check the content, clarify the identification of incidents from their transcripts and categories created from the incidents, and provide an opportunity to identify any incidents that were missed. Participants were sent a password-protected document with the NVivo codebook with their codes (names of the CI and WL) and the descriptive coding. These codes and descriptions were separated into the three classes of helping incidents, hindering incidents and wish list items. Participants were asked to review the operational definitions and self-descriptive titles that emerged from the data in relation to their own experience (Butterfield et al., 2009). All participants were invited to discuss the findings with the researcher and, if necessary, participate in a follow-up interview. However, all of them reported that the operational definitions were accurate and that the names of the codes and descriptions reflected their experiences.

(8) **Experts' opinions.** After all previous credibility checks were completed, an expert was invited to review and provide feedback on the categories created. Specifically, this expert was Dr. Robinder Bedi, who is a registered psychologist with vast clinical practice experience and a nationally recognized expert on professional issues and psychologists' training in counselling psychology in Canada. This review process was guided by Butterfield et al. (2009) questions regarding the categories: (1) usefulness, (2) innovation, and (3) completeness. The expert was provided with a draft of Chapter 4 of the thesis (i.e., the findings chapter). Concerning the initial inquiry pertaining to usefulness, Dr. Bedi affirmed the utility of said categories. Moreover, he observed that, while he found

resonance with all the categories, a significant portion of these categories would not have arisen through recollection. This observation underscores the innovative nature of connecting both the categories and the topic of the present study. Furthermore, Dr. Bedi provided suggestions for changes to the titles of three categories, which were subsequently revised and adjusted to provide more clarity. These adjustments are integrated into Chapter 4.

(9) **Theoretical agreement.** Theoretical agreement is conducted in two steps: (1) articulating and reporting underlying assumptions of the study; and (2) efforts to find theoretical support for the categories in the literature (Butterfield et al., 2009). I articulated explicitly the assumptions that underscored the study in Chapter 1. In Chapter 5, the findings of the present study are discussed to previous research as part of my discussion of theoretical validity.

Ethical Considerations

Before recruiting and contacting participants, the present research project underwent a thorough review by the University of Calgary's Conjoint Faculties Research Ethics Board (CFREB) to ensure compliance with ethical research standards. Various considerations were implemented, including informed consent, confidentiality, benefit and risk assessment, funding, and conflict of interest.

Informed consent

Informed consent was a crucial aspect of the study. Before commencing the interview, each participant engaged in a conversation to fully understand the study's aim, which focused on their practices rather than their clients' experiences. Consent was obtained to use anonymized quotes in the thesis and any other knowledge dissemination activities. They were also made

aware of potential risks related to confidentiality breaches in online interviews and the significance of using pseudonyms to protect their privacy and that of their clients. Detailed procedures were explained to eliminate identifiable information, and participants were informed about the university's data storage policy, which retains data for at least five years. Participants were also reminded of their right to withdraw consent at any time. They were also informed about options to remove previously contributed data if they chose to withdraw from the study. Participants confirmed their voluntary participation in the interview by signing a password-protected document on Adobe Sign.

Confidentiality

Confidentiality was strictly maintained throughout the study. Real names and other identifiable information, such as geographical places, dates, and clinic were not used in the description of the findings. Instead, pseudonyms were utilized to offer a representation of experiences while safeguarding the privacy of all parties involved. However, detailed descriptions and direct quotations were included in Chapter 4 to provide an accurate and relevant context without revealing identifiable data. Identifiable information (e.g., participants' real names contact information) was stored separately from non-identifiable information to strengthen security measures. After the completion of the present study, video and audio recordings were destroyed. In addition, all the remaining data was stored in password-protected and encrypted files and will be retained until at least September 2028, after which it will be deleted.

Benefits and Risks of Participating

Considering the benefits and risks, the present study posed a low risk to participants. Although none of the nine participants actually experienced distress, there was a potential that

they could have experienced distress while recalling cases during the interview. To address this, participants were reassured of their option to take breaks or reschedule the interview if needed. Appropriate measures would have been taken in case of verbal or nonverbal signs of distress. As all participants were registered psychologists, I assumed they were aware of mental health support services available in their local areas. Nevertheless, a list of places for accessing counselling support was provided in advance (see Appendix E).

A potential risk was the possibility of a data security breach during the online interviews. To mitigate this risk, Zoom was used, as it adheres to the University of Calgary's security protocols and FIPAA compliances, ensuring secure research interviews. All names and details that could potentially identify participants were changed (e.g., pseudonyms) or removed from the transcripts, ensuring privacy while maintaining the accuracy of their statements. Furthermore, all electronic files were encrypted.

Participating in this project offered several benefits, including contributing to the improvement of counselling psychology education and helping future counsellors in their practices. It also provided an opportunity for participants to voice their practices and challenges in implementing the social justice framework and engage in reflective thinking on the topic. In some cases, participants reported that their participation led to a better understanding of their practices.

Chapter Summary

In this chapter, I discussed the recruitment, data collection and data analysis procedures I used to conduct this study. The findings that resulted from this research process are detailed in the next chapter.

Chapter 4: Findings

A sociodemographic description of participants is followed by descriptive statistics for the helping CI items, hindering CI items, and WL items shared by participants. Then a qualitative description of helping CI, hindering CI, and WL categories and items is provided, supported by examples highlighting how participants support LGBTI clients in developing self-advocacy skills.

Participant Demographics

The participant sample consisted of nine licensed or registered (including provisional) psychologists. All participants were licensed in Alberta, British Columbia, New Brunswick, Nova Scotia, or Saskatchewan during the study, with a length of time as a licensed psychologist ranging from one to three years. Participant ages ranged from 30 to 45 years (M = 36, SD = 6.2). Eight participants reported their cultural background as White; one identified as a second-generation Canadian with a Southeast-Asian cultural background. Similarly, all participants reported that English was spoken at home, and one reported speaking a Southeast Asian Language in addition to English at home. Eight participants had a counselling psychology degree, and one had a clinical psychology degree. Table 1 provides gender identity, sexual orientation, and educational level information.

Table 1

Summary of Gender Identity, Sexual Orientation, and Educational Level of Participants

Demographic	Frequency (n)	Percentage (%)
Gender Identity		
Cisgender woman	5	56
Queer/Gender Non-Conforming	3	33
Non-Binary	1	11
Sexual Orientation		
Queer	3	33
Heterosexual	2	22
Bisexual	1	11
Bisexual/Pansexual	1	11
Lesbian	1	11
Pansexual	1	11
Education Level		
MA/MSc	5	56
Ph.D.	4	44

Four participants reported owning a private practice; three others worked in private practice, one worked in public healthcare, and the final one worked for a non-profit organization. In terms of the preferred approach to therapy, two participants reported using Emotion-Focused Therapy, two participants reported using Cognitive-Behavioural Therapy in combination with other modalities, two participants reported using Narrative Therapy in combination with other modalities, one participant reported using Relational Gestalt Therapy, one reported using

Acceptance Commitment Therapy in combination with a client-centred approach, and one reported using Dialectical Behavioural Therapy.

Critical Incident Findings

Data analysis yielded a total of 373 helping and hindering CIs and WL items, out of which 248 (66%) were helping, 89 (24%) were hindering, and 36 (10%) were wish list items (see Table 2). The frequency of items reported by each participant ranged from 20 to 43 helping items ($M = 27$, $SD = 7.79$), 4 to 15 hindering items ($M = 10$, $SD = 3.01$), and 2 to 5 wish list items ($M = 4$, $SD = 1$). The helping, hindering, and wish list items were classified into the subcategories described below, to delineate further how participants guide their clients in self-advocacy.

Table 2

Number of Helping CIs, Hindering CIs, and Wish List Items by Participant

Participant	Helping CIs	Hindering CIs	Wishlist Items	Total
P01	27	9	4	40
P02	21	11	5	37
P03	43	15	4	62
P04	20	9	5	34
P05	24	12	4	40
P06	34	10	3	47
P07	34	8	5	38
P08	23	4	4	31
P09	22	11	2	35
Total	248	89	36	373

Helping CIs

The 248 helping items reported by participants were grouped into 13 Categories of helping CIs (see Table 3).

Table 3

Categories of Helping CIs

Helping CI Category	Frequency (*n*)	Participation Rate (%)	Total Number of Items
Boundary Setting	9	100	20
Increasing Self-Awareness of Clients' Needs, Rights, and Life Context	9	100	20
Specific Strategies to Support the Development of Self-Advocacy	9	100	27
Processing Trauma and Navigating through Clients' Complex Experiences	9	100	28
Self-advocacy Psychoeducation	9	100	23
Psychologists' Competency with Relevant Cultural, Diverse Sexuality, Practice and Ethical Considerations	9	100	28
Providing Safe Spaces and Social Support Systems	8	89	20
Psychologists' Research, Resources, and Training	8	89	15

Careful Self-advocacy through Risk Management, Harm Minimization, and Safety Planning.	8	89	23
Psychologists' Support System	7	78	10
Validate and Normalize Clients' Experiences	6	67	9
Increasing Clients' Hope, Resilience, and Empowerment	6	67	18
Psychologist support for and involvement in the LGBTI Community	5	56	7

Category 1: Boundary Setting

All participants described some form of boundary setting as helpful in the context of developing LGBTI client self-advocacy skills. Although participants worked from different therapeutic approaches, there was a general convergence of opinion that boundary setting benefits self-advocacy skill development. Eight percent (20/248) of helpful items shared by participants pertained to boundary setting. This category of incidents generally reflected three dimensions of helpful boundary setting: self-awareness of professional limitations (i.e., recognizing factors that are outside their scope of practice and that they have no control over), setting boundaries with clients, and supporting clients in setting boundaries in their personal lives.

First, some participants described the importance of being aware of their limitations as professionals. Most examples of role limitations included working with clients experiencing significant emotional distress due to lacking basic needs (e.g., housing) and domestic violence.

Sometimes, these psychologists reported feeling compelled to solve client problems, and as Participant 03 illustrated, “There is a fine line between working for the client and working with the client.” Some participants reported that keeping occupational limitations in mind supported their ability to work effectively by actively creating a space where clients could explore their limits.

Participants narrated the importance of trusting in client strength and resilience and that “telling them what to do” often caused ruptures to the therapeutic relationship. For some, recognizing professional boundaries also included respecting the client's decisions, letting go of some responsibility for being the agent of change, and learning when to step back by trusting clients’ problem-solving ability while ensuring proper access to resources.

Second, some participants described the helpfulness of setting boundaries to clarify expectations for the therapeutic relationship and process. For Participant 02, setting boundaries with clients included “encouraging the client… you may [rely on me], I can benefit you, I am here to help you, but you don't need to rely on me.” In general, participants suggested that this type of boundary setting supports the therapeutic relationship because client awareness of their psychologist’s boundaries supports clients in self-advocacy; solving client problems “or advocat[ing] on [their] behalf … would potentially lose [their] trust and disempower [them]” (P06).

Finally, some participants identified supporting clients in setting boundaries in the clients’ personal lives as a helpful factor in building self-advocacy skills. They shared that LGBTI clients might loosen boundaries out of fear of rejection, social exclusion, or punishment in response to their gender identity or sexual orientation. Participants added that these boundaries may be related to clients’ lack of awareness of their level of comfort or tolerance. Participant 05

shared that clients would ask for their needs to be met "as long as they do not disrupt other people's perception of comfort." Participants also described challenges stemming from harmful societal influences such as homophobia and intolerance towards non-conforming gender expressions clients engaged in self-advocacy might encounter from others. By helping clients to self-advocate, participants expressed that clients generally learned to set boundaries in their personal lives to stand up for what they need in their close relationships.

Different participants used different interventions to support clients in developing healthy boundaries. Three participants spoke about using a somatic (i.e., mind-body) approach to help clients understand the treatment they "deserve" from individuals or groups in the clients' relational system. For example, Participant 05 shared that using a somatic approach supports clients in noticing how boundary disruption feels in their bodies. In contrast, Participant 09 stated that they explicitly discuss with clients how they might face pushback after self-advocating. This participant encourages their clients to think about the worst-case scenario and collaborate to develop coping strategies. Participant 01 emphasized the importance of providing psychoeducation on setting boundaries, such as "having open conversations and explaining what a boundary is and talking about the consequences of not having healthy boundaries."

Category 2: Increasing Self-awareness of Clients' Needs, Rights, and Life Context

All participants described the importance of their awareness of clients' needs, rights, or life context to develop client self-advocacy skills. Eight percent (20/248) of helpful items shared by participants pertained to this helping CI category. Most participants expressed that their clients had little knowledge about their rights and experienced difficulties understanding their feelings. According to some of the psychologists' perceptions, this is related to the client's history (e.g., trauma, abuse, neglect, and rejection) and how clients built their relationships in the

past. Also, many participants navigated through very complex situations (e.g., gender transitions, having other mental health concerns that need medication, and other life transitions such as parenting) in which competing and conflicting needs emerged. All participants agreed that knowing what to stand up for is the first step of the self-advocacy journey. As Participant 09 highlights:

> Unfortunately, some people don't even realize that's something that they should have access to or that that should be a right of theirs. So, when you see people that they haven't even, it's just kind of almost like they just accept that.

Participants also addressed the importance of clients meeting basic needs (e.g., safe housing) before exploring other concerns related to the clients' sexuality and gender expression, which also require self-advocacy. As Participant 08 pointed out, access to mental health services often requires that clients have the financial means to obtain therapy. Three participants (P03, P05, P06) disclosed that there was little space to intervene psychologically when clients' basic needs were unmet (e.g., living in poverty). In other words, when clients were in this situation, therapy focused more on supporting the client to access proper care and resources rather than focusing on their mental health and well-being. They also reported that their clients had not 'paused' their mental health struggles while the therapy focused on addressing their basic needs. Still, things as important as proper nutrition, sleeping, safety and housing were substantially more important to address before advocating for themselves in relation to LGBTI concerns.

All nine psychologists reported that, once their clients had their basic needs met, creating a space where clients can explore their needs becomes crucial to self-advocacy. According to some participants, members of the LGBTI community often experience social repression, and they cannot fully express themselves. This social repression comes in many forms. For example,

clients were told what to do and what not to do; there was little room in their upbringings to explore their desires, interests, and needs; or they experienced violent acts (i.e., microaggressions or physical violence) when they tried to speak up. Many psychologists in the present study reported that their clients felt undeserving, impacting their self-concept and identity and that LGBTI community members tended to avoid causing other people discomfort. Therefore, therapy provides a space to explore those aspects of themselves that were *'shut down,'* allowing clients to have a deeper understanding of their authentic beliefs, options, what they wanted to do, what they liked, what they disliked, and their context.

As mentioned earlier, exploring aspects of the clients that were shut down provided many participants with better information on how to support their clients. Others, such as Participant 05, supported clients by writing a list of options and prioritizing their needs; they supported clients in finding out what is best for them, focusing on what they want as opposed to what they want to avoid. Furthermore, Participant 07 used art (e.g., sculpture and writing) to invite their clients to identify what they need, explore internal and external factors and adopt a different perspective of their identity. For this participant, what clients create in the room also served to express their needs to others once those needs have been identified by the client.

One psychologist shared that their LGBTI clients' experiences happen within multiple systems, and sometimes competing needs exist. For example, clients may want their financial needs to be met, but they also want their health needs to be met, and it may not be possible to achieve both at once. These competing needs are also influenced by other factors that need to be framed and understood by clients. As Participant 08 explained:

> I guess what I'm illustrating here is how those micro meso and macro levels all kind of influence…how we understand our needs and how we can go about advocating for those

needs. It's kind of like this web… in a way, having the understanding and the validation of how the meso and macro level influenced the micro level that this person was able to advocate for a need at the micro level.

Category 3: Specific Strategies to Support the Development of Self-advocacy

All participants described specific strategies to support LGBTI clients in developing self-advocacy skills. Eleven percent (27/248) of helpful items shared by participants pertained to this category, which included three specific types of strategies used by the participants: modelling, practicing and normalizing self-advocacy.

Psychologists identified modelling as one beneficial strategy to promote client self-advocacy. According to Participant 01, modelling self-advocacy in sessions refers to creating the experience of healthy self-advocacy in the room. This experience may include involving clients' relatives in counselling to support them on how to create an environment where clients can engage in self-advocacy. This process recognizes that the therapy room is the first opportunity for many clients to explore and talk about their needs:

> Just asking them straight out and really letting them inform me. And then offering what I can and [let] them choose as to what would be helpful or to what degree that is necessary… Like sometimes [clients] will respond, 'No one's ever actually asked me that before.' Like, 'You're the first mental health professional to ask me what I need,' which kind of breaks my heart a little. (P05)

One participant shared the importance of setting an example of what advocacy looks like by engaging in self-advocacy in their own work. For instance, Participant 09 set the following example at their workplace:

> I did bring it up to the group and advocated for a review of our forms and systems that we were using. Then also had done some research about getting a community organization that had specialized in educating people on those types of topics to come in to do a workshop for [my colleagues].

As Participant 04 shared, modelling can also be a tool to develop other skills related to self-advocacy, such as self-validation, self-compassion being in balance, and holding frustration. Furthermore, clients can look for models of other individuals who have advocated for themselves in LGBTI community. According to participants, this is important because healing experiences do not happen exclusively in therapy. Psychologists also highlighted the importance of recognizing when clients have advocated for themselves in the therapeutic room. As Participant 07 said:

> I think self-advocacy actually starts before me. So, their self-advocate. Part of self-advocacy is deciding to come to see me in the first place and saying, I have a barrier. I need help with it. And actually, deciding and reaching out to me.

A second specific strategy to support the development of client self-advocacy that the participants described is clients practicing self-advocacy activities with the psychologist before they try it with others. This can happen in many different forms. For example, Participant 03 stated they could begin by exploring clients' past experiences when they had asked for help (including how, when, with whom, and how it turned out). Many of the psychologists in the present study reported that the first place their clients are invited to feel comfortable and self-advocate is in the psychologist's office and within the therapeutic relationship. Participants invited their clients to tell them what works and what is not working in therapy and recognized that this might be the first time the client has ever disclosed who they are or what they need.

When clients can advocate for themselves with the psychologist and say, 'this is not working' or are able to be open about something (e.g., sexual orientation or gender identity), it is a huge step for their self-advocacy development. As Participant 03 mentioned, "[after disclosing something 'big' in therapy] …the likelihood that they can say that to someone else increases that much more." Participant 09 described the strategy of practicing self-advocacy as an iterative process. In other words, clients may sometimes feel empowered while other times discouraged. Therefore, they sometimes need to rehearse several times before they feel ready to self-advocate outside the therapy room. This practice occurs keeping in mind, as Participant 05 shared, that self-advocacy and advocacy are not mutually exclusive.

Moreover, in the present study, practicing included co-advocacy. Co-advocacy was included within the strategy of practicing advocacy with the psychologist because co-advocacy serves as a bridge for clients to increase their independence and agency. Participants shared that co-advocacy involves providing emotional support inside and outside the therapy room without the psychologist leading the process (advocacy). For example, Participant 5 stated that clients can call relatives or a doctor in the room to express their needs or set some boundaries, or a psychologist might go to a doctor's appointment and sit down with the client. However, most participants also highlighted at some point in the interviews that what best supports the client needs a case-by-case evaluation, and that it is essential to assess the client's level of resources and agency, the needs, and the support system that the clients have.

Additionally, psychologists provided examples of different ways their clients can practice advocacy in sessions. These examples included writing down what they want to communicate, where, to whom, and how; using role-play as a tool; taking moderate risks to self-advocate in between sessions and then debriefing what felt good and what did not. Other examples within

this strategy included (a) encouraging clients to self-advocacy in safe environments such as supportive communities; (b) using resources to support them in how they could present their needs; (c) discussing possible scenarios, things that they could say, how might other people react and what they can do about; and (d) visualizing how self-advocacy might look like for the client.

The third specific type of strategy within Category 3 involved normalizing self-advocacy. This type of strategy included letting clients know that they are not alone (i.e., backing up the clients), and that other people who have gone through similar concerns were able to stand up for themselves, as well as reminding the client that it is their right to advocate for themselves. As Participant 02 described, "realizing like it is okay to stand up… And so realizing like, 'no, you aren't alone. There is other people, this isn't weird. You're allowed to advocate.'"

Category 4: Processing Trauma and Navigating Clients' Complex Experiences

All nine participants cited processing trauma and navigating clients' complex experiences as helping to develop LGBTI client self-advocacy skills. This category accounted for 11.3% (28/248) of the total helpful items. As mentioned in Category 1, many clients who identify as part of the LGBTI community have experienced challenges throughout their life, and some face social invalidation daily. Additionally, some experience intersectionalities that could make their situation more challenging due to other external barriers (e.g., financial, language). In other words, clients from the LGBTI community might not come to therapy with only one concern but, instead, may be experiencing multiple intersecting struggles. Participants, in general, reported that it is important to address things that happened in the client's past and find solutions to alleviate some of the daily triggering and retraumatizing events.

Working with the core of shame and self-worth is an important step toward building self-advocacy for some psychologists. Some participants associated shame with difficult themes

clients had not spoken about before. Specifically, participants shared that some of their LGBTI clients associated shame with unexplored components of their sexuality. Reducing the struggles with shame and self-worth prepares the client to express authentically.

Psychologists participating in this study also reported that working with past traumatic experiences was very useful for promoting self-advocacy. This includes breaking down past negative experiences, processing trauma by creating an art piece, exploring difficult emotions, helping clients deal with conflicting emotions, integrating and rebuilding identity, reprocessing negative past experiences and working with conflicting inner parts. Other participants utilized re-processing, re-storing, repairing relationships, re-parenting, somatic experiences, finding the primary and secondary emotions to find their needs, and working with their identity and self-concept. As Participant 09 highlights:

> Sometimes the focus of the intervention is repairing clients' relationships. Asking if the relationship can be repaired, building up confidence, identifying where the hurt and harm come from and if they feel safe and want to address it productively. This is particularly useful when the clients have meaningful relationships with other people. Clients' other values need to be acknowledged than "leave that situation."

One of the key steps participants reported in this category is to name what harmed the client by 'teasing out' their worries and hidden meanings (i.e., extracting essential information about the relationships and other factors that worry them). This provides a space to reprocess the trauma and supports self-advocacy. Participant 03 explained that this is achieved by "playing" with different terminology and checking how it lands on the client. The concept of naming the harm also includes promoting a deeper understanding of the impact that discrimination causes clients harm and alleviating some of the stress through psychoeducation.

According to participants, many clients of the LGBTI community experience a variety of complex situations, and, most often than not, they are expected by others to feel in certain ways. Participant 04 provided the example of a client who had decided to transition to another gender but then felt they could not express doubt or “hesitation” about that decision due to society’s negative judgements about gender transitions. Naming the external influences affecting them and expressing those influences allows the client to separate the problem and reprocess those experiences (more specifically, working with self-blame).

Participants reported that externalizing the problem and recognizing who really is doing the wrongdoing is crucial to working with trauma because the combination of shame, self-worth and past trauma normally takes clients into a place where they assume that they are causing all their own distress. Acknowledging clients' difficulties and not pretending that everything is fine supports clients to see problems in the system (e.g., invalidation from other professionals, dismissal, etc.) and reinforces the idea that the client is not the problem. Participants also found it helpful to understand why self-advocacy is difficult and how it relates to other trauma symptoms. They reported that, as part of the therapeutic process, it is essential to break down the experience to gain a better understanding. This opens a space for clients to reprocess memories and realize they are not the problem. This helps clients to make the people or systems who harmed them accountable. Additionally, when the client builds enough resources and confidence, psychologists can challenge clients to make others accountable for the harm they have caused the client. At the same time, breaking down experiences allows clients to uncover how they want to feel differently (i.e., self-worth, having a stronger sense of identity, self-validation, and self-acceptance).

Participants often reported that clients' have a "fragmented experience" that contains both positive and negative aspects. For example, Participant 04 described an incident where a family member might make the client feel loved while also feeling responsible for making 'a big deal about their sexuality (i.e., conflicting emotions). It is challenging to self-advocate when having conflicting emotions. The psychologist can support the client in navigating and holding this space to create balance or find creative solutions to address each part's needs.

Another strategy the participating psychologists reported is challenging clients to get out of their comfort zone by breaking down stereotypes with hierarchy and societal structures and their limiting beliefs. For example, Participant 02 described the self-advocacy promotion strategy of challenging clients' perceptions and associating them with areas clients could improve or express themselves authentically:

> Even sometimes challenging some perceptions. ... helping them see other perspectives. Maybe helping them see areas where they could improve and how they can become more like themselves or more diversion they view of themselves… but then they tend to feel more confident in their expression. So they tend to maybe go from 'I can't have a healthy relationship' [to] 'I deserve healthy relationships. I deserve to be treated well.'

Furthermore, participants note that self-advocacy itself can lead to a traumatic experience for their LGBTI clients. Working on previous traumatic experiences and worries informs why self-advocacy is difficult for clients (e.g., stigma, harm, and sexuality). This also involves recognizing and naming the problem, which could be an external problem, and identifying internal barriers. Working with trauma allows the possibility of speaking on one's behalf and having better ways to express their sexuality (e.g., outing themselves). Addressing anxieties and fears is essential for self-advocacy because clients advocating for themselves might lead to

pushback from other people. Participant 09 stated that talking about the hardships of self-advocacy separates the negative consequences of these actions and reminds clients that there is nothing wrong with them. LGBTI clients experience a lot of invalidation and violence when it comes to self-advocacy. Participant 04 reported that addressing these situations and welcoming everything the client brings (e.g., anger, pain) is vital. This leads to validating what clients are feeling and what they deserve. Another participant (Participant 06) highlighted validating clients' experiences of invalidation, acknowledging systemic barriers, and highlighting clients' strengths, which encourages clients to risk standing up for themselves again after being rejected.

Category 5: Self-advocacy Psychoeducation

All nine participants cited self-advocacy psychoeducation as helping to develop LGBTI client self-advocacy skills, which accounted for 9.3% (23/248) of the total helpful items. In addition, psychoeducation was implied in the content of some other categories. However, the incidents in this category had a primary focus on psychoeducation. Participants reported that clients benefit and increase their chances of standing up for themselves when they have additional resources (i.e., other skills related to self-advocacy) that would serve as a base to support self-advocacy. The psychologists in this study described the importance of psychoeducation to develop their clients' self-concept, identity, and emotional and social skills.

Participants described the importance of supporting clients to positively change their thoughts about themselves (i.e., self-concept and identity). According to participants' narratives, sometimes clients may be highly self-critical or reveal their low self-esteem and self-worth verbally and non-verbally. According to some participants, this lack of self-worth impacts their clients' decision-making ability and sense of control over their lives. Participants described the importance of increasing clients' sense of agency; in other words, increasing accountability and

responsibility for their own choices and accessing their strengths. According to Participant 03, “taking responsibility for themselves is one of the most significant sources of empowerment in the self.” However, taking responsibility involves making active choices and not feeling accountable for others’ reactions. For example, Participant 08 reported, "Clients can make more emotionally informed decisions after exploring their options and priorities…. They might [even] choose not to have [a] need met after a decision balance.” Self-acceptance is another skill related to self-concept, which refers to the ability to feel comfortable in their own skin, particularly if they are waiting to receive medical treatment to support their authentic identity. Participant 04 reported, “self-compassion can be so important for feeling able to self-advocate, feeling like self-advocating is worthwhile.” Another useful strategy reported by participants is to teach self-confidence, which allows clients to feel comfortable expressing their needs.

Another set of skills that was evident in the helping CI items is related to clients’ emotional states. Psychoeducation about these emotional regulation strategies starts by exploring clients’ comfort levels in different scenarios (e.g., disclosing parts of their identity). Participants reported that their clients often need to learn to deal with anger, rage, shame, frustration, and discouragement. For example, Participant 01 suggested engaging in psychoeducation to support clients in managing their emotions instead of trying to control others. Other participants emphasized the importance of helping clients to learn how to deal with frustration and hopelessness because they were shut down when they tried to advocate for themselves. In addition, participants explained that, when reprocessing trauma, some discomfort might appear in the therapy room. However, when clients express their concerns, it provides a different perspective and allows the possibility of psychoeducation and exploration.

Finally, clients may benefit from psychoeducation to promote several specific social skills. One such skill identified by Participant 01 was the ability to express themselves, which was particularly relevant for clients waiting to receive healthcare treatment. Self-expression can be developed when psychologists use creativity and curiosity to understand what clients bring and reflect on what they observe. Also, clients can develop skills to advocate for the needs of other members of the LGBTI community by modelling advocacy in their social network. For example, clients can learn from resources from the community and replicate them in other contexts (i.e., becoming activists). Psychologists in this study found it helpful to support clients in distinguishing what they can and cannot control. Participants also mentioned supporting clients in developing negotiation and confidence skills (how they interact with other people) and learning how to communicate in different contexts (e.g., at work and with their partners).

Category 6: Psychologists' Competency with Relevant Cultural, Diverse Sexuality, Practice and Ethical Considerations

All nine participants cited psychologists' competency with relevant practice, cultural, diverse sexuality, ethical considerations as helping to develop LGBTI client self-advocacy skills. Items in this category accounted for 11.2% (28/248) of the total helpful items. Some participants reported asking questions about clients' sexuality during intake and having LGBTI cultural competency, which demonstrates the psychologist's interest in their clients' community. Some examples of this competency include the psychologist's comfort level with bringing up sexuality topics. As Participant 01 shared:

> I know a lot of clinicians don't ask the question in their intake interview about sexual orientation. They just kind of make assumptions. And… I've had colleagues that haven't asked that question and then found out, you know, a year into therapy that they identified

as LGBTQ. So, I think [that by] asking that question, sometimes they'll almost gasp like a sigh of relief.

Participant 03 also suggested strengthening the ability to overcome the cultural stigma about the community and reflect on and associate different clients' identities (i.e., positionalities) with the concerns:

I think everybody deals with it multiple identities.... that cultural competence piece and being able to get past that cultural stigma we have around, being queer that seems to an overarching sort of theme that prevents people from even wanting to go seek help.

This participant also reported the benefit of knowing how to articulate within the community using correct pronouns or understanding the terminology and why these words are important for clients:

There's just complexity… What is poly, you know, all these terms or like what is asexual, right? And this is the training I take so that I have an idea of when a client says, 'I think I might be asexual,' I know for sure that we're gonna be exploring what that means to them.

Participants recommended keeping in mind that clients from the LGBTI community could always be struggling, making them more vulnerable to particular social messages (e.g., invalidation) -more when it comes from other mental health professionals (P06). Participants were also aware of LGBTI rights; this knowledge has supported their practice and clients' self-advocacy.

Participants reported that having the competency to understand clients' concerns at a micro-level can alleviate distress and relational tensions in some close relationships, providing clients with a space to self-advocate. As Participant 04 shared, these relational tensions manifest

when clients bring polarizing experiences (e.g., feeling angry about being LGBTI; having a family that loves them and rejects them simultaneously): “And the lack of validation that they experienced really led to this like polarizing… [a] really complicated, heavy, challenging experience for them internally about how they felt about [others].” Participant 4 also explained that psychologists need to learn beforehand how to balance and hold the clients’ whole complex experience to support them in learning how they feel about others and how they want to advocate for themselves.

Additionally, some participants achieved cultural competency using a different framework to conceptualize clients’ concerns. For example, thinking outside the Eurocentric outlook of mainstream psychology (P03), or understanding clients’ concerns as part of their identity instead of something that needs to be fixed (P07).

Some participants are members of the LGBTI community themselves or have close relatives who are, and they found self-disclosure to be another helpful competency. Some participants reported that this kind of self-disclosure supports clients in letting their guard down and showing physical reactions that indicate relaxation —sharing personal stories to communicate empathy and understanding of the client’s experiences. Participant 04 shared that self-disclosure is talking about past experiences and expressing how they feel about their clients or what they are experiencing in the room. It allowed them to find deeper meanings of clients' needs and experiences.

Some incidents reported by psychologists reflected the idea of curiosity and exploring the clients' experiences. This competency includes creating a space to question, explore and understand the complexity of the problem and formulate ideas that might support them later. Curiosity and exploration also include asking questions regarding sexuality instead of making

assumptions. Participants reported that having a genuine desire to learn about clients' experiences is essential, as clients notice when there is disconnection. Also, this competency promotes a strong working relationship that can be used to collaboratively join resources to self-advocate inside and outside the therapeutic space.

According to participants, self-advocacy can take a long time; therefore, it is important for psychologists to develop patience and flexibility. Psychologists must adapt their approach to their clients' needs, develop the strength to support them in navigating their challenges and avoid deciding on behalf of their clients. For instance, Participant 05 said, "some clients prefer narrative, while others prefer somatic therapy." This process also involves reflecting on the assumptions of what clients need and when the psychologist is trying to "rescue the client." In other words, it is crucial to step back and not make decisions on behalf of clients. Instead, it is important for psychologists to let clients figure things out for themselves and to accompany them to explore what is best for them, even when the client asks the psychologist to make a decision for them. Giving clients space and time to develop is a crucial competency for promoting self-advocacy.

Localizing Interventions. Psychologists also developed advanced practice competencies to localize interventions, techniques, and assessments. Localizing resources means that they would adapt an intervention from an approach, specifically to use it for the purpose of developing self-advocacy. For example, Participant 02 utilized risk assessment and safety plan questions to develop a plan to safely self-advocate:

> So for this plan… it was almost like a suicide intervention plan… I took that same template and just turned it into a plan for [self-advocacy]. So it would be like…who are you gonna call, when you are feeling overwhelmed or discouraged about this? And what

professionals can you get on? Or what professionals do you need to go to?… With the suicide plan it's like, what are your reasons for living? Instead it was like, what are your reasons for doing this? And then changing that a little bit… of course formatting it there, and then they had it a paper copy similar to like what they would have for a suicide intervention plan where they could look at it.

Psychologists in this study reported developing competence with utilizing self-advocacy as an intervention to meet clients' process goals. Participants reported the importance of navigating double-bind situations that involve ethical considerations. For example, on some occasions, clients disclose information that places the psychologist at risk. When risks are elevated, this situation often leads the psychologist to take a more directive approach. As an example, Participant 09 shared that coaching clients and letting them know how they advocate for themselves is particularly important when clients do not have the means or the resources and are mistreated (e.g., not listening or not taken seriously) by societal systems (e.g., police).

Furthermore, some participants shared that they have experienced success with implementing interventions that are sometimes not considered therapy, such as calling a healthcare provider in session and introducing the client to other people from the LGBTI community. They also recognized the importance of considering the ethics of these kinds of interventions prior to using them with clients.

Category 7: Providing Safe Spaces and Social Support Systems

Eight participants cited providing safe spaces and social support systems as helping to develop LGBTI client self-advocacy skills, which accounted for 8.0% (20/248) of total helpful items. This helping category includes incidents where psychologists described the importance of

providing a safe space for their clients in the therapy room and providing them with a safe social support system outside the therapy room.

Participants mentioned that clients usually present fear or sadness and seek a space and therapeutic relationship to obtain reassurance and security, express worry, and normalize their feelings. For many participants, having a safe space starts in therapy, in which clients are informed they can express their discomfort with any part of the intervention. It is important to build a therapeutic relationship using validation, empathy, and understanding. For Participant 01, it is vital to ensure that the client and psychologist create safe spaces for them to stand up for themselves and set boundaries. This participant shared it is a "welcoming space where they're accepted for exactly who they are, and then they don't have to put on a mask or pretend to be anybody else." As sessions evolve, this safe space might expand and invite other allies or people into sessions. Bringing other close relationships into therapy has helped clients to replicate that safe space outside therapy (i.e., a safe social support system).

This safe space also involves sitting with clients' uncomfortable feelings, some of which might result from invalidation messages from larger systems (e.g., families, healthcare system). According to participants, clients need a space to figure out what they want to do, what is hurtful in a situation and what does not feel safe. Participant 09 mentioned:

> I think just like, just having that space, like, in their room where to explore, they right away recognize that it is a, a safe space for them to express whatever it is, you know, and to make whatever decision, but it's just a space for them to explore what's going to be the best decision for them.

Creating a safe space within the therapy room allows clients to feel understood, hopeful, and empowered to have positive interactions somewhere else or with someone else. This reminds the client of their capability to create those relationships. As Participant 03 described:

> it really helped create safety in the room… if it hadn't even existed, we would not have gotten anywhere….And then [that safety] gave space in the room for us to tease out other things that they really did want to talk about… if you're somebody that you know, can understand them, where they feel understood, they felt like they got help from you, they got positive interaction with you, then the likelihood of them, you know, feeling empowered to go do that with someone else [increases].

Participant 03 mentioned that therapy is only one piece of the healing process. Another piece involves encouraging clients to find a community in which they feel safe to self-advocate. This experience is particularly important, as Participant 07 mentioned that LGBTI clients and particularly those who have experienced trauma tend to isolate themselves. Therefore, it is important to connect clients with all the support they can get to reintegrate and get back into the social support system. Furthermore, Participant 8 noted that sometimes the client's primary need is for connection.

According to the participants, when clients are connected to LGBTI communities in their vicinity, they tend to get to feel safe, know like-minded people, and connect their goals to the community. They also experience more inclusivity and affirmation. When clients are surrounded by people who see the importance of what they are experiencing, clients engage in conversations and educate themselves, and they start modelling other people's useful and successful patterns of behaviour. Clients also benefit from connecting with role models and have a foundation to self-advocate. This connection is the facilitator that helps people advocate for other needs in their

lives (e.g., mitigating the impact of microaggressions which helps them advocate with healthcare professionals).

Some participants asked clients how to gather family, social, and work-related support resources. Other psychologists encouraged clients to reach out to queer groups to bring people together to create a safe community for clients. As Participant 08 shared:

> I help [clients] to advocate for those needs … I would say a big commonality that helps people advocate for their needs is community… when you are around other people, it mitigates the experience of those microaggressions and I think it like helps people have the spaciousness to advocate for themselves… I encourage people to reach out to organizations…. I've directed people to Facebook groups. I've found websites that are about [sport in a city]... [groups] that are about bringing people together, whether it's not-for-profit organizations or just groups that random people [start]…sports leagues, lots of sports leagues that I encourage people to look into.

Furthermore, Participant 02 reported directly connecting clients to groups (e.g., trans groups), providing a sense of belonging. This is particularly important when families are not accepting or welcoming or when broader systems respond poorly. Other participants have involved parents, families, school alliances, and fundraisers. Finally, Participant 01 described incidents where they encouraged their clients to look for mentors and people who make them feel safe and with whom they can express discomfort—for example, teaching families how to support assessing the client's needs.

From these nine psychologists' experiences working with LGBTI clients, finding a community in LGBTI groups represents a "chosen family" and a place where clients feel accepted for who they are. This sense of community positively impacts clients' ability to set

boundaries and allows clients to go to therapy prepared to dive into more profound work. In other words, clients become able to explore themselves in different contexts and start [re]building their identity. These safe places help clients to self-advocate and to reprocess traumatic experiences. Safe communities involve agencies competent in privacy. Two participants (02, 09) also reported creating gender-diverse groups, which helped their clients cope with loneliness, normalize their experiences, and have a base to advocate for themselves. Clients being supported by a group reduce the hardship of receiving, as it helps them overcome challenges, and their burdens do not rely solely on the therapeutic relationship.

Category 8: Psychologists' Research, Resources, and Training

Eight participants cited psychologists' research, resources and training as helping to develop LGBTI client self-advocacy skills, which accounted for 6.0% (9/248) of total helpful items. "Therapy is more than two people can do," shared Participant 03. Having additional resources (e.g., written, created or that exist in communities) can support the therapeutic process by connecting clients to communities which encourages outpatient work. According to some participants, this reduces the pressure of solving everything in the therapeutic space.

Participants mentioned that psychologists could benefit from having resources and passing them on to clients. These resources may include external resources such as agencies and businesses that support the LGBTI community, along with different centres and community outreach. These kinds of resources help to create a path to find places for clients to practice self-advocacy and model other peoples' experiences. Most participants also highlighted the importance of understanding what is available in the community. This allows psychologists to offer their clients resources that are known in advance to be safe.

Most participants did their own research to understand better what community services are safe for LGBTI clients (i.e., to be well-informed regarding policies, procedures, and resources available to the clinic or the area). For example, they visited and contacted agencies to find people in the LGBTI community for referrals. These psychologists also reported that the safe agencies they found provided additional tools (e.g., gender-affirming colouring sheets) to use in therapy. Some of these resources supported clients directly to self-advocate. For example, Participant 06 described obtaining a psychoeducational PFlag resource they used to help clients to talk with their families about sexual diversity. Visiting other agencies also allowed psychologists to work with other professionals who share resources (e.g., lists of agencies, client referrals), particularly for situations outside the scope of psychotherapy. In some cases, this created a sub-community of advocates for clinical practice.

Participants reported that conducting research on LGBTI trends and specific interventions (e.g., gender dysphoria, trauma) can provide psychologists with insights into what to bring up in sessions. Also, conducting research about the population ensures ongoing professional development and competency. For instance, Participant 05 learned self-advocacy strategies by observing online communities and how other people with similar conditions self-advocate. These online communities supported the participant to (a) see what self-advocacy looks like, (b) understand how each person's experience of self-advocacy differs, (c) reflect on when their work turns into rescue or "*white saviourism*," and (d) learn how a community works.

Another aspect of this category was receiving training on intervening and addressing trauma, marginalized communities, queer issues, ethics and duty of care, and sexuality. For example, in obtaining this specialized training, participants developed competency in better understanding the community's terminology. Self-learning helped participants to develop a

deeper understanding of what might harm other people, which is useful because, according to some participants, there is a gap in formal education on how to work with LGBTI clients within the discipline of psychology.

Category 9: Careful Self-advocacy through Risk Management, Harm Minimization, and Safety Planning

Nine percent (23/248) of helpful CI shared by participants pertained to promoting careful self-advocacy for clients by engaging in activities such as risk management, harm minimization and safety planning. The eight participants who contributed to this category disclosed that some LGBTI members in the community where they live and work had experienced emotional and physical violence (e.g., people who had been publicly insulted and who had been shot or otherwise harmed by family members). Additionally, as previously mentioned, participants shared that some of their clients also experienced prevalent stress and social invalidation, which activated strong negative emotions. Therefore, they believed that inviting clients to self-advocate always comes with potential risks and, consequently, acknowledged the importance of assessing and minimizing risk and planning for safety when inviting clients to self-advocate.

Participants associated risk assessment and planning with the clients' support systems, they were aware that they cannot do everything in the therapy room and that the context (i.e., where, when and with whom) for self-advocacy must be as safe as possible. Most participants agreed that contacting agencies before referring their clients and checking the safety of potential resources is vital, considering that referrals to unsafe resources could cause re-traumatization.

Another perception reported by several participants is that their clients take many risks. Sometimes self-advocating does not achieve the desired outcome, and sometimes it can disempower clients. Participants perceived that it is always important to consider if there are

imminent risks, threats to integrity, or legal issues involved. Psychologists also reported that being able to distinguish between self-imposed barriers (e.g., avoiding making other people uncomfortable) and those that put others at risk is essential for supporting clients in assessing risks before acting. For example, Participant 05 shared:

> When we're talking about self-advocacy, we also have to look into [consequences for other people] by asking, does my self-advocacy harm or cost someone else in an unreasonable way?... Those decisions have ripples and consequences beyond ourselves and could result in harm to someone else…

For the participants, taking risks is not necessarily negative. On the contrary, sometimes participants challenged their clients to take controlled risks. The purpose of risk assessment is to minimize harm and maximize benefits. In some instances, self-advocacy includes supporting clients in challenging the system (e.g., challenging diagnoses) and helping them know where to go and whom they can contact (connecting to safe resources). This process sometimes involved validating how the client feels and what they say, which may differ from what professionals say.

Another aspect of careful self-advocacy involves considering the consequences of clients not advocating for themselves. This includes considering the potential consequences and planning an alternative for each undesired outcome. For instance, Participant 08 reported that considering other stressors and the decisions in larger contexts (e.g., tuition, financial stress, school, being a parent, and meeting children's or other family members' needs vs. attending to my needs) might put things into perspective. Many participants disclosed that some of their clients decided not to meet a specific need because it was better for their environment. As Participant 04 explained, self-advocacy does not have to look a certain way; instead, it is about aligning clients' active decisions with their values.

Participants also recognized that, while it is important to respect clients' decisions and see them as experts in their lives, sometimes it is difficult for clients to accept that some of their behaviours might cause harm to themselves or others. When this occurs, careful self-advocacy includes showing genuine worry about clients' decision-making, becoming directive, using motivational interviews, and exploring the consequences of clients engaging in harmful behaviour (or disengaging). As Participant 05 illustrates:

> Self-advocacy does not only come with rights but also with responsibilities. The boundary of self-advocacy is when it harms other people. Sometimes it is essential to discuss the possible consequences of a particular self-advocacy act. For instance, what happens if it impacts others around you?... Exploring the boundaries of self-advocacy: is it harming or costing someone else unreasonably?

Another aspect of careful self-advocacy that was present in several participants' helping incidents was the need to explore power dynamics by asking whether self-advocacy is impacting people with power or people more vulnerable. Understanding the level of vulnerability allowed psychologists to minimize risks by talking about harmful or unsafe scenarios and possible things that can go wrong when the client engages in self-advocacy. Talking through scenarios and practicing in sessions are also ways of safely exposing the client to certain risks (e.g., if someone thinks negatively about them) to produce tolerance and better responses.

Another aspect of the category of careful self-advocacy is for psychologists to conduct a debrief after clients advocated for themselves. For example, it is helpful to determine who might have been discriminatory or racist and who has been supportive. Participant 07 shared how a client was able to successfully self-advocate by exploring in sessions who was safe at the client's

workplace: “Who did you reach out [to]? [Because] sometimes is even like one person, maybe very racist or discriminatory, but the other[s] may not be.”

In general, participants reported using the following process when promoting safe self-advocacy: (1) exploring possible outcomes of different scenarios with clients, (2) letting clients know their rights, (3) supporting clients in formulating how to present their rights and needs, and (4) planning to try self-advocacy in their sessions. Then, after the client engages in self-advocacy, the participant will debrief with them about what happened. Additionally, Participant 06 shared that another important part of careful self-advocacy it to not to make false promises (e.g., “everything is going to be all right”), as self-advocacy can go negatively. Participant 09 highlighted the importance of recognizing these potential negative consequences to support clients in addressing their anxieties and fears around self-advocacy.

Category 10: Psychologist Support System

Seven participants reported having a support system for psychologists as helping to develop LGBTI client self-advocacy skills. Content in this category accounted for 4.0% (10/248) of total helpful items. Working in an environment where there are other people who support having conversations around LGBTI issues is helpful for sharing information about relevant resources for clients. As Participant 09 illustrated:

> Especially within the profession, going through in school, having other students that are going through the program or once you get into your job, other colleagues who are supportive in having those conversations.

Another kind of support within Category 10 is consultation groups. For example, Participant 06 participates in an ongoing LGBTI-focused consultation group where mental health professionals from different fields (e.g., social workers, counsellors) meet monthly and discuss

therapy cases. This participant expressed that many psychologists are not exposed to information about specialized programs addressing LGBTI concerns. The consultation group provides this psychologist with opportunities to they learn about concerns specific to the LGBTI community, including specialized programming for this community. Participants valued this kind of peer-to-peer support and exploration of ideas to better support their LGBTI clients. A similar form of support reported by the participants is informal consultation through informal supervisors, peer support/consultation, and mentorship (e.g., people from the community who are not psychologists but have knowledge about LGBTI community members' experiences).

The participants also reported that working on themselves is very useful for discovering things that could interfere with providing space for clients to self–advocate. For example, some attend therapy sessions and maintain regular sessions with their own psychologist regardless of whether they are experiencing something acute. Additionally, participants shared that self-work supports them to identify and address their own biases and harmful behaviours, engage in self-care (how the psychologist supports themselves in the room), and prevent or mitigating burnout.

Furthermore, psychologists also reported incidents where supervisors provided access to specialized professionals and resources (e.g., referrals to a sexologist) that were helpful for the participants' clients. From the participants' perspective, this supervision allows them to reflect on their practices and course of action with clients. Supervisors can also suggest different ways to address the participants' concerns. Other benefits of a supervisor include having someone with whom they can share their compassion fatigue, work on countertransference, and validate interventions outside Western psychology. Participant 3 reported that supervision is very important to provide support for their work with LGBTI clients:

> I feel an overwhelming amount of compassion and care and love towards the clients and… feeling of burnout, I just wanna do something for them. I often tell my therapist or my own supervisor, like, I just wanna take them in… And it makes it hard for me to, to help the client feel empowered because I'm starting to now feel like I wanna take care of this person versus empowering them that they can do it… but I'm getting supported through supervision and, and my own therapy to really learn how to use that in a good way in the room. Not just to support the client, but actually to support myself as well… I mean, this is where if I was working alone, it might impact negatively, but if I work with a supervisor, I'm constantly, you know, working this out with somebody who's supervising my work. (Participant 03).

Category 11: Validate and Normalize Clients' Experiences

Six participants cited validation and normalizing clients' experiences as helping to develop their LGBTI clients' self-advocacy skills. This accounted for 3.6% (9/248) of total helpful items. For Participant 04, validation reflects the message that the client's needs are valuable and worthy of attention. In addition, validation also supports client in 'being comfortable' with the entire experience of queerness. Participant 09 shared that validating clients' experience provides them with the confidence to negotiate in situations where they are not being heard, as clients frequently experience invalidation when dealing with authority figures.

Participant 08 shared that it is important to recognize that asking for what you need is part of being vulnerable. This psychologist acknowledges and recognizes that struggling clients are still willing to put in the work and must take risks to obtain what they need. Another benefit of validation and normalization mentioned by participants is dealing with "big emotions" and

facilitating presence to explore other possibilities. Additionally, normalizing experiences is a way to honour clients' challenges and give them hope for the future. Participant 04 emphasized the importance of receiving validation from a community:

> I think from like a clinical perspective, [community outreach] also offers, I mean, it's like such intense validation when you are in a room full of people who are like, 'yes, I've experienced this too.' Like, that's so great. And I think it does allow for my clients to come into our space and work on…[and] we can like kind of dive deeper into the work because they're doing a lot, they're getting so much of this like, sort of like basic validation and holding from the group itself.

According to Participant 08, validating clients' experiences supports them to make sense of some of their barriers. In other words, supporting clients in understanding why they could not self-advocate provided a deeper insight into their difficulties.

Telling clients that other people are experiencing similar situations and reinforcing that systems impact their well-being also supports externalizing the problem and making others who have harmed clients accountable for their actions. Participant 03 said:

> Just hearing from somebody else that they had a tough experience of discrimination … gives me a clear perspective of the barriers the community is seeking. And it gives me that much more confidence when I am in the room with a client to say, you know, this is not you. Other people are experiencing this. You're not alone. This is a tough, you know, this is really tough to go through.

Category 12: Increasing Clients' Hope, Resilience and Empowerment

Six participants cited increasing clients' hope, resilience and empowerment as helping to develop LGBTI client self-advocacy skills. This accounted for 7.3% (18/248) of total helpful

items. According to participants, hope, resilience and empowerment are crucial aspects of self-advocacy. Participant 07 shared that the most powerful thing they can do is to support clients in feeling empowered to navigate the challenges for themselves and think and act more out of what they want, as opposed to what they fear. Similarly, Participant 02 reported that she thought about "bringing light and supporting clients where needed to be able to be the best version of themselves."

As Participant 09 described, in some cases it is helpful to build clients' confidence and support them in expressing the hurt and harm other people have caused them. Clients have meaningful relationships with people who hurt them, so simply telling the client "just avoiding them" might not serve the client's best interest. Confidence allows clients to speak up when they are uncomfortable, and to open the possibility of restoring important relationships. This also frequently happens with healthcare providers. Participants reported that sometimes other professionals do not even realize they might be causing harm and, when LGBTI clients express their concern, some professionals react positively and relate better to them.

Some participants increased clients' sense of hope by using projective interventions (i.e., art therapy) to explore their desired outcome and visualization to create a hopeful future for themselves. Through projective interventions, clients can communicate their whole experience (e.g., what they have been through, and how they want their world to unfold). Art and visualization are helpful tools for exploring different identities, especially when clients' identity is fragmented. Participants described visualization strategies from solution-focused therapy, such as "as if it was a perfect world" questions and the miracle question, which can also help clients reflect on their support system and things they had not thought existed in their context.

According to Participant 06, clients feel more empowered when they are able to make decisions for themselves. This process involves accepting the impact of negative situations. Even though clients have not caused negative experiences (e.g., social rejection), they benefit from learning how to deal with them. Participant 02 addressed these situations by encouraging clients' strengths and inviting them to be the best version of themselves.

Another aspect of Category 12 described by three participants is that, with time, clients tend to become empowered and start advocating for others. For example, advocating to bring awareness of the struggles at schools or workplaces. Clients increase their motivation if they are capable of advocating on behalf of other people and supporting other members of the LGBTI community (e.g., starting groups in other contexts like at work)

Category 13: Psychologist Involvement and Showing Support for the LGBTI Community

Five participants cited psychologists becoming involved with and showing support for the LGBTI community as helping to develop LGBTI client self-advocacy skills, which accounted for 2.8% (7/248) of total helpful items.

One way of showing support is to use visual indicators that psychologists are allies of the LGBTI community. For example, Participant 01 talked about how clients reported they contacted her because her office had a rainbow heart, which the participant had placed to show support to the community. According to this participant, these "small" actions allow some clients to express how they really feel. For Participant 03, showing support included having a rainbow flag in the office, displaying resources for the trans community, and using a purse that says "protect QTIPOC." These visual indicators provided clients with encouragement to seek help and a feeling of safety to talk about diverse sexuality concerns.

Participants' involvement in the community can also include attending LGBTI events. This has allowed them to hear other community members' experiences regarding self-advocacy. According to participants, attending LGBTI events has provided them with a broader perspective, which includes understanding differences within the community and learning about experiences they have not lived, such as gender dysphoria. Involvement in the community also boosted psychologists' confidence in their decision-making process as they developed greater understanding of what might serve or harm clients. Some participants stressed the importance of beecoming familiar with various resources that might be available for clients because the needs of the LGBTI community subgroups are diverse. Some of these resources could only be accessed through direct exposure to the LGBTI community. For example, some participants have met people in the community who can have supportive conversations on LGBTI issues.

Hindering CIs Categories

The 89 critical incidents reported by psychologists as hindering their work around self-advocacy were grouped into nine categories. The ninth category did not reach the minimum 25% of participation, so only eight categories are presented in this thesis. Table 4 provides a breakdown of the content of these categories, including the category that did not meet the 25% participation rate.

Table 4

Categories of Hindering CIs

Hindering CI	Frequency (*n*)	Participation (%)	Number of Items
Clients Dealing with Social Rejection	7	78	13
Clients' Inner State	7	78	16
Clients' External Challenging Factors	7	78	13
Clients' Previous Negative Experiences with Healthcare Providers	7	78	8
Barriers to Healthcare and Resources	7	78	11
Psychologists' Burnout and Strong Emotions	6	67	10
Psychologists' Lack of Control	5	56	12
Burdens of Promoting Self-advocacy	3	33	4
Psychologists' Difficulty Accessing Training	2	22	2

Category 1: Clients Dealing with Social Rejection

Fifteen percent (13/89) of hindering items shared by participants pertained to clients dealing with social rejection. According to participants, clients are repeatedly isolated, socially excluded, stigmatized, and discrimination against. Examples provided by participants included clients being pushed away by family members; clients not having a support system (e.g., a transgender support group); and people referring to clients using derogatory slang or comments. Furthermore, Participant 07 shared that people have been shot in communities for being gay.

This discourages many LGBTI clients from self-advocacy, more so when there is a lack of safe spaces for the LGBTI community to seek support after being attacked. In addition, participants explained that clients must sometimes return to where they felt invalidated and replicate the help-seeking situation because that is their only choice. For example, when clients have to return to health professionals who have misgendered them or verbalized their disagreement with the clients' choices (e.g., taking hormones to facilitate a gender transition).

Concerning treatment, the psychologists in this study reported that their clients are frequently dysregulated due to the experiences mentioned above. Therefore, occasionally, therapy must focus more on dealing with the effects of social rejection on clients' well-being, as opposed to exploring clients' needs and goals. According to participants, social rejection makes clients feel dismissed, which discourages clients from practicing self-advocacy. For example, Participant 08 reported that clients who are repeatedly misgendered sometimes lose interest over time to self-advocate about this issue.

According to participants, clients' lack of interest in self-advocacy and their sense of disempowerment impacted the therapeutic process. Specifically, lack of interest and disempowerment sometimes forced the psychologist to improvise, making it more difficult to plan for sessions. In contrast, experiencing disempowerment can also be beneficial if this experience causes clients to become more self-aware of their responses to challenging situations with micro-aggressions (e.g., fight, flight, freeze, dissociate, appease), which allows the psychologist to support them in developing other social skills associated with self-advocacy.

Participants shared incidents where clients struggled to meet their basic needs or learning accommodations and are still expected to be assertive with other professionals. These clients encounter dismissive authority figures (e.g., medical gatekeepers, employers, educators), and

psychologists must do extra work filling out forms or contacting other professionals to advise them of the harm these professionals are causing. Participant 07 shared that LGBTI clients tend to associate speaking up with negative consequences and that this association is difficult to unlearn. For instance, some of their clients grew up in families with inflexible expectations about gender behaviour. For these clients, the consequence of authentically expressing themselves was negative, and they were "shoved back into those boxes." Some clients even experienced harassment for self-advocating to achieve better working conditions.

Within the category of clients dealing with social rejection, some participants reported that clients who are exposed to negative rhetoric (e.g., pathologizing) in the media receive it as invalidation. Participant 06 shared that clients receive messages that disempower them in movies and social media. While social media and mainstream media have changed, according to Participant 06, there is still one dominant narrative: Portrayals of the LGBTI community do not reflect this community's resiliency, but instead focuses only on the suffering or "coping with substance abuse." This participant explained that this narrative brings up much pain from the clients' past. Additionally, clients receive many violent, homophobic, and transphobic messages, which are enacted in interpersonal relationships. According to the same participant, invalidating messages from people like J.K. Rowling, the impact of social media, and articles that belittle the LGBTI community, are all a form of passive-aggressive violence that discourages self-advocacy.

The psychologists in this study also reported it is difficult for LGBTI clients to deal with rejection, more so if clients have to process this violence in isolation. According to participants, when clients are rejected, it becomes more difficult to self-advocate, and they feel uncomfortable with the idea of doing it again. Their clients are constantly confronted with social rejection that can be exhausting to the point of clients preferring not having to deal with this rejection. For

example, this intolerance can be present in clients' life context at family events or someone coming out to their extended family members.

Category 2: Clients' Inner State

Eighteen percent (16/89) of hindering items shared by participants pertained to clients' general sense of unworthiness challenges clients' readiness to change. Seven participants described incidents that reflected this category. One participant's experience suggests that clients' sense of unworthiness might be related to their upbringings, the kind of attachment they developed and how they dealt with emotion in the past. As Participant 01 shared:

> Attachment and how emotion was dealt with throughout their lifetime growing up if they were allowed to express themselves, if the emotion was validated and accepted and welcomed in their household, if a lot of pressure was put on them and they were shamed for certain things or, or it wasn't a safe environment emotionally to just kind of be who they are. I find that [these clients] really struggle to advocate for themselves. Like I said, that lack of, that of confidence, that lack of self-esteem is there.

Also, participants reported that their clients feel that the system cannot help, which leads to clients experiencing hopelessness. Furthermore, some clients have multiple concerns that require receiving support from various professionals. For example, one participant described having clients who struggled to share in therapy what they were going through due to concerns that the psychologist would disclose this information to the client's other healthcare providers. According to this participant, this increases the clients' level of vulnerability as they isolate themselves and have to figure out by themselves what to do or put themselves in danger.

Participants expressed having a strong sense of identity is difficult for clients when they feel disjointed within themselves because of the discrimination they experience in society.

People become tired of having to deal with microaggressions and heteronormativity over and over and, therefore, also become tired of self-advocating. Participants reported that clients tend to cling to heteronormativity stereotypes, which are difficult to reframe or deconstruct. This is a reason why resilience and empowerment are very important. Sometimes clients also have to live with unique intersectionalities (e.g., a trans person who has not been through transition yet) or are often present with overlapping conditions such as ADHD and trauma.

Participants also narrated that clients face many issues around stigma in their culture. Clients internalize these cultural barriers, and the psychologist needs to support the client in externalizing them. This internalization affects their self-esteem (e.g., having a self-concept of being "deviant" or "horrible" as opposed to feeling worthy) and leads to higher risks. Some participants suspect that this internalization leads clients to deal with prevalent distress, which makes it harder for psychologists to promote self-advocacy. According to Participant 07, many clients have developed relational trauma (complex trauma), which provokes internalizing shame and blame associated with their identity. Clients then learn that their voice is not important at all. Although they have a strong sense of justice, these clients create a narrative consistent with feeling unworthy and undeserving. Furthermore, Participant 05 reported that LGBTI clients have a sense of justice for others but not for themselves. More specifically, this participant shared that clients "might come after someone who hurts someone a client loves, but when it comes to them, they do not have the same capacity."

According to participants, people get punished for self-advocating, which becomes traumatic for clients. Participants reported that many LGBTI community members have experienced trauma, producing fractures in identity. Furthermore, LGBTI clients need to try again and again because society sends the message that speaking up is not allowed. This makes

them less willing to stand up for themselves or engage in self-advocacy. Finally, participants also shared incidents where the COVID-19 pandemic increased clients' hopelessness and added barriers to community outreach and accessing support.

Category 3: Clients' External Challenging Factors

Seven participants cited external challenges experienced by their clients as a hindrance to developing LGBTI client self-advocacy skills. This accounted for 14.6% (13/89) of total hindering items. The specific kinds of external challenges described by participants included (a) lack of gathering spaces, (b) unsupportive relational systems, (c) systemic barriers to accessing basic needs, (d) diminished autonomy and (e) the impact of microaggressions.

Participant 01 expressed that there are few recreational gathering spaces for the LGBTI community beyond establishments that serve alcohol, making self-advocacy difficult for some socially isolated clients. Therefore, it is unsurprising that participants in general emphasized the importance of their LGBTI clients seeking community. However, some participants shared that the therapeutic benefits of becoming part of a community might be reduced if clients subsequently return to unsupportive systems that may exacerbate stress. Participant 07 reported that trauma and experiences related to one's gender identity or sexual orientation are often intertwined (e.g., clients who have experienced familial transphobia or homophobia). Participant 07 further shared that their LGBTI clients sometimes struggle as they make progress toward therapeutic goals while navigating relationships with relatives who trigger or retraumatize them.

Some participants also reported that LGBTI clients sometimes experience barriers to safe housing, employment, and education. When clients experience systemic barriers to accessing basic needs, stabilization then becomes the priority, as self-advocacy is challenging if these basic needs are not being met. Participants voiced frustration with societal attitudes such as beliefs that

individuals experiencing homelessness could find housing if they wanted to. They also voiced frustrations that, for LGBTI clients experiencing significant life disruptions, therapy sessions are overtaken by bureaucracy and filling out forms. Participants' frustrations highlight the sense of 'fighting against the system' some psychologists feel when working with underprivileged clients, which participants perceived as detracting from time spent building self-advocacy skills. Participants also shared that listening to stories of clients' difficulties with obtaining basic needs sometimes leads to compassion fatigue and overidentification with their clients.

Highlighting the importance of safe spaces for LGBTI clients to self-explore and develop agency, some participants shared that their clients' external support systems (e.g., family members) try to solve problems for them. These participants further expressed that the removal of autonomy sometimes leads clients to feel like their choices are wrong, as the choices might not align with others' expectations.

Participants also shared that the frequency and influence of microaggressions experienced by LGBTI clients over time can reduce the energy clients have for self-advocacy. Participant 09 stated some clients might raise awareness about pronouns with psychologists, while others might disengage from this kind of self-advocacy altogether. Participants emphasized the importance of remaining aware that client needs, desires, and advocacy are not always well received or safe due to oppressive systems of power. Many participants reported that they keep this awareness at the forefront of their minds to mitigate the harm of microaggressions, especially microaggressions that may increase once the client begins to self-advocate. Participant 06 expressed fear of clients stating, "You didn't warn me that this could be this terrible," which highlights the importance of preparing clients for possible negative consequences of self-advocacy.

Category 4: Clients' Previous Negative Experiences with Healthcare Providers

Seven participants cited clients' previous negative experiences with healthcare providers as a hindering CI to developing LGBTI client self-advocacy skills. This accounted for nine percent (8/89) of total hindering items.

These seven participants reported that some of their clients experienced negative consequences for self-advocating within the healthcare system, leading to retraumatization and relational distress. Some participants reported that their LGBTI clients have been warned by healthcare providers against speaking up about their needs. Participants also shared examples where their clients were told that the chances of "being taken seriously" would be reduced because speaking up about what they want (e.g., hormones or using the right pronouns) is perceived as "aggressive behaviour." These types of warnings and attitudes from healthcare providers discourage LGBTI clients from voicing their individual needs and rights.

Participants reported that many LGBTI clients have experienced being invalidated by other healthcare professionals. They emphasized that the LGBTI community has been historically over-pathologized, which leads to having their concerns dismissed by healthcare providers. For example, Participant 06 reported that invalidating healthcare system experiences are often the result of misguided assumptions by healthcare professionals, including mental health professionals. Many participants shared the observation that, when clients experience invalidation within healthcare settings, clients become disempowered and less inclined to seek other mental health services. Some participants also shared that, even if these clients seek other mental health services, LGBTI clients with past negative healthcare experiences might present as hesitant or defensive in therapy. Participants also expressed that some healthcare providers are not interested in learning more about the LGBTI community. They speculated that interest is

likely lower in rural communities that do not have access to mental health resources compared to urban communities. Some participants were also concerned that mental health professionals specializing in LGBTI issues are scarce in rural areas.

In response to these negative experiences, participants generally expressed that it is necessary for them to spend extra time building trust with LGBTI clients who have experienced invalidation from other healthcare providers. Some participants emphasized the importance of supporting LGBTI clients in understanding how to navigate and cope with these kinds of invalidating interactions. They also expressed that, while teaching clients ethical and safe self-advocacy is important, self-advocacy skill building detracts from therapeutic process time. Some participants expressed feeling an overwhelming amount of responsibility because they might be the last resource if their LGBTI clients were dismissed or harmed by other professionals.

Category 5: Barriers to Healthcare and Resources

Seven participants described barriers to mental healthcare and resources that their clients had experienced as a hindering CI to developing LGBTI client self-advocacy skills. This accounted for 12.4% (11/89) of total hindering items.

Participants reported that sometimes LGBTI clients wait for long periods of time and must make several attempts to receive social or mental health services, if they receive any at all. For example, some participants expressed that even high-risk clients must wait for psychiatric services or are sometimes dismissed when presenting for mental health crises at hospital emergency departments. Participants reported that, for some LGBTI clients, the amount of work required to access mental healthcare outweighs the benefits. Participants reported that some clients might live far from service providers and resources. According to the participants, this lack of resources is exacerbated by a general lack of awareness among clients and psychologists

regarding how clients can fulfill their needs through other communities and social services. Participants also expressed concern for the lack of safe places for clients across provinces, especially because they have LGBTI clients whose physical integrity is at risk, making self-advocacy more challenging. Further description of participants' perspectives on the concept of safe spaces can be found in Category 7 of the helping incidents.

Some participants pointed to challenging issues such as the role of religious beliefs among some mental healthcare providers that discourage expressions of sexual orientation and gender beyond a hetero- and cis-normative understanding. Participants also shared that LGBTI clients often receive advice from people who do not understand their experience. For example, Participant 09 shared that their LGBTI clients have been told by mental health professionals that if they do not restore ruptured familial relationships, "they would never be happy." While the advice might be well-intentioned, this example highlights that professional advice does not always serve clients' best interests. Other participants shared that LGBTI clients might have strong relationships with their healthcare providers, but these professionals may unintentionally display microaggressions, highlighting the importance of more professional development.

Category 6: Psychologists' Burnout and Strong Emotions

Six participants cited psychologist burnout and strong emotions as a hindering CI to helping psychologists assist LGBTI clients in developing LGBTI their own self-advocacy skills. This category accounted for 11.2% (10/89) of total hindering items and included content related to compassion fatigue, burnout, negative emotions and pressure.

Psychologists reported working extra hours to support clients from the LGBTI community (e.g., to conduct research on specialized LGBTI resources). Some participants are members of the LGBTI community themselves. These participants reported sometimes over-

identifying with client experiences, resulting in compassion fatigue and burnout. For Participant 03, burnout correlated with attempts to save instead of empowering the client. This participant stated that they believe burnout is derived from listening to overwhelming stories from clients who have tried to self-advocate to no avail with other professionals. This participant reported that when they experienced burnout, they tried to 'fix clients' problems,' preventing clients from self-advocating. Another participant shared that sometimes burnout presents itself in therapy when the psychologist mirrors the client and loses hope. In addition to long hours, participants expressed that the amount of emotional energy required to work with LGBTI clients can be excessive, as clients are often 'beaten down' by oppressive and invalidating relationships and systems. Participants voiced that burnout prevented them from seeking learning opportunities to better support the LGBTI community; professionals tend to be interested in client self-advocacy but are "lost along the way." Consequently, psychologists might switch to advocating on behalf of their LGBTI clients as this takes less time than helping the client to self-advocate.

Participants reported feelings of guilt, anxiety, and worry regarding the effectiveness of therapeutic interventions for LGBTI clients. Participants 04 and 07 reported that this is a barrier because it feels scary to encourage things that might "go bad" as it is sometimes difficult to fully understand what a client is experiencing. Similarly, Participant 07 also felt pressure to manage multiple presenting concerns in one session when clients cannot afford a therapy session more than once per month. They emphasized the importance of having space and time to promote self-advocacy, but sometimes resources are limited.

Category 7: Psychologists' Lack of Control

Five out of nine (56%) participants cited the factors outside the psychologists' control as a hindering CI to developing LGBTI client self-advocacy skills, which accounted for 13.5% (12/89) of total hindering items.

Participants shared that many aspects of their work with LGBTI clients are out of their control, resulting in frustration, uncertainty, and loneliness. As Participant 09 explains:

> When you're a part of a system, there are a lot of things that are outside of your immediate control. So… there are a lot of barriers for you even to create a safe space. It's not impossible. You can, and you can do things like acknowledging [the flaws in the system].

The above quotation also addresses the many barriers involved to make systemic changes, which sometimes diminishes psychologists' motivation to promote self-advocacy. As another example, Participant 05 noted that sometimes there are a limited number of sessions to address several concerns, which puts a lot of pressure to perform quickly and effectively. Participants also shared that sometimes clients are referred for a specific mental health issue, but then disclose having other needs that are outside the scope of what the psychologist has been contracted to provide (e.g., exploring gender identity or sexual orientation). Two participants (P06 and P09) shared that, when working with clients who require multiple supports from different healthcare professionals (e.g., people with developmental disabilities), it is challenging to plan sessions and extra flexibility is needed to support clients with multiple concerns.

Some psychologists in this study also reported becoming frustrated because they cannot get through to some people, which led to advocacy rather than promoting self-advocacy, as Participant 05 shared. For example, when clients have not met their needs after several attempts,

one participant has spent more than two hours explaining to other people the impacts of their behaviour on the client's well-being. In contrast, some participants also described having to respect clients' decisions when the client thinks differently from the participant (e.g., the client remaining in contact with people who harm them). Furthermore, in some cases, participants reported that they must accept very challenging situations. For example, P02 shared that sometimes all they can do is make challenging situations more bearable for clients because they do not have control of many variables. Participants further shared that psychologists sometimes feel that they have 'hit a wall', which causes frustration and helplessness. Participant 02 stated, "I can't make some of these things go away for them no matter how many interventions we do." Psychologists might also experience extra pressure because of trying not to minimize or make promises they cannot keep about the risks and benefits of self-advocacy (e.g., encountering invalidating healthcare professionals).

The following quotation from Participant 03 summarizes the feelings of isolation and uncertainty that can arise due to aspects of the work that are outside of psychologists' control:

> Sometimes psychologists perceive that the clients' issues are out of the scope and feel isolated. There is a feeling of not knowing where to go and who to go. This feeling can be passed on to clients, and could potentially create a traumatic experience for both, client and psychologist. It is also navigating with uncertainty. Isolation leads psychologists to feel that "everything is on them," like the whole well-being is in the psychologist's hands, and lose track of promoting self-advocacy.

Category 8: Burdens of Promoting Self-advocacy

Three participants described various burdens associated with their work to promote LGBTI client self-advocacy skills. Content related to this hindering CI accounted for 4.5%

(4/89) of the total hindering items. These burdens included the risks involved in performing tasks outside the scope of their duties and the extra mental and emotional labour involved in promoting self-advocacy.

Participants reported having to do various tasks outside the scope of their professional duties to support LGBTI clients. For example, Participants 03 and 05 reported needing to educate other professionals on LGBTI issues, such as using correct pronouns. Participants also discussed the mental and emotional toll associated with helping their LGBTI clients develop self-advocacy. Participant 08 stated, "You just get so tired that you, you don't bother, or you, you put your energy somewhere else." Additionally, they described the challenges of witnessing how clients are 'burned' in their efforts to engage in self-advocacy because of sexism, systems of power, and heterosexism. Participant 04 sometimes felt hesitant about encouraging clients to self-advocate due to these risks, reporting "It is hard not to feel responsible for the outcome, and it is hard to navigate the clients' decisions and explore the risks when sometimes is uncertain." Also, participants described experiencing difficulty encouraging clients to self-advocate after several unsuccessful attempts. Some clients have already tried many times to self-advocate and have been dismissed. This, in turn, creates an emotional burden for the psychologist.

Wishlist Items Categories

The 38 critical incidents reported by psychologists as wish list items, which were grouped into seven categories. The seventh category, "Financial Resources for Healthcare" did not reach the minimum 25% of participation. Therefore, only six categories are presented in this thesis. Table 5 provides a breakdown of the findings pertaining to the six final categories, as well as the category that failed to reach the minimum participation rate.

Table 5

Categories of WL Items

Wishlist	Frequency (*n*)	Participation rate (%)	Number of Items
Access to Community and Other Resources for Clients	6	67	6
More In-Depth Training for Psychologists	5	56	9
Systemic Changes	5	56	5
Collective of Mental Health Professionals	4	44	5
Education for Other Professionals and Society	4	44	5
Exposure and Support to the LGBTI Community	4	44	5
Financial Resources for Healthcare	2	22	2

Category 1: Access to Community and Other Resources for Clients

Six participants expressed a desire for their clients to have more access to community and other resources as a Wish List to developing LGBTI client self-advocacy skills. This category accounted for 15.8% (6/38) of the total number of wish list items that were present in the data.

To elaborate, Participant 07 suggested that psychologists could help to create safer communities where clients could self-advocate. Similarly, Participant 03 proposed having more LGBTI community events to create a greater sense of community and support, getting clients into the community, and promoting education. This participant proposed that such events would also facilitate peer-to-peer connection and allow their clients to connect with other LGBTI adults. Furthermore, Participant 01 similarly suggested hosting events that would support youth

who also identify as LGBTQ to increase understanding of their peers' experiences and to have a place to speak up. In this way, more community events would be very helpful to increase clients' self-confidence, self-worth, and self-esteem. Additionally, Participant 05 suggested that reducing the amount of paperwork required to access resources could allow sessions to focus on improving client mental health, "Because then we're not working on any sort of trauma work or, or anything else that they came to me to deal with. Were busy, you know, filling out forms."

Category 2: More In-Depth Training for Psychologists

Five participants cited the need for training specific to working with the LGBTI client population as something that would facilitate developing LGBTI client self-advocacy skills. This accounted for 23.7% (9/38) of total wish list items.

Psychologists reported that surface-level training exists; for instance, instruction in the use of pronouns. However, many participants thought it would be beneficial to have more in-depth training to learn how to deal with more complex issues experienced by LGBTI clients. For example, Participant 02 thought it would be great to have worksheets for gender dysphoria similar to the resources that exist for PTSD. Participants stated that a gender dysphoria worksheet would allow more specialization and increase the opportunity to learn more about minorities' experiences. Other participants thought learning about other sexual minorities would support them to better understand how to address specific needs that they might not be aware of. Also, according to some participants, having more educated professionals, resources, research, and support would encourage the development of models for LGBTI affirmative therapy. This would, in turn, increase the chances of clients advocating for themselves.

Category 3: Systemic Changes

Five participants cited systemic changes as something they would wish for, which accounted for 13.2% (5/38) of the total LGBTI client self-advocacy wish list items. For example, a world without homophobia and transphobia would provide safe spaces and safety for people to advocate for themselves. Participant 06 proposed reducing homophobia and transphobia by increasing positive representation of the LGBTI community in mass media:

> Having more inspiration of what it can be done rather than just, uh, only or exclusively focusing on what's wrong. We don't wanna assume that every person that comes to us is having a [LGBTI] related issue. We want to acknowledge their context and the world that they're in from their perspective… [LGBTI community members] are not broken, nobody's broken… The messages that we see in the media, [have] changed actually a lot. If you look at the representation [of the LGBTI community members] [on] TV there's a lot more good being shown I've noticed… people that are just being… [being transgender] is just one part of who they are... I think we're starting to see more of that.

Within Category 3, Participant 06 shared a desire for social media, movies and messages to challenge stigma around the LGBTI community and control social media (e.g., hate groups). Similarly, Participant 07 also addressed systemic change in the form of increased control of intolerant groups, "also patrolling the social media. So you don't get hate groups that react to these other groups that pull these other groups down." As mentioned earlier, participants shared that clients become emotionally dysregulated because of constant invalidation, which includes hate speech posted on social media.

Participant 08 suggested encouraging businesses to incorporate gender-neutral options:

> Like what are the very practical things that, um, all the different types of workplaces can adopt that get people practicing inclusion, you know?... You go to a hotel and it's still Mr. and Mrs. and Miss as options, [and] there aren't really any gender-neutral options for that. Or, um, you know, we still have this, these old sayings or own marital status that still kind of assume a hetero kind of dynamic.

Category 4: Collective of Mental Health Professionals

Four participants cited creating a collective of mental health professionals as a Wish List item for developing LGBTI client self-advocacy skills, which accounted for 13.2% (5/38) of total wish list items.

Participants thought that having a collective of psychologists and other mental health professionals to address issues for the queer community and to plan and take action would improve the psychologists' practices with their LGBTI clients. The four participants who contributed to this wish list category imagined that this collective would provide insights as to what techniques are used to help barriers, consulting with other colleagues, building a network or a group to consult with other peers, learning what kind of strategies are used and how they think about certain topics, which would help their practices and add some skills. Additionally, it would be a space to challenge beliefs and perceptions and validate their work. Participant 03 suggested that having a collective of mental health professionals could show solidarity and support the LGBTI community from a professional perspective:

> I would love to see a collective of psychologists, queers and allies, you know, come together to address the issues we are seeing for the queer community … I feel like having that type of hub would birth so much safer spaces, um, not just for us as therapists, but

> for our clients. And I would, I don't know, I just envision that big change can happen with psychologists, you know?

In addition, participants speculated that having a collective to provide more integrated healthcare for the LGBTI community would reduce the difficulties of having a disintegrated healthcare system. For example, Participant 04 stated that having a network of care providers and the ability to work with other professionals directly would be very helpful:

> It is easier to create a path for self-advocacy with a collective of care providers who are educated and open to connecting with clients. This creates a safe environment for the psychologist, the client and the therapeutic relationship.

Collaborating with physicians, psychiatrists, and other professionals working with LGBTI clients who need healthcare attention (e.g., trans community) would provide more education and resources for both the client and the psychologist.

Category 5: Education for Other Professionals and Society

Four participants highlighted the importance of educating other professionals and society as a whole as a Wish List for developing LGBTI client self-advocacy skills. This category accounted for 13.2% (5/38) of total wish list items.

For some participants, educating other healthcare professionals about the LGBTI community is important by challenging stereotypes and myths about LGBTQ and creating safe spaces for people to stand up for themselves. This includes thinking more inclusively for people who work in institutions and think in more diverse ways, to get out of automatic ways of thinking (assumptions). Furthermore, educating society as a whole about these issues would create more tolerant environments. In turn, this would allow LGBTI clients to have more energy to advocate for themselves instead of being impacted by microaggressions. Participant 02

suggested this form of education can be achieved through handouts for other professionals who are not familiar with LGBTI:

> There's stuff that they can give to doctors ... So I know the [institution] is working on, um, a little booklet that they can hand to their doctors who aren't familiar with [LGBTI individuals' needs]. But more resources like that for people where then even if they're in a place where they have to educate their doctor, they can [say] 'here's a resource, please look at it. It will help you'

Category 6: Exposure and Support to the LGBTI Community

Four participants cited the importance of improving exposure and support to the LGBTI community as a Wish List for developing client self-advocacy skills, which accounted for 13.2% (5/38) of total wish list items.

Conducting more research, which includes identifying some of the experiences and needs of the LGBTI community, was identified as one way to increase exposure for the community. Participant 09 expressed that hearing more experiences of LGBTI clients and how they have struggled or been successful with self-advocacy would improve psychologists' interactions with clients. Participants also noted that research produces articles that can be passed on to clients. Participant 07 suggested having a platform where they could centralize those articles:

> Even doing research …I've read research studies, the recent research studies that come out in these magazines. What I'd love is to have, I don't know whether there is a specific, place where you can put articles for the LGBTI community.

Other participants also noted the importance of supporting the LGBTI community and increasing political representation to facilitate the development of their clients' self-advocacy. This representation could support other psychologists and their clients to obtain greater access to

better resources and safely advocate for their needs. For example, Participant 03 shared that the likelihood of receiving funding to build a specialized shelter for LGBTI clients would increase if a network of professionals represented the LGBTI community and their needs. This example also represents how advocacy and self-advocacy are not mutually exclusive; on the contrary, they are complementary.

Chapter Summary

To summarize, this chapter comprised a detailed description of the nine participating psychologists' practices to support LGBTI clients in developing self-advocacy skills. Data analysis revealed 13 helping CIs, 8 hindering CIs, and 6 WL viable ECIT categories. Two additional possible categories (1 hindering CI, 1 WL) were initially identified during the analysis process but failed to meet Butterfield et al.'s (2009) recommendation of at least 25% participation rate as a criterion for trustworthiness. . These findings will be discussed and interpreted in light of the existing literature in Chapter 5.

Chapter Five: Discussion

In this chapter, I begin with a discussion focused on the overarching themes suggested by the categories detailed in Chapter 4 and discuss the findings in light of existing scholarly literature and theory. Then, I describe the implications, strengths, and limitations of the study, along with recommendations for future directions regarding clinical practice and research. I conclude this chapter with recommendations for future directions for research.

Overarching Themes and Theoretical Agreement

In the previous chapter, the findings obtained from participant interviews were categorized by class (i.e., helpful CIs, hindering CIs, and WL). However, the process of data analysis revealed overarching themes that spanned across all these categories. Three primary themes were observed within the context of psychologists promoting client self-advocacy in their therapeutic work: (1) factors that influence the psychologists' abilities and effectiveness to promote self-advocacy, (2) factors that influence clients' ability to self-advocate, and (3) factors that influence the therapeutic relationship as a means of self-advocacy.

Factors that Influence Psychologists' Abilities and Effectiveness to Promote Self-advocacy

The theme, "factors that influence psychologists' abilities and effectiveness to support clients in developing or promoting self-advocacy," includes two aspects: (1) strategies that influence the well-being of psychologists, and (2) resources related to their practice.

Strategies that Influence the Well-being of Psychologists. Psychologists reported that their well-being enhanced their efficiency in supporting clients to develop self-advocacy. Participants' well-being in relation to promoting their clients' self-advocacy was associated with burnout and self-care. Studies have shown that burnout is prevalent among psychologists (Rupert & Morgan, 2005; Simionato & Simpson, 2018). Participants shared helpful, hindering, and

wished for strategies associated with experiences in mitigating burnout and increasing self-care (i.e., well-being). Consistent with Simionato and Simpson (2018), participants also shared that burnout and neglecting self-care impeded their enthusiasm for empowering clients to practice self-advocacy, inadvertently causing them to take on the role of problem solvers for their clients.

In terms of specific strategies, participants reported benefiting from professional support provided by people such as therapists, supervisors, peer support, consultations, and a network of fellow professionals. In addition, some participants reported lacking professional support as a hindrance to their ability to promote client self-advocacy. The findings suggest two potential explanations for the importance of having professional support:

1. Having access to professional support may enable psychologists to effectively navigate the challenges of promoting self-advocacy, especially when working with LGBTI clients who endure prolonged periods of distress, particularly those suffering from gender dysphoria.
2. Professional support may reduce the likelihood of burnout. Participants shared that burnout, frustration, isolation, and a sense of helplessness could stem from unelaborated countertransference, overidentification with clients' narratives, and inadequate self-care. However, professional support may mitigate these challenges.

In summary, the present study suggests that having access to professional support not only safeguards the overall well-being of psychologists but also equips them with the capacity to support clients in developing self-advocacy skills. These findings are consistent with the responsibility psychologists in Canada have to maintain and ensure ethical behaviours and attitudes, “promoting those principles, values, and standards through formative and continuing education, supervision, peer modelling, and consultation” (CPA, 2017, p. 3).

Another strategy was the importance of recognizing professional boundaries and the psychologists' role when empowering clients to self-advocate effectively, especially in potentially high risk situations. Toporek and Williams (2006) elaborate on the concept of "dual roles and professional boundaries," which suggests that some counselling psychologists might take on various roles beyond individual counselling. This emphasizes the importance of considering and defining appropriate boundaries in different situations, as well as the ability to identify possible boundary issues that could come up. Moreover, the findings suggest that setting boundaries is, at least to some extent, associated with psychologists being aware of their professional limitations and learning to ethically navigate double-bind situations. In other words, consistent with Toporek and Williams (2006), these limitations include recognizing when clients' issues were beyond the participants' professional scope, and sometimes having to take actions outside of what is expected from Western psychology. Furthermore, according to Nadal's (2017) findings, professional boundaries represent one of the five ethical dilemmas outlined in his article. Nadal explained that this ethical concern has the potential to discourage psychologists from engaging in social justice initiatives, which is also consistent with the narrative of the current study's participants.

The present study also indicates that setting boundaries and psychologists' lack of control of factors outside therapy are related to the burdens of the profession, the uncertainty about taking risks (i.e., promoting self-advocacy to a vulnerable client) and the emotional pressure. First, psychologists described various burdens associated with promoting LGBTI client self-advocacy skills. For instance, working extra hours and doing tasks outside the scope of their professional duties, such as educating other professionals on LGBTI issues. This finding is line with Rupert and Morgan's (2005) study, which shown that psychologists who demonstrated

increased burnout also worked longer hours and felt less control over their work activities. In addition, participants in this study reported experiencing self-imposed pressure due to having limited resources and time to address multiple presenting concerns in limited (or one) sessions.

Second, psychologists also expressed hesitancy about encouraging clients to self-advocate. This hesitancy is associated with the risks involved, especially when clients have already experienced dismissal after multiple attempts. Participants reported sometimes feeling overwhelmingly responsible for the outcome of promoting self-advocacy. Toporek and Williams (2006) have also addressed this issue, highlighting psychologists' inherent desire to "do no harm" to clients. An additional study conducted by Simionato and Simpson (2018) suggests that hesitancy could also be associated with burnout.

Finally, a novel finding from the present study that goes beyond the existing literature is that participants discussed the mental and emotional pressure they felt when helping clients develop self-advocacy, witnessing clients' struggles due to sexism, systems of power, and heterosexism. For instance, participants reported experiencing feelings of helplessness and frustration when they could not change challenging situations for their clients, leading to a sense of 'hitting a wall.' Participants reported that, over time, this frustration led them to advocate on behalf of the client rather than promoting self-advocacy.

Resources Related to Psychologists' Practices. Participants shared that working with other agencies (i.e., safe resources) supported them in promoting self-advocacy. Additionally, some participants shared that their LGBTI clients were exposed to many untrained professionals in other health-related fields, which inflicted harm. This is consistent with previous research, which expresses concern about the quality and quantity of training that counsellors and psychologists receive on how to address LGBTI issues (Alderson, 2004; Alderson & Oxenbury,

2015; Singh & Shelton, 2011). In addition, participants reported their desire to have a collective of mental health professionals, which could improve their therapeutic practices on assisting LGBTI clients by providing opportunities for sharing strategies and techniques to promote self-advocacy with other professionals.

Participants reported that having confidence in promoting self-advocacy was another important aspect of their practice. Some psychologists reported that being trained, working on their own biases, getting involved in and being culturally informed about the LGBTI community, and self-disclosure all supported them to enhance their professional confidence before working with LGBTI clients. In contrast, sometimes participants' confidence in promoting self-advocacy was negatively affected by the overwhelming responsibility to use interventions outside mainstream psychology, which is consistent with Toporek and Williams (2006) arguments. In response to this challenge and to increase their confidence, participants in the present study reported developing practice competencies to tailor interventions, techniques, and assessments to promote self-advocacy. Moreover, some participants reported that self-disclosure was helpful, as they observed that this strategy provided a safe space for clients to let their guard down and express themselves. This finding is consistent with the existing literature; Dowrkin et al. (2012, p.30) indicate in their casebook for counselling LGBTI people, "self-disclosure is an important interpersonal process issue that can impact both the therapeutic environment and the client's internalization of the counselor."

Additionally, participants highlighted the importance of learning about the experiences of various sexual minorities to improve how they address specific needs that may not be widely known or understood. This observation aligns with Singh and Shelton (2011), who accentuated the lack of research on LGBTI concerns and associated it with power disparity. Weir and

Piquette (2018) also pointed out the need to conduct more studies with the transgender community. Furthermore, the finding is also related to Moradi and colleagues' (2009) study, which depicted the challenges of conducting research on sexual minorities. Participants in the present study also shared that more awareness and knowledge about LGBTI clients' needs would enable psychologists to provide more targeted support to their clients. In relation to acquiring more knowledge about the specific needs of minorities within the LGBTI community.

Singh and Shelton (2011) highlighted that mental health professionals' training on LGBTI concerns remains inadequate due to limited formal instruction. This is consistent with the need to access more in-depth training on LGBTI concerns that was present in helping CI category 8 and WL category 2. Moreover, Alderson (2004) and Alderson and Oxenbury (2015) found that, in Canada, graduate students perceive they receive little training on LGBTI concerns. Findings from the present study concur with Alderson's conclusions, as some participants expressed the poor quality of training they received before they started working with members of the LGBTI community. In summary, the existing literature and present findings together suggest that, while basic training exists, there is a need for graduate programs to provide psychologists in training with more information about complex issues experienced by LGBTI clients, such as gender dysphoria and developing affirmative therapy models.

Factors that Influence Clients' Ability to Self-Advocate

The factors influencing clients' ability to self-advocate can be organized as (1) intrapsychic schemes related to self-concept and inner state, and (2) relational resources, such as community outreach and support systems. Psychologists can address both types of factors in their therapeutic work with LGBTI clients.

Intrapsychic Schemes Related to Self-Concept and Inner State. Participants reported that their clients' feelings of unworthiness and low self-esteem hindered their readiness to engage in self-advocacy. Participants also highlighted several social rejection challenges faced by their clients, including isolation, rejection, and receiving derogatory comments. Social rejection discourages self-advocacy and leads to clients feeling dismissed and dysregulated, requiring therapy sessions to focus more on dealing with the effects of intolerance rather than exploring their needs and goals.

According to participants, clients who have experienced relational trauma may internalize shame and blame related to their identity, making them feel unworthy and undeserving. This finding is consistent with Alderson's (2013) literature review identifying internalization as one of the common concerns that LGBTI clients present when seeking counselling. Some clients may have a strong sense of justice for others but struggle to advocate for themselves. In addition, participants reported that some of their clients experienced punishment for self-advocating, which created fractures in their identity and made clients feel hesitant to stand up for themselves.

Clients' Relational Resources. Participants highlighted the limited availability of recreational gathering spaces for the LGBTI community beyond establishments that serve alcohol, leading to social isolation and difficulty in self-advocacy. Becoming part of a community might have therapeutic benefits; in contrast, returning to unsupportive systems can exacerbate stress for clients. However, the community allows the opportunity for clients to model, practice, and normalize self-advocacy. Communities are also places where clients have found allies. Moreover, LGBTI members can collectively advocate for their needs with other members of the community.

The narratives recounted by Callaghan (2018) serve as an illustrative example of how the community in which individuals develop can exert an influence on their overall growth. These narratives encapsulate the experiences of harm inflicted upon LGBTI individuals within a particular community, specifically, publicly funded Catholic schools in two Canadian provinces. Among the myriad of experiences presented, the author delved into accounts detailing the challenges faced by LGBTI teachers and students and the difficulties "straight allies" face when they support the LGBTI community. Furthermore, Callaghan also shared an experience of students collectively self-advocating to establish an LGBTI. Callaghan's findings are consistent with the present study, where participants reported that their LGBTI clients often encountered dismissive authority figures who do not accommodate their needs or validate their identities. As a result of this dismissal, some clients associated self-advocacy with negative consequences, making self-advocacy difficult, especially when they have experienced harassment or invalidation for doing so.

Factors that Influence the Therapeutic Relationship As a Means of Self-Advocacy

Supporting Healthy Client Boundaries. In the present study, participants used various interventions to support clients in developing healthy boundaries. These included somatic approaches to understanding boundary disruption, discussing potential pushback after self-advocating, and providing psychoeducation on setting boundaries and their consequences, which included setting boundaries in the therapeutic relationship (i.e., setting the example in the therapeutic process). Participants recognized the importance of helping LGBTI clients set boundaries in their personal lives, particularly in the face of fear, rejection, or social punishment related to their gender identity or sexual orientation. By supporting clients in self-advocacy, they learned to set boundaries in close relationships. Setting clear expectations for the therapeutic

relationship and process was found to be beneficial. Clients' awareness of psychologists' boundaries supported their self-advocacy. The findings also indicated that it was crucial for psychologists not to solve client problems for them, as doing so might disempower them.

Clients' Empowerment. Consistent with Sinacore and Enns (2005), who identify empowerment as a key element of teaching social justice, the present study's findings underscore the significance of fostering hope, resilience, and empowerment in the therapeutic process with LGBTI clients. By empowering clients and helping them build resilience, participants facilitated the development of self-advocacy skills, leading to positive personal growth and increased motivation to advocate for themselves and others within the LGBTI community. Additionally, the findings on empowerment align with the model proposed by Savage et al. (2005) to enhance self-advocacy skills using the SEM model, which will be broadly discussed later in this section.

Creating a Safe Space for Clients. Participants described important ideas of providing safe spaces and social support systems. These key ideas highlight the significance of providing safe spaces, increasing clients' social support system, and encouraging clients to connect with LGBTI communities to enhance their self-advocacy skills. This is consistent with Weir and Piquette (2018), who argue that creating a safe space and an accepting environment encourages LGBTI clients to access various supports. In the present study, psychologists reported that by connecting their clients with supportive communities, those clients developed resilience and found validation, which led to more effective self-advocacy within and outside the therapy room. Furthermore, participants stated that validating and normalizing clients' experiences was a key strategy in creating a safe and accepting environment.

Past Negative Experiences with Health Professionals. Singh and Shelton (2011) conducted a ten-year review of existing research that unveiled the history of mistreatment the

LGBTI community has within counselling and psychology, alongside the persistence of societal homophobia and heterosexism and disparity in relation to resources that have been provided to other dominant populations. Mental health professionals' mistreatment of LGBTI clients manifested in acts of pathologizing same-sex behavior and diverse gender identities. According to the authors, these trends remain prevalent in the present day. The findings of the present study are consistent with Singh and Shelton's conclusions, as participants shared that one of the challenges in promoting self-advocacy is clients' negative past experiences with other mental health providers who had harmed their clients.

Alignment with The SEM-empowerment Model

The findings of this study are consistent with Savage and colleagues' (2005) Social Empowerment Model, which was described in Chapter 2. This model connected empowerment, self-determination and self-advocacy. Savage and colleagues emphasize how language and biases, such as homophobia, oppress LGBTI individuals. SEM presents empowerment, defined as an ongoing process involving control, awareness, and participation, as a means to address oppression and social injustice. Savage and colleagues explain that the SEM model is rooted in conflict theory, assuming societal divisions due to power disparity. They also suggest community empowerment as a way for LGBTI clients to support each other collectively. Participants in the present study also provided connections to empowerment and self-advocacy. All participants stated that their LGBTI clients suffered from power disparity and highlighted the importance of community outreach to enhance self-advocacy skills.

The SEM model involved five steps: establishing a positive foundation, defining empowerment goals, implementing self-acceptance strategies, incorporating psychological empowerment components, and driving societal change (Savage et al., 2005). This approach

aims to tackle homophobia and heterosexism by empowering clients systematically. The present study's findings encompass all these steps.

Implications for Practice and Social Justice

The findings of this study provided valuable contributions to the limited existing literature on practice in the field of psychology on how to support LGBTI clients in developing self-advocacy. Overall, many of the findings are consistent with previous studies. Nevertheless, new insights emerged from the analysis. Of particular significance is the emergence of expert knowledge and technical skills regarding the interventions and strategies that participants provided from each of their therapeutic approaches to mental health, which are addressed in Chapter 4 and in the first section of the present chapter.

Implications for Mental Health Professionals

The purpose of this study was to explore factors that influence psychologists' practices to support clients in developing self-advocacy skills. The aim was to provide information and recommendations to improve psychologists' practices when working with the LGBTI community and indirectly to address the systemic oppression this population faces and improve their overall well-being. Hence, combining relevant findings from the present study and the existing academic literature, I put forth the subsequent seven recommendations to provide additional insights for professionals engaged in working with gender and sexually diverse clients:

The first recommendation is for psychologists to make use of professional support. Access to case consultation, supervision and personal therapy may vary depending on the context. For instance, both formal and informal avenues exist for seeking consultation. In general, making use of professional support yields advantages for professionals working with LGBTI clients. For instance, validating interventions, receiving supervision on the actions taken

with clients, mitigate burnout, regulate strong emotions, and enhance overall self-care. Furthermore, supervision and consultation are psychologists' duties to maintain ethical practice (CPA, 2017).

The second suggestion involves psychologists working on their own biases. One of the most challenging aspects of working with marginalized populations stems from the fact that societal stereotypes can become ingrained within every individual. It is imperative to deconstruct these internalized stereotypes in order to effectively engage with clients, as even well-intentioned and evidence-based practices could inadvertently result in harm to certain cultures and populations (see: CPA, 2018).

The third suggestion regards searching, contacting, and verifying agencies. Whilst psychologists may not have control over all factors, therapeutic change and self-advocacy do not happen only in the counselling setting. In fact, findings from the present study suggest that having multiple resources outside their practice supports mental health professionals to know how and where they can refer their clients when concerns are out of the scope of their professional practice. Additionally, it is important to verify that agencies are safe for LGBTI clients. Findings from the present study reveal that some community agencies are not supportive of LGBTI individuals. Therefore, verification is needed so that psychologists can avoid making referrals to places that are unsafe for their clients.

The fourth suggestion centres on mental health professionals supporting and involving themselves in the LGBTI community. The involvement and engagement with the LGBTI community will provide helping professionals to:

1. Exploring and Understanding Diversity: This enables professionals to comprehensively explore and grasp the diverse nature of populations within the LGBTI community, recognizing that the community is not a singular entity.
2. Developing Cultural Safe Approaches to Sexual Diversity: Professionals can develop essential skills in cultural safety and diverse sexuality aspects and enhance their ability to connect effectively with clients. Cultural safety refers to the approach of considering professionals' and clients' power disparities in therapeutic relationships, and emphasizes the need for professionals to engage in reflexive practice (Curtis et al., 2019; Moucessian, 2020). For instance, the importance and correct use of pronouns and learning about different sexual orientations.
3. Accessing Valuable Resources: Engagement with the LGBTI community offers opportunities to acquire resources, including educational handouts and reliable referrals, which can prove invaluable in supporting clients' self-advocacy.
4. Understanding Community Dynamics and Coping Strategies: Becoming involved in the community can provide psychologists with insights into its dynamics and learn valuable coping strategies that can be shared with clients.
5. Sensitization: Involvement with the LGBTI community provides sensitivity to the issues, challenges, and concerns that this population face.

Moreover, expressing support for the LGBTI community contributes to creating a secure and inclusive space for clients, reinforcing a sense of safety and acceptance.

The fifth suggestion involves encouraging clients to expand their social support system. As explained in Chapter 4, the idea of self-advocacy is based on the premise that clients are empowered enough to stand up for themselves. However, self-advocacy does not mean they have

to stand up alone. Furthermore, increasing the clients' social support system might decrease the likelihood of dependency on the psychologist, which is presumably the ultimate goal of all therapy. Participants' narratives suggest that having social support from LGBTI communities has been beneficial for clients, as they have an opportunity to meet other allies (i.e., people they can rely on and share the same experiences), reduce their feelings of loneliness and receive validation of their experiences outside the therapy room.

The sixth recommendation pertains to fostering clients' empowerment and cultivating a sense of hope. This involves psychologists aligning with clients' aspirations for empowerment, which also enhances their sense of hope. It is important to remember that not all presenting concerns are directly associated with LGBTI issues, although recognizing the significance of LGBTI intersectionality in case conceptualization is vital. Consequently, establishing a connection with meaningful goals that resonate with the client becomes crucial. This connection not only supports their emotional well-being but also contributes to their overall resilience.

The seventh and final suggestion centres on the related concepts of risk management, harm minimization and safety planning. Considering that all interventions have risks and benefits, self-advocacy should always be accompanied by careful risk management to minimize harm because it involves other individuals' responses to the client's attempt to self-advocate. The potential for harm does not always manifest in physical violence. There are many non-violent ways that other people's response to the self-advocacy attempt can lead to harm and even re-traumatization. For instance, silence treatment, ignoring, rejecting, and other microaggressions could affect clients. To address all these possible scenarios, it might be useful to create alternative plans for each of them to minimize harm. In addition, it could be beneficial to consider the timing and context -increase protective factors- before self-advocating.

In summary, these recommendations collectively aim to improve psychologists' practices when supporting LGBTI clients in developing self-advocacy skills. By having professional support, working on their biases, expanding community involvement, and showing support, encouraging social support, promoting client empowerment and hope, and risk management, mental health professionals can contribute positively to the well-being of this population and work toward reducing systemic oppression.

Implications for Social Justice

Psychologists have an ethical obligation to confront instances of injustice (Sinacore & Ginsberg, 2015). However, a common misconception exists that the realm of social justice is solely confined to collective efforts. Ginsberg (2012), as cited by Sinacore and Ginsberg (2015, pp. 266-267), emphasizes that "social justice must not only be theoretical, but also practically implemented at individual, community, and macro societal levels." Moreover, Collins' (2018) Culturally Responsive and Socially Just Counselling Model reveals several intervention levels (i.e., micro, meso and macro), prompting mental health professionals to assess the appropriate level of intervention depending on each case. Among the different categories of levels of interventions, micro-level interventions are the actions taken by psychologists with individuals, couples, and families to improve a situation. Based on these underlying concepts, it becomes apparent that self-advocacy operates, in principle, as a micro-level intervention and can be a means to address social injustices. Furthermore, while some of the data from the present study suggests that community self-advocacy might also be possible and desirable, regrettably, this phenomenon was out of the scope of the current research question.

Studies suggest that LGBTI individuals experience heightened levels of mental health distress compared to heterosexual populations (King et al., 2008; Semlyen 2016) due to the

effects of oppression and discrimination (Balsam et al., 2011; Lange et al., 2020; Mays & Cochran, 2001; Williams et al., 2021). Additionally, they encounter greater challenges in accessing mental health services (Alderson & Oxenbury, 2015; Xiao, 2021). In the present study, participants actively engaged in direct interpersonal interactions with members of the LGBTI community, with the aim of addressing this significant social disparity. The participants shared their firsthand experiences delivering services to LGBTI clients who endured persistent social rejection and re-traumatization. Participants consistently emphasized the need to restructure the foundations within the healthcare system to render more effective support to this marginalized group. However, they also provided alternate solutions and shared how they have addressed clients' concerns while mitigating some of the effects and barriers resulting from systemic oppression that their clients faced.

Strengths and Limitations

Due to the study's qualitative research design and the small participant size ($N = 9$), the findings are not intended to be generalizable; they solely mirror the experiences of this specific group of participants. However, the insights obtained concerning the factors that support LGBTI clients in developing self-advocacy may be transferable to other psychologists and potentially also a wide range of mental health professionals, including clinical social workers, psychotherapists, counsellors, and psychiatrists. More specifically, the present study's findings provide various interventions and techniques to address clients' unmet self-advocacy needs, including individual, relationship, family, group, and community interventions that could potentially be used in practice with LGBTI clients. Additionally, this information holds relevance for training future counselling psychologists and other mental health practitioners, as it provides a valuable guide for assisting LGBTI clients.

This study explored promoting client self-advocacy specifically in the context of sexual minority clients. Results advanced understanding about the lives of sexual minorities, which are marginalized groups. Therefore, findings could also be transferable to other ethnic and non-ethnic marginalized clients that also experience systemic oppression and power disparity. For instance, refugees, religious minorities, individuals struggling with substance abuse, without stable housing, veterans, senior citizens, individuals with a disability, and with criminal records. Moreover, some authors argue that studies on sexual minorities can "contribute to understanding human behavior in general" (Moradi et al., 2009, p.8).

Another strength is that the categories that emerged in the present study appear to play not only a role in developing self-advocacy as a skill but also in fostering LGBTI clients' overall personal growth and may also be useful for promoting other clients' social skills. According to participants, promoting self-advocacy also positively influenced their clients' self-worth and self-esteem. Therefore, these strategies may serve not only to promote self-advocacy but they could also to improve other areas of clients' lives. Additionally, the general practice recommendations this research provides may also apply to support clients in understanding and developing other social skills (e.g., conflict resolution, tolerance, advocacy, and inclusion).

There are also notable strengths in relation to the ECIT research method that I used. The present study indirectly conceptualized the construct of self-advocacy through inductive research, which can support future research. The findings derived from employing ECIT and adopting a post-positivism perspective facilitate studying self-advocacy from a quantitative approach. Specifically, by providing these constructs based on empirical evidence, researchers might encounter fewer challenges in maintaining consistency in concepts concerning self-advocacy across their studies.

Alongside these strengths, this study has several notable limitations, which should be considered in evaluating the value and usability of this information. From a social justice perspective, the most prominent limitation was prioritizing the voice of psychologists instead of the LGBTI clients' voices. Studying psychologists' practices exclusively can also be considered an advantage, as the results illustrate different ways in which training and cultural safety (see: Wessel, 2023) could be acquired. Nevertheless, there may be a significant variance between psychologists' and clients' experiences in terms of how they both perceive the effectiveness of self-advocacy interventions. Therefore, it is vitally important to obtain additional information about what clients themselves perceive to be helpful and hindering for their self-advocacy.

Concerning the demographics of the sample, four limiting factors were observed. The first is that there were no participants who self-identified as male. Having participants who identify as male may have provided a different input as to how to intervene and practice to promote self-advocacy with LGBTI clients. To address this issue, researchers addressing this topic in the future will need to make additional efforts to recruit cisgender men in their sample, including potentially adopting a stratified sampling strategy where a certain proportion of spaces in the study are reserved for psychologists who self-identify as cisgender men.

The second limiting factor is that all participants had a strong direct relationship with the LGBTI community or were themselves members of the community. Consequently, these findings may not easily transfer to psychologists with no direct relation to the community. However, having a sample with direct connections to the LGBTI community is also an advantage because it could be argued that these individuals are insiders who have insights that are particularly important to consider in understanding self-advocacy within this population. It is

possible that outsiders without any connections to the LGBTI community would not be able to provide as much information.

One limitation pertains to the professional diversity among participants. While participants shared their experiences, their answers to the CIs questions were informed through the lens of their respective psychological/therapeutic orientations, which are reported in the demographics section in Chapter 4. This diversity holds an advantage, as it introduces multiple perspectives and strategies for addressing self-advocacy with LGBTI members. Nevertheless, in some instances, there were challenges in establishing connections between the experiences reported by different participants due to differences in the way that they conceptualized their practice and in the kinds of interventions that they used. To address this issue, descriptive coding (i.e., operational definitions) was used to conduct the cross-check with participants (credibility check). Each participant was sent a separate Word document via email containing the codes derived from their respective interviews. Subsequently, they were asked to confirm whether the incidents (i.e., codes) and their descriptions accurately reflected their experiences and if they wished to make any adjustments or provide additional insights. All participants confirmed that the provided information accurately portrayed their experiences.

Another limitation revolves around my status as someone who has lived in Canada for less than two years. Despite adhering to all credibility checks proposed to enhance the study's trustworthiness, it is important to consider that, although I am fluent in English, my primary language is Spanish. There is a possibility that I might have misconstrued the intended meaning of participants' statements or the underlying social or cultural assumptions of what they shared. Furthermore, as I detailed in Chapter 1 regarding my positionality, I am a member of the LGBTI community and have received training in Mexico in client-centred and relational psychotherapy

approaches. Additionally, my undergraduate studies had clinical and psychodynamic theoretical backgrounds, which might have influenced my perspectives and guided my interview follow-up and data analysis decisions. Despite these considerations, I was committed to rigorously upholding the ECIT credibility checks. Readers are encouraged to consider my positionality and experiences when evaluating the findings of this study.

It should also be noted that participants spent a majority of their interview time focused on describing helping and hindering factors. There is a possibility that participants were fatigued by the time they were asked to explore the Wishlist Items, which could elucidate the small number of items and categories in this section of the findings. Future research may benefit from splitting up the interviews into multiple sessions, to ensure that participants have sufficient energy to discuss all parts of the interview protocol.

Another possible limitation is that findings may only apply to certain populations. For instance, Canadian psychologists or Canadian LGBTI clients. While it is undeniable that Canadian LGBTI individuals suffer from marginalization due to power disparity, this may not manifest in the same way in other countries. Canada has legalized same sex marriage and a strong set of public policies against discrimination that protects individuals for gender and sexual minorities (Waite et al., 2019). As it has been mentioned throughout the study, risk is involved when clients are encouraged to act and speak on their behalf, and psychologists and clients do not possess control over other individuals' responses. Therefore, readers from outside of Canada are invited to reflect on the degree to which the findings and suggestions apply to their workplace, professional scope, and, more importantly, their clients' welfare and safety.

Another limitation centres on social desirability bias. One of the limitations of this study is that some of what participants shared may have been selective. This might be particularly

relevant due to the fact that I am a counselling psychology student, and they are professional psychologists. Participants may have dissembled their genuine opinions or experiences and only provided answers to questions they believed would portray them positively to the researcher.

Similarly, all research that relies on retrospective interview data is designed to collect information on things that participants are consciously aware of. Since this study used ECIT, it was not capable of identifying incidents beyond the awareness of the psychologists themselves. Therefore, to get a full picture of what helps and hinders self-advocacy, it may be important to conduct future research to get other individuals' perspectives. As explained in the next section, the perspective of LGBTI clients about how their psychologist has helped and hindered their development of self-advocacy.

The theoretical framework that informed the present study was CAT instead of SEM. At the research proposal stage of this study, CAT appeared to be a better fit for the social justice focus of this study: As it is addressed in the implications for social justice section of Chapter 2, the current study aimed to explore an intervention that belongs to the micro-level category, and therefore, CAT seemed to be more suitable this project. However, as I explained earlier in Chapter 5, in hindsight, the findings that emerged from this study seemed to fit SEM more than CAT. Nevertheless, these two frameworks do not seem to be incompatible. On the contrary, they appear to be complementary. Furthermore, this study was not a quantitative study designed to test hypotheses from CAT. Therefore, the findings remain useful for the field regardless of whether they fit better with CAT or SEM.

Future Directions for Research

Building upon the findings and considering the limitations of the present study, the subsequent directions for future research are proposed for researchers who are interested in this

topic. Foremost, there exists a need to explore LGBTI clients' perspectives on the factors that supported, hindered, and would have facilitated their self-advocacy. The outcomes of this study could lay the groundwork for conducting a fidelity assessment between psychologists and the firsthand experiences of clients, thereby increasing the robustness of both study outcomes. In contrast, if the client-focused study resulted in a set of findings that are very different from the present study, then it would be important for psychologists and other mental health practitioners to prioritize the voices of the clients in their future work.

Researchers might also consider delving into the experiences and narratives of self-advocacy, self-determination, and clients' agency among different LGBTI community members. The LGBTI community, often perceived as a singular entity, in fact, is characterized by having a significant number of diversities. Therefore, future qualitative studies could offer deeper insights into the distinctive self-advocacy needs of different specific groups (e.g., transgender, queer, two-spirited, other sexually diverse individuals, and non-conforming gender identities). Examining these experiences separately could shed more light on the challenges, including mental health struggles, coping mechanisms and resilience strategies employed by LGBTI individuals. It could also identify strategies for promoting self-advocacy that may be unique to a particular group. As a purely hypothetical example, a study focused on self-advocacy in two-spirited clients might have a finding related to promoting a connection to indigenous traditional practices that may not be present for other groups within the larger LGBTI community.

Another avenue entails researching the dynamics of community engagement and advocacy, which could yield strategies for collective self-advocacy. Furthermore, exploring and understanding the experiences of family members and close relatives of LGBTI-identified individuals might provide valuable insights. As an example, this research outcome could

illustrate which family factors promote and prevent self-advocacy. Overall, future research focused on these other groups could equip psychologists with additional insights necessary for developing social interventions within the environments (e.g., formal and informal organizations) where LGBTI individuals develop and advocate for themselves, such as in educational institutions, the military, families, and other social groups.

A quantitative assessment test designed to measure self-advocacy can be designed from the categories and overarching themes that emerged from this study and validated in future psychometric research. The process of creating and validating such a test could provide information on the internal and external validity and the reliability of the components of the construct (i.e., self-advocacy). Reviewing validity and reliability would evaluate the categories from a quantitative perspective and provide more information on the phenomenon of self-advocacy in the LGBTI community.

Psychological tests are often used to conduct research on larger scales. Therefore, developing a way to quantitatively measure client self-advocacy could support researchers and clinicians by systematically examining the degree to which individuals show or possess specific attributes (Ghiselli et al., 1981). This examination could also provide the design for longitudinal and cross-sectional studies (Caruana et al., 2015). The test may subsequently support the creation, implementation and evaluation of research-informed generalizable guidelines, policies, and standards of practice for psychologists when working with sexual minorities. The results of conducting research on a larger scale could inform public policy. Moreover, using a quantitative test to assess self-advocacy could guide future mental health professionals in treatment planning, implementing strategies, and goal setting with clients.

Evaluating the efficacy of the interventions suggested by the present study is an essential step to inform future psychologists and other mental health practitioners. Therefore, future researchers could also explore designing and evaluating a self-advocacy psychoeducational program. Most participants thought that more in-depth training would help them and their clients to develop self-advocacy skills in their practices. A psychoeducational program to train professionals to promote self-advocacy would meet the needs of psychologists to have in-depth training and would provide increased knowledge mobilization.

Conclusion and Reflections

This research makes a valuable contribution to the existing qualitative research and practices on social justice, with a particular focus on LGBTI and other diverse sexual minority studies. It emerged from the idea of enhancing LGBTI individuals' agency while serving social justice principles, which evolved from my interest in the term 'self-advocacy' in the American Psychological Association's Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015), Psychological Practice with Sexual Minority Persons (2021), and Hailes and colleagues' (2020) article "Ethical Guidelines for Social Justice in Psychology." The drive that motivated this study was to clarify how psychologists in Canada have navigated this intersection with their clients in their practice. The results provided theoretical and practical insights and suggestions to serve the LGBTI community, especially for psychologists and other helping professionals who are interested in working with this population.

As a general reflection, one thing that stood out to me was the finding that some psychologists tend to advocate on behalf of clients in the long run, as opposed to promoting self-advocacy. This is partially because it simplifies and avoids adding burdens to the already demanding nature of the profession. Self-advocacy takes time and patience but provides space to

develop agency and self-determination. In my view, it also honours the first human right in the International Covenant on Economic, Social and Cultural Rights adopted by the United Nations in 1966: the right to self-determinate and self-govern our lives. Additionally, supporting LGBTI individuals to self-advocate might have long-lasting impacts on clients' development by shifting their self-concept, self-worth, and self-esteem, as it creates therapeutic experiences that support clients' self-realization and belief in themselves.

I hope my reflection will not be confused or associated with meritocracy. As I have addressed in Chapters 4 and 5, actions of advocacy, co-advocacy and self-advocacy are not mutually exclusive; I believe professionals should address power disparities and evaluate with the client which one of the three strategies fits best for both depending on the circumstances. Self-advocacy is one additional small piece of the big social justice puzzle.

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Appendices

Appendix A: Recruitment Email

Werklund School of Education
University of Calgary

We are looking for psychologists to take part in a study of barriers and facilitators to support clients of the LGBTI to develop self-advocacy skills.

As a participant in this study, you will be asked to take part in two sessions: one 60-90 minute face-to-face or online interview and one brief, follow-up email/telephone interview. The interview questions will ask participants to discuss their practices in supporting clients to develop self-advocacy skills within counselling and mental health services, what interventions they have used, what has helped and hindered their self-advocacy development practices, and what services and supports would have been helpful to them.

Your participation in this study will be kept confidential, and you will have an opportunity to verify transcripts and alter information that might be used to identify you. Please note that this study is not about clients per se, but about your skills as a psychologist.

In appreciation for your time, you will receive a gift (valued at approximately $25).

For more information about this study or to volunteer for this study, please contact:

Luis Gerardo Ibarra Alexanderson
MSc Student, Counselling Psychology Program,
Werklund School of Education
At (403)-220-3364 or email: luis.ibarraalexanderson@ucalgary.ca

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study (REB22-0782).

Appendix B: Participant Screening

UNIVERSITY OF CALGARY

SCREENING FORM

The following questionnaire asks some questions to determine your entry into the study. These questions are asked of all prospective participants.

Name: _____

I am studying the ways that counselling psychologists support their clients from the LGBTI community in developing their self-advocacy skills. In the context of this study, I am defining self-advocacy as, "learn[ing] how to advocate on their own behalf rather than letting others advocate for them."

How close does this definition reflect your understanding of self-advocacy?

a) Completely agree b) Partially agree c) Partially disagree d) Completely disagree

(Discontinue if the participant partially or completely disagrees).

Inclusion criteria

1. Are you a registered or licensed psychologist in Canada?
   - Yes ___ (Proceed to question 3)
   - No ___ (Proceed to question 2)
2. Are you in the process of becoming a registered or licensed psychologist? (e.g., provisional)
   - Yes. ___ (Proceed to question 3)
   - No ___ (Discontinue screening questionnaire)
3. Have you been practicing as a registered psychologist in Canada for at least one year?
   - Yes ___ (Proceed to question 4)
   - No ___ (Discontinue screening questionnaire)
4. Have you previously supported clients from the LGBTI community in developing their self-advocacy skills?
   - Yes ___ (Proceed to question 5)
   - No ___ (Discontinue screening questionnaire)

All participants will be asked to take part in two sessions: one 60-90 minute face-to-face or online interview and one brief, follow-up cross-checking interview, which can be conducted by email, telephone or online, depending on the participant's preference.

5. Are you willing to meet the time commitment required by the study?
   - Yes ___ (Proceed to the next step)
   - No ___ (Discontinue screening questionnaire).

Thank you for your information. I will be in contact with you soon to let you know whether you have been selected to participate in this study. What is the best way to contact you?

_____

Appendix C: Informed Consent

UNIVERSITY OF CALGARY

Educational Studies in Counselling Psychology
Werklund School of Education

Consent Form for Participation in Thesis Research

Name of Researcher: Luis Gerardo Ibarra Alexanderson
Faculty, Department, Telephone & Email: MSc Student in Counselling Psychology, Werklund School of Education, University of Calgary, (403)-220-3364, luis.ibarraalexanderson@ucalgary.ca
Supervisor: Dr. José Domene, Werklund School of Education, University of Calgary.
Title of Project: "Supporting clients in developing self-advocacy skills: Exploring Psychologists' practices"

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study (REB22-0782).

Purpose of the Study
The purpose of this study is to explore Canadian psychologists' experiences with promote the development of self-advocacy skills with their clients from the LGBTI community. The focus is on psychologists' experiences; participants will not be asked to disclose information about their clients. This study is being conducted for the researcher's master's thesis project.

What will I be asked to do?
You will be asked to participate in two Zoom/telephone interviews with the primary researcher. The initial interview will consist of several questions about your experiences in working with clients. The exact questions have been provided to you in advance so that you are fully aware of the topics being covered in the interview. Your participation in the initial interview portion of the study will require approximately 60 – 90 minutes of your time. Interviews will be video-and audio-recorded and transcribed by the researcher.

Approximately 4-6 weeks after the initial interview, you will be asked to schedule a brief second Interview, where you will be asked to review a draft of the analysis of your data. You will receive an invitation to view a password-protected Word document of the analysis of the transcript through secure, web-based software. This gives you the opportunity to review the discussion that took place, clarify sections, and request changes.

Participation in this study is entirely voluntary. You may choose to not participate in parts of this study, and you may decline to answer any and all questions. You may withdraw from the study at any time up until you have completed the second interview (i.e., after you have reviewed the interview transcript). You may also choose to withdraw any data that you have previously

provided up until the completion of data analysis. After that point, it will not be possible to remove your data from the study, but you can still choose to not to be quoted in any presentations or publications arising from the study, including the thesis.

What type of personal information will be collected?
Should you agree to participate, you will be asked to share your experiences with helping LGBTI clients in developing self-advocacy skills. Prior to the interview, you will be asked to provide your full name, telephone number, and email address.

Only the primary researcher and the academic supervisor will have access to your name, telephone number, email address, and this signed consent form. Only the primary researcher, the academic supervisor and research assistants (who will assist with validation of the data analysis), will have access to the audio-taped interviews and accompanying transcripts.

Prior to audio-recording transcriptions, you will have the option of creating a pseudonym to which you will be referred throughout the interview's transcripts. Using a pseudonym ensures that your name will not be linked to any of the written data in the future.

There are several options for you to consider if you decide to take part in this research. You can choose all, some, or none of them. Please review each of these options and select Yes or No.

I wish to remain anonymous, but you may refer to me by a pseudonym: Yes: ___ No: ___
The pseudonym I choose for myself is: _____
I wish to be emailed a copy of the study findings: Yes: ___ No: ___
I wish to participate in the follow-up interview via Zoom:__ Telephone: ___

Are there Risks or Benefits if I participate?
Although the risk is low, there is a potential for participants to experience unpleasant memories or emotions during the interview. The interview questions will ask about practice experiences with LGBTI clients and could create some discomfort for some participants. The focus will be on the factors that have helped and have hindered your ability to support them in developing self-advocacy skills. You will also be asked about what would have been helpful to you during these times. If the interview topics bring about negative memories or emotions, you are encouraged to let the researcher know, a break or rescheduling is always an option, and you could be provided with a list of community resources and supports will be provided to you.

You may find it interesting and helpful to talk about experiences that have both hindered and helped you in promoting your clients' self-advocacy. Your participation in this study may also help to identify ways to improve the provision of self-advocacy and better
meet the needs of LGBTI clients.

You will receive a gift (valued at approximately $25) in appreciation for your time.

What Happens to the Information I Provide?

Participant and other people's names will be removed from the transcript. All identifying information for participants will be summarized for any presentation or publication of findings. Participants may consent to the use of direct quotes with pseudonym identifiers.

The video-and audio-recordings will be deleted immediately after project completion. The transcripts will be stored on a password-protected computer file for five years, after which time it will be permanently erased. The information you provide will be used toward the completion of a master's thesis, and potentially presentations at psychology conferences and publications in scholarly journals.

There is the potential for you to reveal information that would require the primary researcher to breach confidentiality and report to law enforcement or other legal authorities. The following information would require confidentiality to be breached: 1) if you disclose intent to harm either yourself or someone else; and 2) if you report child abuse or neglect.

By signing this form, you are providing written consent to participate in the interview and consent to the terms listed above.

Signatures

Your signature on this form indicates that:

1) you understand to your satisfaction the information provided to you about your participation in this research project, and
2) you agree to participate in the research project.

In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature: _____ Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Luis Gerardo Ibarra Alexanderson
MSc Student, Counselling Psychology Program
Werklund School of Education
at (403) 220-3364, luis.ibarraalexanderson@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, the University of Calgary at (403) 210-9863; email cfreb@ucalgary.ca.

A copy of this consent form has been given to you to keep for your records and reference. The researcher has kept a copy of the consent form.

Appendix D: Confidentiality Agreement

Werklund School of Education
University of Calgary

Name of Researcher: Luis Gerardo Ibarra Alexanderson

Faculty, Department, Telephone & Email: MSc Student in Counselling Psychology, Werklund School of Education, University of Calgary, (403)-220-3364, luis.ibarraalexanderson@ucalgary.ca

Supervisor: Dr. José Domene, Werklund School of Education, University of Calgary.

Title of Project: Supporting clients to develop self-advocacy skills: Exploring Counselling Psychologists' practices

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Before you participate in the data analysis for this study, you must agree to not to reveal any of the contents of the tapes, transcriptions, nor to reveal the identities of the participants.

If you agree to these conditions, please sign below.

Participant's Name: (please print) _____

Participant's Signature: _____ Date: _____

Appendix E: List of Counselling Support

Across Canada:

a. **Crisis Services Canada**
   The Canada Suicide Prevention Service
   Crisis: Call 1.833.456.4566 | Text 45645
   Details: For crisis.
b. **Wellness Together Canada**
   Immediate Crisis Support: Text WELLNESS to 741741
   Website: https://www.wellnesstogether.ca/
   Details: On-demand products for well-being.
c. **Better Help**
   Website: www.betterhelp.com
   Details: Online counselling services
d. **The LifeLine App**
   Website: www.thelifelinecanada.ca
   Details: Website and free smartphone/ tablet app with a variety of resources
e. **Bridge the Gapp**
   i. Website: https://bridgethegapp.ca/
   ii. Coping resources for anxiety. Offers services, referrals, and online resources.

01. Alberta

a. **Alberta Health Services**
   i. Mental Health Helpline 1-877-303-2642
   Details: The Mental Help Line is a 24-hour, 7-day-a-week confidential service that provides support, information and referrals to Albertans experiencing mental health concerns. The line is staffed by a multidisciplinary team comprised of nurses, psychiatric nurses, social workers, occupational therapists, and psychologists.
   ii. Access Mental Health is a non-urgent service. Anyone can call for information, consultation, and referrals for individuals with mental health concerns.
      - Contact: 403 943-1500

   Website: http://www.albertahealthservices.ca

b. **Distress Centre (24h line)**
   i. Crisis Line (24 hours): (403) 266-HELP (4357)
   ii. Chat Support: www.distresscentre.com
   iii. Details: Crisis intervention, support, and referrals for counselling

In Calgary:

c. **Eastside Community Mental Health Services (ECMHS)**
   i. Phone (see Website for hours): (403) 299-9699
   ii. Website: https://www.woodshomes.ca/programs/eastside-community-mental-health-services/
   iii. Details: Connects callers to community resources based on their needs (including single session or extended counselling services)

02. British Columbia

a. **Crisis Line Association of BC**
   i. 1800SUICIDE (24 hours): 1-800-784-2433
   ii. Mental Health Support (24 hours): 310-6789

03. Manitoba

a. **Government of Manitoba: Care for your mental health**
   i. Website: https://www.gov.mb.ca/mh/mh/crisis.html
   ii. Details: information on mental health crisis and non-crisis regional contacts.

b. **Shared Health Manitoba**
   - Website: https://sharedhealthmb.ca/services/mental-health/mental-health-and-wellness-resource-finder/
   - Details: Concentrates different mental health resources for referral.
   - Crisis line: 204-940-1781

c. **The Mental Health Crisis Response Centre in Winnipeg**
   - Details: is a central point of access for adults experiencing a mental health crisis, accessible 24 hours a day, seven days a week, within an atmosphere that promotes healing and recovery.
   - Phone 204-940-1781.

d. **Klinik Crisis Line (24/7)**
   - Phone: 204-786-8686
   - Toll-free: 1-888-322-3019

04. New Brunswick

a. **Government of New Brunswick: Mental health**
   i. Website: https://www2.gnb.ca/content/gnb/en/corporate/promo/covid-19/mental_health.html
   ii.

b. **Chimo Helpline**
   i. 24/7 crisis phone: 1-800-667-5005
   ii. Helping with: suicidal thoughts, emotional distress, anxiety, general information and resources, loneliness, relationships, depression and mental health.

05. Newfoundland and Labrador

a. **Government of Newfoundland and Labrador: Mental health and wellness**
   i. Healthline: 8-1-1
   ii. Information line: 2-1-1
      1. 211 is an information and referral service that connects Newfoundlanders and Labradorians to critical human, social, community and government support. The service is free, confidential, and available 24 hours a day in 170 different languages.
   iii. Mental Health Crisis Line: 1-888-737-4668
      1. If you are experiencing a mental health crisis, you can call the Mental Health Crisis Line 24 hours a day.

iv. Website: https://www.gov.nl.ca/covid-19/public-health-guidance/mental-health-and-wellness/
v. Individuals needing crisis response or mental health and addictions support can dial 811, day or night, to speak with a registered nurse who is a trained crisis intervener.

06. Nova Scotia

- **a. Government of Nova Scotia: Mental health and wellbeing**
  - i. Helpline crisis: 2-1-1
  - ii. For non-emergency advice and information about mental health and addictions, phone: 8-1-1
  - iii. Crisis text line
    1. Text: NNSTRONG to 741741
- **b. Nova Scotia Health Authority**
  - i. Mental health and addictions services
    1. Website: https://mha.nshealth.ca/en
  - ii. Provincial Mental Health and Addictions Crisis Line. 24/7: 1-888-429-8167
  - iii. Mental health and addiction locations website: https://mha.nshealth.ca/en/clinics

07. Nunavut

- **a. Government of Nunavut**
  - i. Website: gov.nu.ca/health
- **b. Nunavut Kamatsiaqtut Help Line (crisis line)**
  - i. Phone: 1-800-265-3333
  - *ii. Employee and Family Assistance Program*
    1. If you find the anxiety overwhelming and need to talk to a professional, please call the Employee and Family Assistance Program through Homewood Health at 1-800-663-1142.

08. Ontario

- **a. Government of Ontario: Mental health, wellness, and addictions support**
  - **i. General Information across Ontario**
    1. Call 2-1-1 for referrals.
- **b. MindBeacon**
  - i. iCBT free guided CBT therapy for Ontario residents. Low-cost virtual sessions.
    1. https://www.mindbeacon.com

09. Prince Edward Island

- **a. Government of Prince Edward Island: Mental health and addictions services**
  - *i.* 24-hour telephone service for non-emergency health information: *8-1-1*
- **b. Family Service PEI**
  - i. Website: www.fspei.ca
  - ii. Telephone: 902-892-2441
  - iii. Information: offer therapeutic counselling to individuals, couples, families and groups, credit counselling services, and workplace wellness training, regardless of their ability to pay.

c. **Mental Health Walk-In Clinics**
    i. Website: https://www.princeedwardisland.ca/en/information/health-pei/mental-health-walk-in-clinics
    ii. See the website for telephone numbers and clinic hours.
    iii. General inquiries phone: 902-368-6130
    iv. Locations: Montague, Charlottetown, Summerside, O'Leary, Lennox Island, Elmsdale.
    v. Information: offer immediate mental health support to help with anxiety and life events causing stress and other mental health issues for Islanders aged 16 and older.

10. Quebec

a. **Gouvernement du Québec: Protecting your well-being in the COVID-19 pandemic**
    i. Info-Social: 8-1-1
        1. Details: Psychosocial telephone advice and referral
    ii. *En français:* Tel-Écoute – Ligne Le Deuil
        1. Détails: Ligne d'écoute téléphonique sans frais
        2. Téléphone: 514 493 4484

À Montréal

b. **Clinique universitaire de psychologie au campus de Montréal (Université de Montréal)**
    i. Téléphone: 514-343-7725
    ii. Clinique de psychologie low-cost offerte par des psychologues et des étudiants cliniciens

11. Saskatchewan

a. **Government of Saskatchewan: Mental health**
    i. The Saskatchewan Health Authority and the Saskatchewan Cancer Agency provide most health services in Saskatchewan, either directly or through health care organizations.
    ii. Website: https://www.saskhealthauthority.ca
    iii. Download PDF for MHAS directory: https://publications.saskatchewan.ca/api/v1/products/85744/formats/106350/download
    iv. Healthline: 8-1-1

12. Yukon

a. **Government of Yukon: Mental health**
    i. Website: https://yukon.ca/supports-mental-wellness
    ii. Email: hssweb@yukon.ca.
    iii. Phone: 867-456-3838 / Phone toll-free: 1-866-456-3838
    iv. Details: This government service continues to offer Rapid Access Counselling (RAC) for adults. RAC is a short-term counselling service with a 1st appointment available within 72 hours.

Appendix F: Interview Guide

Semi-Structured Interview Guide: "Supporting clients to develop self-advocacy skills: Exploring Counselling Psychologists' practices"

Pseudonym: _____ Date: _____
Interview start time: _____

1. **Contextual Component of Interview: Initial Rapport Building**

Preamble: As you know, I am investigating the practices that support LGBTI clients in developing self-advocacy skills. This is the first of two interviews, and its purpose is to collect information about the events and incidents you have experienced that have facilitated or interfered with your practices and interventions.

   a. As a way of getting started, perhaps you could tell me a little bit about your current work with LGBTI members? (Possible prompts: What kind of setting do you work in? How much of your client work involves members of the LGBTI community?)
   b. You volunteered to participate in this study because you identified yourself as a psychologist who has supported clients to self-advocate. What events precipitated your need or desire to promote self-advocacy among LGBTI clients?
   c. What does self-advocacy mean to you?

2. **Critical Incident Component**
   a. Transition to Critical Incident questions: I'm going to ask you some questions about how you supported LGBTI clients to develop self-advocacy skills. Self-advocacy refers to helping clients advocate for themselves instead of advocating for them. What has helped you in supporting LGBTI clients to build self-advocacy skills? (Probes: What was the incident/factor? How did it impact the client? Can you give me a specific example of this incident/factor? How did that help you support them?)

Helpful Factor & What It Means to Participant (What do you mean by…?)	Importance (How did it help? Tell me what it was about [insert event] that you find so helpful)	Context (What led up to it? What was the incident? What was the outcome of the incident?)

   b. What are some things that have made it more difficult for you to support LGBTI clients to advocate for themselves? What kinds of things have happened that made it

harder for you to support them? (Probes: What was the incident/factor? How did it impact?)

Hindering Factor & What It Means to Participant (What do you mean by…?)	Importance (How did it make things more difficult? Tell me what it was about [insert event] that made it harder to support the client)	Context (What led up to it? What was the incident? What was the outcome of the incident?)

c. Summarize what been discussed: We've talked about what's helped you to support LGBTI clients in their self-advocacy and things that have made it difficult for you. Are there other things that you have not experienced, but which would help you to continue to promote self-advocacy for these clients? / I wonder what else might be helpful to promote self-advocacy for these clients that you haven't had access to?

Wish list item & What It Means to Participant (What do you mean by…?)	Importance (How it would help? Tell me what it was about [insert item] that you would find so helpful)	Example (In what circumstances might this be helpful?)

3. Demographics Component

1. Years working as a psychologist
2. Age
3. Gender (pronouns)
4. Sexual Orientation
5. Cultural Background
6. Language Spoken at Home
7. Education Level (MSc/Ph.D.)

Interview end time: _____