2022

“What if this happiness doesn’t last forever?”: Stressors faced by racialized SOGIE refugees

Moni Sadri-Gerrior
sadr6430@mylaurier.ca

"What if this happiness doesn't last forever?":

Stressors faced by racialized SOGIE refugees

by

Moni Sadri-Gerrior

B.Sc. Biology and Psychology, Neuroscience, & Behaviour, McMaster University, 2019

THESIS

Submitted to the Department of Psychology in partial fulfilment of requirements for Master of Arts in Community Psychology

Wilfrid Laurier University

Abstract

Racialized refugees with diverse SOGIE (Sexual Orientation, Gender Identity, and Expression) experience the unique intersection of racism, homo- and/or transphobia, and anti-refugee sentiments. As a result, this group (herein: racialized SOGIE refugees) often face poor mental health and well-being. The purpose of this study is to identify stressors faced by racialized SOGIE refugees in Ontario through the lens of Meyer's Minority Stress Theory and Crenshaw's intersectionality theory. The interviews from ten racialized SOGIE refugees and two service providers living in Ontario were taken from a larger study looking at the life trajectories of SOGIE refugees. Participants identified both explicit and implicit stressors in their daily lives, ranging from feelings of isolation and community disconnect, to anticipatory fear of stigma and violence. Consistent with the distinction of distal and proximal stressors proposed by Minority Stress Theory, this negatively affected their well-being. Our results point to a need to acknowledge the unique positionality of racialized SOGIE refugees in Ontario, and to find ways to facilitate positive mental health and well-being despite the presence of minority stress.

Keywords: Refugee, SOGIE, Racialized, Well-being, Mental Health, Minority Stress, Intersectionality

Acknowledgements

I would like to begin by thanking my thesis supervisor, Dr. Robb Travers of the Department of Health Sciences. Without his ongoing support and guidance over the last two years, this paper would not have been possible. Dr. Travers has always steered me in the right direction while also giving me the room to explore and grow my own interests along the way. Thank you to Dr. Todd Coleman, co-director of the Social Inclusion and Health Equity Research group alongside Dr. Travers. Dr. Coleman has been a source of valuable input and support throughout this process. This completion of this project would not be possible without funding support from the Wilfrid Laurier University Internal Grants Program (Grant: SOGIE 240500).

I would also like to take the time to thank my internal committee members, Dr. Travers and Dr. Coleman, as well as Dr. Simon Coulombe of the Département des Relations Industrielles at L'Université Laval. Dr. Coulombe has provided important insights and perspectives throughout this process that I greatly appreciate. A special thank you to my external committee member, Dr. Sarilee Kahn, whose expertise and passionate participation throughout the defence process was deeply appreciated.

Lastly, I would like to express endless gratitude to my mother, sister, and partner, who have encouraged me to pursue my passions and go after what I believe in for the past two years and beyond. Without their unfailing support, this paper would not have been possible. Thank you.

I would like to acknowledge that this research was conducted on the traditional territory of the Neutral, Anishinaabeg, and Haudenosaunee peoples, the land promised to the Six Nations. I am deeply grateful for the caretakers who have resided on and cared for this land for thousands of years for allowing me the opportunity to live, work, learn, and grow here.

Table of Contents

Background

Out of 195 countries, 72 criminalize Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) people and their relationships, and as many as 11 impose the death penalty (Mendos, 2019). Individuals fleeing their country of origin due to the persecution and violence faced by LGBTQ+ people are known as Sexual Orientation and Gender Identity and Expression (SOGIE) refugees (Ferreira & Dustin, 2017; Murray & Murray, 2020). With Canada being one of the 42 countries that accepts refugees on the basis of sexuality and gender as of 1990, an influx of SOGIE refugees have entered the country over the past three decades (Mulé, 2020). As of 2002, at least 2,500 SOGIE refugees landed in Canada (LaViolette, 2009), and it is expected that the number of SOGIE refugees worldwide will continue to intensify (Fournier et al., 2018). While there are no current estimates on the number of racialized (i.e. non-white) SOGIE refugees landing in Canada, a majority of all newcomers in Canada are racialized (Government of Canada, 2017). Within Canadian-born citizen groups, those who are racialized are more likely to experience higher levels of anxiety, stress, and depression than their white counterparts (Veenstra, 2011). This in turn, puts them at a higher risk of suicide, addiction, and violence (Noh et al., 1999). And yet there is little pre-existing research regarding the exact need for mental health and support services for the racialized refugee community, and this lack of knowledge extends to those who claim SOGIE status as well. This study will provide greater insight into the lived experiences of those at the intersection of being a racialized SOGIE refugee in Ontario, to contribute to a better understanding of their mental health and well-being.

Literature Review

SOGIE Refugees: Mental Health and Well-Being

LGBTQ+ individuals have higher rates of mental health problems such as depression, anxiety, and suicide when compared to their heterosexual and cisgender counterparts (Alessi et al., 2021b; Brennan et al., 2010; Collins et al., 2011; Kidd et al., 2016; Meyer, 2003; Ross et al., 2018; Steele et al., 2016). Many systemic barriers are currently in place that prevent both people who are LGBTQ+ and refugees from accessing mental healthcare – so much so that many SOGIE refugees face severely worsening mental health conditions when moving to Canada (Mulé, 2020). Fox et al. (2020) found that, similar to results yielded for LGBTQ+ Canadians, SOGIE refugees have high levels of mental stress – as many as 80.2% screened positive for distress in 2020. Social isolation is also associated with particularly high mental distress for refugees when coupled with SOGIE status (Fox et al., 2020). Alessi et al. (2021b) similarly demonstrated that structural stressors such as financial instability and lack of healthcare access often exacerbate poor mental health in SOGIE refugees. Given how discrimination, lack of community belonging, stigma, and structural systems of oppression all play a significant role as social determinants of mental health (Fox et al., 2020; Hynie, 2018; Mawani, 2014), those who belong to each of these marginalized communities (but feel safe in none) are at a higher risk of developing mental illness or poor mental health. For many SOGIE refugees, the realization of worsening mental health post-migration is enough to cause even more distress, in turn negatively affecting well-being (Golembe et al., 2020).

Racialized Canadians, newcomer or not, are often uncomfortable discussing or seeking out mental healthcare in Western environments – particularly worrying given that they are more likely to be diagnosed with a lifetime depressive disorder when compared to their white

Canadian counterparts (Hansen & Huston, 2016). These numbers were even higher for racialized refugees (Hansson et al., 2012), who often have language barriers and fear of stigma that make them less likely to communicate their feelings of distress and isolation in a new environment (Mental Health Commission of Canada, 2016). When specifically investigating mental health, less than 68% of refugees self-report high mental health status compared to 72.1% of Canadian-born respondents; those arriving from countries in Western/Middle-Eastern and Eastern Asia report high mental health standing only 65% and 62% of the time respectively (Government of Canada, 2020). Moreover, there is a high prevalence of pre-existing Post-Traumatic Stress Disorder (PTSD) in refugees fleeing violence and trauma, and it has been found that elevated rates of mood disorders and psychotic illnesses are very common in racialized refugee groups (Hynie, 2018).

Effects of Discrimination

There have been many studies showing a direct link between discrimination and poor mental health and well-being, particularly for those who ethnic, sexual, and/or gender minorities (Berger & Sarnyai, 2015; Lee et al., 2016; Noh et al., 1999; Pascoe & Richman, 2009; Veenstra, 2011). Hynie (2018) found that discrimination was one of the main social determinants of mental health, with persistent experiences of discrimination upon landing in Canada associated with higher levels of stress, anxiety, and depression. This relationship is often exacerbated by those discriminated against in multiple ways, namely those who are newcomers, racialized, LGBTQ+, and so on. Kidd et al. (2016) noticed that those who are LGBTQ+ have a higher chance of developing mental illness due to the link between discrimination and risk of poor mental health outcomes. In a systemic review of 138 studies, Mawani (2014) similarly found a strong relationship between experiences of discrimination and poor refugee mental health and well-

being. When considering self-reported experiences of racism, demographic factors, socioeconomic status, and pre-existing health risk factors, the author found a strong link between poor mental health and systemic, institutional, and individual discrimination (Mawani, 2014). Mawani (2014) also notes that refugees often flee their countries of origin based on discrimination, and that facing discrimination upon landing in Canada can be a re-traumatizing experience that may lead to worsening mental health conditions. In addition, when compared to non-SOGIE migrants, SOGIE refugees are often at additional risk of abuse and discrimination because of their LGBTQ+ identity (Yarwood et al., 2022).

Community and Social Exclusion

Upon arrival, refugees often struggle with language and financial barriers, making it more difficult to access stable transportation, employment, and housing (Wilkinson & Garcea, 2017). This can occur in spite of previous education or employment training, as foreign educational and trade experiences often do not translate to Canadian equivalents (Kelly et al., 2014). Without the assistance of settlement or support organizations, the lack of language and financial dependance can make it very difficult to feel accepted and welcomed into Canadian society, leading to loneliness and isolation (Giwa & Chaze, 2018). Esses et al. (2017) found that a majority of Westerners in Europe and North America hold negative attitudes towards refugees, particularly those coming from racialized and/or Muslim countries. Oudshoorn et al. (2019) found in a study with Syrian refugees that negative perceptions often trickle down into the housing sector of Canada, so much so that landlords deny, ignore, and/or discriminate against potential refugee tenants – particularly those who are non-English, Arabic speakers.

Those who belong to *both* racialized and LGBTQ+ communities may be ostracized from not only the broader Canadian society, but their own communities as well. Giwa and Greensmith

(2012) found strong evidence that racism heavily exists within Canada's predominantly white LGBTQ+ communities. On the other hand, those who are marginalized due to their race often have to advocate for their existence, leading to homophobia and transphobia in racialized (particularly immigrant or newcomer) communities in Canada (Balsam et al., 2011). Hudson (2015) found that those who are racialized and LGBTQ+ often find their experiences of both identities to be the driving factor that affects the degree of community belonging they feel. The same respondents often cited the lack of intersectional awareness of *others* as one of the largest factors inhibiting their sense of belonging in a community. Other research has shown that LGBTQ+ refugees are more likely to face rejection from their cultural and familial community as well as mainstream society upon arrival in a new country (Kahn, 2015). Boles et al. (2018) found that only 25% of racialized newcomers in one Ontario community were involved in cultural or ethnic organizations – none of which specifically include those who are LGBTQ+. By not finding safety or belonging in either the LGBTQ+ or racialized communities, refugees who hold both identities are particularly ostracized, alienated, and lonely – all factors that lead to worsening mental health conditions and well-being (Giwa & Greensmith, 2012).

Minority Stress Theory

Meyer (1995) coined the term *minority stress* to apply to gay men living in a world full of stressors caused by heterosexism, "an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behaviour, identity, relationship, or community" (Herek, 1990, p. 316). Meyer (2003) defines minority stress as "excess stress experienced by individuals from stigmatized social categories as a result of their social, often a minority, position" (p. 675). Since publishing his first paper, Meyer (2003) has investigated the effects of minority stress on Lesbian, Gay, and Bisexual (LGB) individuals, and other researchers have since argued for the

theory's applicability to other marginalized groups, including those who are racialized, have disabilities, and those from lower socioeconomic backgrounds (Cyrus, 2017).

Distal and Proximal Stressors. While direct forms of violence and discrimination against LGBTQ+ people have their own effects on mental health and well-being (Bayrakdar & King, 2021), Meyer (1995) argues that the *stress* of stigmatization, discrimination, and violence may lead to severe distress, even in the absence of direct interpersonal harm; whether "direct" confrontation or violence is taking place, distress in itself can be categorized as psychological violence (Meyer, 1995). Meyer (2003) categorizes these stressful events as being distal (external) and proximal (internal) stressors. Distal stressors are often defined as explicit events such as violence, discrimination, and harassment, also encompassing microaggressions and invalidation (Ramirez & Paz Galupo, 2019). Proximal stressors are defined as implicit events, such as internalized homophobia, transphobia, and racism (Lei et al., 2022). However, proximal stressors may also include the *anticipated* stress of stigma, violence, or rejection – in other words, the fear of facing distal stressors even in the absence of such events. This often leads to the concealment of identities in an attempt to avoid stressful situations, or to continue to receive necessary support from loved ones (Alessi et al., 2021a). Therefore, those who are at the intersection of multiple marginalized identities are more likely to have negative beliefs about their identity, making it difficult to form healthy peer relationships (Radkowsky & Siegel, 1997) and adjust psychologically throughout life (Hetrick & Martin, 1987).

Social Inclusion and Well-Being. The need to belong is not only a fundamental human motivation, but an important factor in positive health and well-being (Baumeister & Leary, 1995; Chow, 2007). Meyer (2003) cites community belonging and individual social support as a protective factor against negative mental health outcomes. With the acknowledgement of one's

minority identities comes community involvement with others of similar life experiences, contributing to positive well-being and improved coping abilities (Meyer, 2003). Regular interactions with others who share similar identities leads to a greater sense of self, resulting in an increased development of well-being (Meyer, 2003). The ability to rely on community members and services for social support is crucial for building resiliency in LGBTQ+ refugees, a protective factor for both mental health and well-being (Alessi, 2016).

To better understand the mental health and well-being of racialized SOGIE refugees, we must first understand the complex stressors resulting from having multiple marginalized identities. These multiple stressors can be examined through a theoretical lens of intersectionality, a term coined by Crenshaw (1989) that describes how race, sexuality, gender, and other marginalized identities intersect to create a unique lived experience. Bowleg (2008) describes intersectionality as beyond the addition of one's marginalized identities; therefore, social identities and concomitant experiences of inequality cannot be mutually exclusive of each other (Bowleg, 2008). In other words, racialized SOGIE refugees would not *individually* experience racism, homophobia/transphobia, and anti-refugee sentiments – the intersection of these identities creates an experience of marginalization that is unique. The combination of these identities creates new areas of minority stress that must be considered when navigating life in a new country. While everyone carries their own unique life experiences that shape them, viewing these experiences through the lens of Minority Stress Theory while also considering intersectionality allows for a more holistic understanding of the issues facing SOGIE refugees.

Research Objectives

Given the vulnerability of SOGIE refugees to adverse mental health challenges, it is crucial that we utilize empirical research to effect policy change. This paper draws upon data from a larger study *"Innovative means for exploring SOGIE refugees' life trajectories in the Canadian context"*. The two objectives of that study were to 1) examine the diverse, intersectional life experiences of SOGIE refugees and 2) identify barriers, challenges, and opportunities at individual, community, and structural levels for SOGIE refugees arriving in Canada.

The primary objectives of this paper are to 1) explore the daily experiences of racialized SOGIE refugees in Ontario, 2) better understand the stressors faced by this unique group at individual, community, and structural levels, and 3) determine what steps may be taken to improve social inclusion and well-being. These objectives are considered through the theoretical lens of Meyer's Minority Stress Theory, which was chosen due to the distinction between distal and proximal stressors (including anticipatory stressors), and how these may contribute to well-being. Crenshaw's (1989) intersectionality theory is also utilized to elucidate the unique life experiences of those living with multiple marginalized identities. For the purpose of this study, well-being is defined as follows: "a positive state of affairs, brought about by the simultaneous and balanced satisfaction of diverse subjective and objective needs of individuals, relationships, organizations, and communities" (Prilleltensky, 2012, p.2). This definition acknowledges how the multi-faceted levels of marginalization faced by racialized SOGIE refugees can affect their well-being.

Although literature exists regarding the well-being and mental health of individual marginalized groups, there is a significant gap in knowledge documenting the unique challenges

faced by racialized SOGIE refugees through this combination of theoretical lenses. Therefore, this paper attends to the following research questions: 1) what are the daily stressors faced by racialized SOGIE refugees? 2) what experiences do racialized SOGIE refugees have with their respective communities upon arrival? 3) what recommendations and next steps can be suggested for enhanced well-being?

Methods

The project *"Innovative means for exploring SOGIE refugees' life trajectories in the Canadian context"* collected data across four life domains: General, Integration into Society, Well Being, and Healthcare. Data from all four domains of the larger study were used for the purpose of this paper, to broadly understand varied stressors.

Participants

SOGIE refugees and other relevant stakeholders participated in this study. To be eligible for participation, refugees had to obtain refugee status in Canada within the last 10 years, be over the age of 16, and identify as SOGIE in any capacity. Eligible stakeholders had to be over the age of 18, have worked with SOGIE refugees for over one year, and work in policy, law, healthcare, and/or mental health in Ontario. This paper draws upon interviews from 10 racialized SOGIE refugees and two stakeholders.

Recruitment. Participants were recruited through Ontario organizations that serve LGBTQ+ and immigrant, newcomer, and refugee populations – such as the member organizations of the Ontario Council of Agencies Serving Immigrants (OCASI). Snowball sampling, where current or past participants recruit future participants by word of mouth (Naderifar et al., 2017), was used. Recruitment via electronic posters and social media was also employed. Eligibility was determined through a screening questionnaire, where participants were

asked to self-identify in terms of ethnicity, age, sexuality, gender, and socioeconomic status. Heterogeneity of the sample ensured that the impact of intersectional identities – such as race and SOGIE status – on lived experience could be captured. Informed consent was collected before the interview process using an electronic consent form cleared by the Research Ethics Board (REB) of Wilfrid Laurier University, as well as at the beginning of each interview. The consent forms outlined the general interview themes and processes to ensure privacy.

Interviews

Data were collected through semi-structured interviews, led by faculty and graduate students at Wilfrid Laurier University. The interviews were one to two hours in length and included the following kinds of questions: 1. Where do you feel a sense of belonging, if anywhere? 2. Are there barriers to being able to connect with others in the community?; 3. How do you think your settlement has influenced your well-being? (See Appendix for full interview guides). All interviews were audio recorded, and participants were compensated for their time with a $50 online gift card.

Data Analysis

All interviews were transcribed verbatim by members of the research team, research assistants, and/or an external transcription company "Transcript Heroes". Identifying information was anonymized, and participants were only referred to by their identification numbers pre-assigned to each participant. Transcription and data analysis was conducted in accordance with the six steps of thematic analysis laid out by Braun and Clarke (2006), beginning with preliminary familiarization of existing literature as well as the transcripts. Transcripts were then coded using QSR-International NVIVO 12 software to identify key recurring themes, phrases, and ideas. Codes were developed based on themes in the literature regarding similar topics in

qualitative research, and discussions amongst the research team. Once coding was complete upon saturation (Saunders et al., 2018), broader themes were identified in the data. To establish trustworthiness in our data, we used reflective commentary and iterative questioning, and ensured multiple team members were significantly involved in discussions surrounding chosen codes (Lincoln & Guba, 1985).

Results

Sample Characteristics

The 12 interviewees included in this analysis were comprised of 10 racialized SOGIE refugees, and two SOGIE refugee stakeholders. Of the 10 racialized SOGIE refugees, all settled within Ontario, Canada, with five (41.7%) each settling in London and Toronto, and one (8.3%) in both Ottawa and Kitchener-Waterloo. Eight percent of participants were newly landed in Canada in the past year, and 75% had been settled for two to five years; 17% had come to Canada more than five years ago. See **Table 1** for a complete list of participant characteristics.

Results

Twelve interviews produced over 70 codes, and a thematic framework emerged highlighting the different categories of stressors in accordance with Meyer's (2003) Minority Stress Theory (**Figure 1**). Proximal stressors and the presence of anticipatory stress was linked to concealment of identities (i.e. staying in the closet) and feelings of disconnect from participants' culture(s). Lingering fear (including feelings linked to PTSD) and the burden of proof were found to be connected to *both* proximal and distal factors, as participants may have encountered explicit instances of discrimination or violence, but also the stress of the *possibility* of experiencing this. As social inclusion and the ability to cope through the presence of robust support systems are protective factors against stress (Meyer, 2003), feelings of isolation prevent

this protection, often heightening stressors and therefore negatively affecting mental health and well-being.

Table 1. Sample Characteristics

Characteristic	**n (total n = 12)**	**% of sample**
Sexuality		
Gay	7	58.3%
Bisexual	4	33.3%
Other	1	8.3%
Gender		
Cisgender	6	50%
Transgender	2	16.7%
Non-Binary and Other	4	33.3%
Age		
20-29	6	50%
30-39	1	8.3%
40+	5	41.7%
Area of Origin		
Africa	7	58.3%
Middle East	3	25%
Americas and Caribbean	2	16.7%

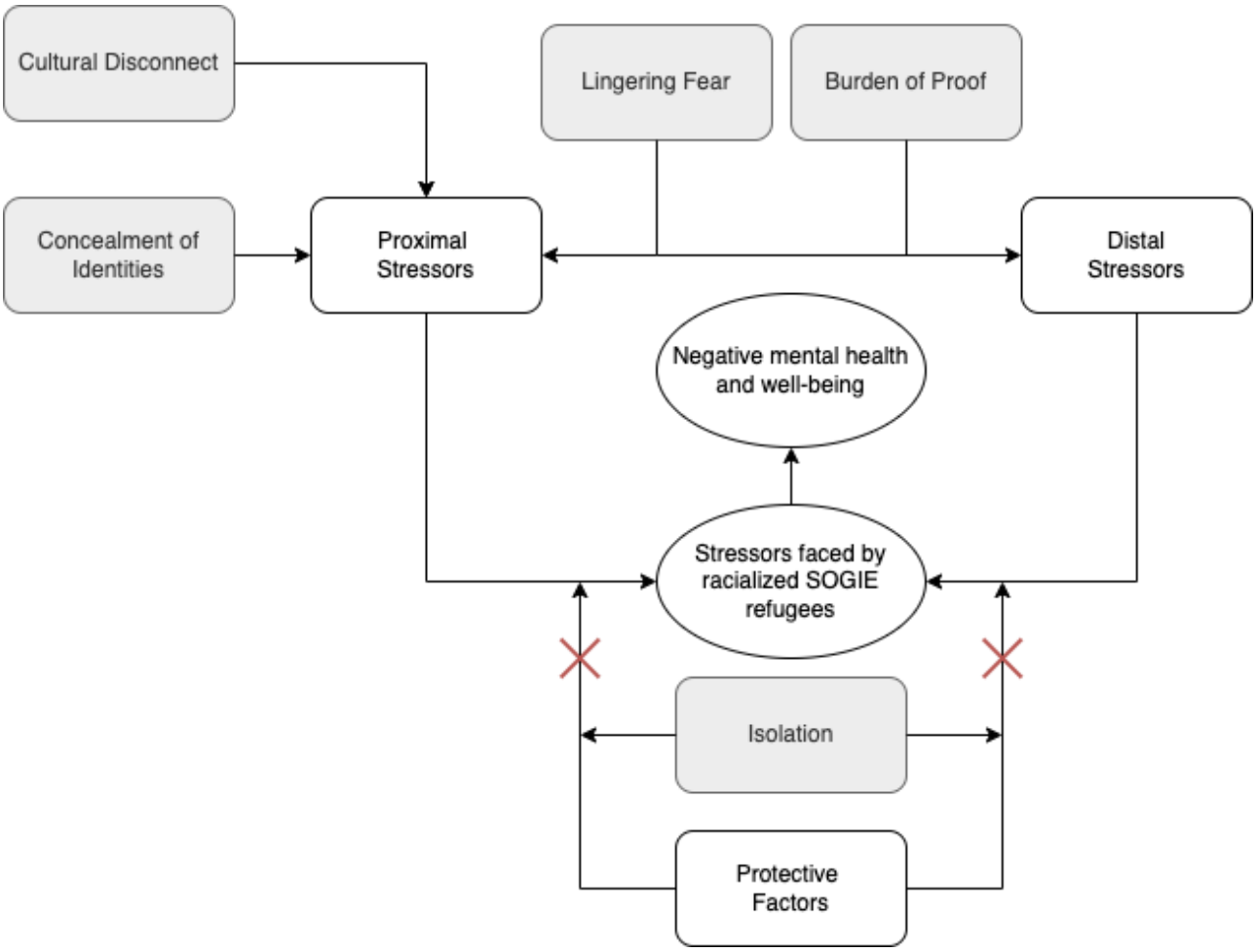

Fig 1. Stressors faced by racialized SOGIE refugees

Themes

Burden of Proof

The process of entering Canada as a SOGIE refugee claimant often requires an individual to "prove" their sexual and/or gender identity to gain refugee status. Many participants viewed identity as subjective but still felt the pressure of needing to prove who they are to gain Canadian status; one noted:

> It's trying to make a case to prove what cannot be proven by something objective. So yes, I am gay and we're trying to prove this to someone else. That's why it is very important

> for them to get what I am saying and whatever documents I'm presenting because I'm trying to prove something that is very subjective. – P1 (Gay man, Ethiopia)

One participant pointed out that this proof must sometimes be gathered through others:

> For the hearing, that is where the proof comes in…I have to get supporting letters from people who are a part of the story that I have put forward, or a part or my life, who would know what I've been through. – P2 (Queer woman, Barbados)

This can be especially anxiety-provoking for SOGIE refugees who are not out to their family, friends, or peers, prompting them to rely on unconventional methods to acquire proof. One participant was initially hoping to claim refugee status in Canada with a family member, before eventually cutting ties to avoid the need to share his sexuality:

> I removed myself from my brother's application so I can mention that I'm gay, and we created a whole [SOGIE] case. I have both my history and my Grindr[1] and my everything. – P3 (Gay man, UAE)

Participants felt pressure to provide proof through difficult or uncomfortable means; stakeholders in the decision-making process may have their own subjective opinions on what is "fake".

A service provider described how proof must be collected, and seen to be authentic:

> There are certain things that may give a decision-maker the wrong impression about whether this is something [SOGIE refugees] are faking, just for status. – P11 (Immigration Lawyer)

Isolation

Many SOGIE refugees landing in Canada do so alone, and face the task of creating new support systems, friendships, and community. This task can be particularly difficult for those

[1]Grindr is an online dating application for men who have sex with men.

with a language barrier, or for those still learning to navigate a new life. One participant spoke of how difficult building a new life can be:

> So it's very hard… to meet people. I've been affected by who I am, where I came from and here in Canada I'm just locked in my room. I don't get a chance to meet people. – P4 (Gay man, Rwanda)

COVID. For participants who arrived in Canada before or during the COVID-19 pandemic, the feeling of isolation was exacerbated by lockdowns and safety protocols:

> One thing that I really miss – and everyone does – is the social interaction. Like, if it wasn't for COVID, I would have volunteered in a lot of places, met new people, expanded my social circle here…because of COVID actually, I haven't seen anyone. – P5 (Trans man, Bahrain)

When specifically asked if COVID had added to feelings of isolation, one participant said:

> Yes. I think so…because there's no social life. Everybody is at home. So, for now I – there is not much places to go hang out, like discuss with people or talk. – P6 (Queer man, Nigeria)

Separation from Loved Ones. Participants spoke of the difficulty of being separated from those they love back home – even if those were difficult relationships. One spoke of the loneliness and despair associated with leaving a partner behind:

> To be honest I feel lonely because I'm not even with the person I love. He's back in Rwanda. I feel when I'm here, I feel lonely. Sometimes I feel like I can't carry on. – P4 (Gay man, Rwanda)

Being separated from family, and worrying about their safety back home, was painful for some:

> When I think about Venezuela, the only thing that I think of is my family because there are, it's a very challenging time in Venezuela…I'm in fear that a time might come where they might suffer, and that affects me. – P7 (Gay man, Venezuela)

Concealment of Identities

Upon arrival in Canada, choosing whether to come out as a SOGIE refugee raised safety issues for many participants.

Staying Closeted. While many participants regarded Canada as more accepting compared to their country of origin, decisions to come out as LGBTQ+ were situational. Participants often chose to conceal their sexuality and/or gender identity based on how comfortable they felt. Two participants in a relationship, spoke of the importance of discretion while living as a gay couple in a smaller city:

> We have a Canadian friend; he is gay and that's it. The whole city, two people know about us… Yeah, so you can't do it, we can't pronounce we are gay in public or anything. – P8 (Gay men, Syria via Lebanon)

A service provider recalls a conversation with a transgender woman she worked with regarding pronoun use and safety:

> So, when I asked her what her pronouns are, she told me that it's she and her, but she also goes by he and his sometimes, depending on, you know, safety reasons, who she's talking to. – P12 (Settlement counsellor)

Even upon being given the space to safely share her gender identity, choosing who could call her by her pronouns in public remained a matter of personal comfort.

Even if one's safety was not at risk, some chose to still pass as cisgender:

> I'm living here as a man and no-one, well not in the professional context, they don't know that I'm a trans man and I don't tell people that. I just don't think that I will be treated the same if they knew. So regardless of their, like whatever background they come from, I don't feel comfortable. – P5 (Trans man, Bahrain)

Although it is illegal in Canada to require employees to disclose personal information such as sexual orientation, many SOGIE refugees still endured challenges when applying for jobs:

> There is somewhere I apply for the job and in the form we filling in they mention it like, are you homosexual? I was like OK what should I do? If I tick maybe gay I not get the job… It's like I have to lie. I had to put no because I feel like what if I don't get a job? – P4 (Gay man, Rwanda)

Negative Attitudes Towards Refugees. Similar to how attitudes towards LGBTQ+ people in Canada are varied, many participants felt hostility from others in regard to their refugee status. This created difficulties in finding housing:

> I started looking for house, but it was difficult to get a house… And as a newcomer, the landlords, they want to – they don't feel comfortable giving a newcomer that I don't have a job a house. – P9 (Bisexual man, Nigeria)

For this participant, potential employers made it difficult to secure a job once they realized his refugee status:

> I believe that now that they know that I'm a refugee… because apparently, my number, my SIN, shows that I'm a refugee. It's like a 9-0 something… [Sighs] I'm trying to find a job, but what's the use if like, I am refused 'til now. – P3 (Gay man, Palestine via UAE)

Lingering Fear

Past experience (e.g., trauma) follows newcomers to their new countries. Despite how living in Canada may allow SOGIE refugees to live a life free of specific fears such as prosecution or death, many participants felt as though they could not move past the feelings they were so used to carrying. One recounted how a transgender women she worked with still felt she was in direct threat of harm upon arrival:

> She didn't feel safe and felt her landlord had sons who were onto her, like they knew that she was part of the LGBTQ community. And she's like, you know… I sleep with one eye open, I'm afraid they might do something to me. – P12 (Settlement counsellor)

Incarceration. Many participants had poor relationships with police and broader justice systems and had faced police brutality or jail time in their country of origin. Upon arriving in Canada, this distrust towards the police lingered. When asked about police, one participant said:

> When I came earlier, if I see police or hear sirens, I'd panic and feel anxiety. – P6 (Queer man, Nigeria)

Another shared many negative experiences with police in his country of origin, but also a similar incident while crossing the US border into Canada:

> I was detained for I would say an hour in the police station at the border because of course, I was breaking rules in trying to move across a border illegally. I had an interview with an officer and I explained why I made this decision and then they automatically put me in detention and sent me for immigration processing. – P1 (Gay man, Ethiopia)

Deportation. Achieving permanent status once in Canada can take many years. Participants felt varying degrees of stress throughout this process, and many believed deportation to be a constant possibility. The fear of deportation was often linked to fear of incarceration, or

legal troubles. This was particularly worrying for this participant, who would face up to 14 years in prison if deported:

> Most times I don't sleep well, most times I get panic. But I was so much worried because of my court here and that was what was giving me a lot of troubles. I was thinking if they tell me to go back, if they don't accept me, what am I going to do? So I had so much tension on me. – P6 (Queer man, Nigeria)

For some, it was especially difficult to feel at ease upon arrival to Canada, as that feeling of comfort and safety could potentially be taken away at any time:

> I have thought like… What if this happiness I'm having right now, it doesn't last forever? Maybe there is some people who will have the right to push me back to where I came from, where things are very hard. – P4 (Gay man, Rwanda)

Cultural Disconnect

Racialized SOGIE refugees experience a unique intersection of identities, belonging to both the LGBTQ+ community as well as their own cultural and/or religious ones. The unfortunate reality many participants faced when arriving in Canada was feeling that they did not belong in those communities simultaneously and felt that they were forced to choose one. One participant shared the conflicted feelings that accompany this separation of identities:

> I fit into that group in terms of homosexuality but in terms of other values, in terms of mentality, in terms of my language, in terms of culture, in terms of the food we eat, I fit into the Ethiopian community. So I'm like confused, OK where do I fit now, where do I belong, you know. – P1 (Gay man, Ethiopia)

This man remained closeted when interacting with his cultural community, but still found it difficult to connect to the local Rwandan community:

> So the people from my community, I don't get a chance to be around them and it is very hard to make friends in my community because they don't know really who I am. It's really hard for me to socialize with them because most of them, they still have the tradition thing, you know? Even if they in Canada, they still believe it because that's how they were grown. That's what they were told so it's very hard for me to socialize with them. – P4 (Gay man, Rwanda)

Gossip in the Diaspora. All participants feared that word of their sexuality or gender identity would get back home to their families and communities. They feared that interacting with members of their cultural diaspora communities here in Canada would lead to their sexual orientation and/or gender identities being revealed back home. One participant spoke about how his sexuality would be tied back to his surname, and consequently his family:

> Palestinians, I believe that they know each other. So, if I told someone that I'm gay, they might deliver the message and it just goes around, because we go by the family names. So, you know, that family names…they honour it so much. So, [Sighs] I believe like if I told someone I'm gay in Canada, a message would be delivered to my family in UAE or to my brother in Edmonton. – P3 (Gay man, Palestine via UAE)

Another participant also discussed family name, and the importance of maintaining honour and preventing shame, even if it meant remaining closeted or minimizing interactions with his cultural community:

> I would rather be seen as a guy and live just without anyone knowing I'm transgender than people know and maybe in the future I might be harmed, or maybe someone will tell someone who knows me in my country…when it comes specifically to Arab community, I'm scared. Because I still – people still don't know that I'm trans back home. And I

> don't want them to know. This is the thing. Like when I left, I wanted to be considerate, I didn't want to bring any shame to my family name. – P5 (Trans man, Bahrain)

One service provider discussed seeing this spread of information firsthand:

> But for my little experience, I think most times these people got reporting people, you know, neighbours reporting neighbours. So I believe even if someone's identity is out in the open, one person or the other might have seen these people and partners and others, so they might report. – P11 (Immigration lawyer)

Another service provider summarized the experiences of racialized SOGIE refugees avoiding their cultural communities:

> I think the challenge is that…sometimes it's a tightknit community that they come from, and so sometimes they don't want to see someone else from their own community. Because it's so tightknit…if you're coming to see this group and you see someone who belongs to your community, now the word is going to spread that, you know, this person, so-and-so came here. Sometimes we assume that if you are within your own community, you might feel a sense of comfort and, you know, a sense of belonging. And sometimes for newcomers who are part of the community, it could be the opposite. – P12 (Settlement counsellor)

Discussion

The purpose of this study was to gather insight into the stressors faced by racialized SOGIE refugees, and to understand how these stressors affect mental health and well-being. While there have been studies looking at the mental health and well-being of racialized, LGBTQ+ individuals, this study provides a nuanced understanding of racialized SOGIE refugees, where empirical work is needed. These findings contribute to the existing research

related to minority stress and intersectionality theories, shedding light on how racialized SOGIE refugees experience minority stress in multiple, novel ways because of their marginalized identities.

During the initial process of entering Canada as a SOGIE refugee, claimants often must provide "proof" of gender identity and/or sexuality to be granted asylum (LaViolette, 2009). This often results in psychological burden and strain on claimants who fear that declaring SOGIE status may put them at risk of violence (Kahn & Alessi, 2018). As one service provider mentioned, the decision to be granted asylum is often in the hands of decision-makers who must deem the proof authentic, therefore SOGIE refugees may be denied entry based solely on the judgement of others. This was consistent with research conducted by Kahn et al. (2017), who found that service providers often have legitimate concerns of how "performing gay" incorrectly may negatively affect their client's claimant process. Other participants felt worried that declaring their SOGIE status would lead to family members back home discovering their sexuality and/or gender identity. This, coupled with the fear of being judged or ridiculed during the process of entering the country, aligns with both Meyer's (2003) proximal (expecting prejudice) and distal (facing prejudice) stressors. Many SOGIE diverse people across the world already feel the need to "prove" themselves in society (Peleg & Hartman, 2019), therefore the added stress on participants to collect – often intimate – pieces of their lives (i.e. letters, dating profiles, photos) to be deemed worthy of SOGIE refugee status carries a psychological burden.

Research has shown that refugees have high rates of Post-Traumatic Stress Disorder (PTSD) and mental distress due to previous traumatic experiences (de Jong et al., 2001; Hollifield et al., 2002; Knipscheer et al., 2015; Shrestha et al., 1998); preliminary research has shown that SOGIE refugees may have higher prevalence of PTSD and mental distress compared

to their non-SOGIE refugee counterparts (Yarwood et al., 2022). Upon arrival in Canada, the impacts of PTSD and/or traumatic experiences – either from their country of origin or the refugee process itself – do not simply disappear. Participants were often left with the lingering fear of being attacked or facing violence, whether from police and law enforcement, or from other members of society. In some cases, this fear stemmed directly from previous experiences of incarceration and detainment, leading to distrust in police and a visceral response to hearing police sirens. For others, the fear of the *possibility* of violence or discrimination alone led to distress and feeling that one always had to be alert, even while sleeping. These findings were once again consistent with Meyer's (2003) model of anticipation as a proximal stressor. Similarly, some participants feared the possibility of being sent back to their country of origin and facing repercussions for claiming SOGIE status, even when deportation was not necessarily a direct threat. This anticipatory stress prevented some participants from feeling safe, comfortable, or happy upon arrival, negatively affecting their well-being even in the absence of distal stressors.

The prevention of minority stress includes the presence of protective factors and coping strategies (Meyer, 2003). A lack of community, social support, positive peer relationships, and sense of belonging are, therefore, risk factors for negative mental health and well-being (Baumeister & Leary, 1995; Chow, 2007; Hynie, 2018; Mawani, 2014; Meyer, 2003). Fox et al. (2020) found that even *perceived* social isolation is positively associated with mental distress, meaning even the presence of meaningful relationships may not act as a protective factor if participants feel isolated from others. Due to the COVID-19 pandemic, many participants did not have the opportunity to make friends, join communities, or find volunteer, work, or social opportunities, intensifying pre-existing feelings of loneliness or isolation. In addition, being

separated from loved ones – including romantic partners – was a source of loneliness for participants. Some felt worried for the well-being of those they care about back in their country of origin, so much so that their daily lives were affected by these feelings.

Racialized SOGIE refugees are in the unique position of holding multiple marginalized identities, and therefore in many cases must choose when, and with whom, to be themselves. For some participants, this meant remaining closeted indefinitely, preferring not to share their gender identity and/or sexuality. This was done for multiple reasons, including fear of harm, worrying about public perception, and/or to avoid microaggressions in daily life – something racialized SOGIE refugees are likely to face (Balsam et al., 2011). For others this meant sharing their identity with people close to them, but purposely leaving out SOGIE status when it came to applying for jobs or housing, out of fear of discrimination – findings consistent with research conducted by Oudshoorn et al. (2019). In addition to being LGBTQ+, refugee status was something participants often chose to keep private rather than disclose, due to negative attitudes Canadians often feel towards refugees (Esses et al., 2017). However, when applying for jobs, refugee status was directly identifiable by a person's Social Insurance Number. This made it impossible to conceal refugee status in some cases, leading one participant to feel particularly distressed. This concealment of identity, in either case of SOGIE or refugee status, aligns directly with Meyer's (2003) concept of a proximal stressor. The need to potentially conceal *multiple* identities further demonstrates how intersectionality and minority stress combine to create further experiences of distress.

Participants often came from rich cultural communities in their country of origin but felt disconnected from the very same diaspora communities upon arrival in Canada. This could, in part, be due to homophobia and transphobia in cultural communities in Canada (Balsam et al.,

2011; Hudson, 2015), leading participants to hide their sexual and/or gender identity when interacting with their cultural communities, or, simply avoiding them altogether. It is important to note that in some cases, homophobia and transphobia may not be present in the community, but the *anticipation* of negative attitudes alone could be enough to make participants feel disconnected, nonetheless. Perhaps most significantly, SOGIE refugees felt excluded from their cultural communities, fearing that others would expose them through gossip. Participants feared that upon interaction with their diaspora community, word would somehow spread about their gender and/or sexuality, and would reach their families, friends, and loved ones back home in their country of origin. Many had not disclosed their SOGIE status to those back home, thus they avoided interaction with their cultural communities altogether. This was also verified in interviews with service providers. Meyer (2003) maintains that community exclusion negatively affects mental health; he also proposed that the anticipatory fear associated with being outed, or bringing shame to one's family, was also very distressing.

Implications for Policy and Practice

Currently, racialized SOGIE refugees in Canada are legally protected against discrimination based on race, sexuality, gender identity, religion, and national origin under the Canadian Human Rights Act (Bill C-16, 2016). Similarly, in Ontario racialized SOGIE refugees are legally protected from discrimination on the grounds of their citizenship, place of origin, gender identity and/or expression, and sexual orientation (Ontario Human Rights Commission, 2014). Although these protections exist, a further societal, cultural, and holistic level of protection is needed for racialized SOGIE refugees in Canada. This could remove anticipatory stressors by ensuring a greater sense of belonging, particularly in areas of employment and housing.

The findings presented in this paper indicate that further policy and community action must be taken regarding the mental health, well-being, and community inclusion of racialized SOGIE refugees. Racialized SOGIE refugees experience both explicit forms of stressors such as difficulty in finding work due to their status, and implicit stressors such as the anticipation of violence, prejudice, and stigma. It is up to policymakers to fund initiatives that would connect racialized SOGIE refugees to appropriate community services and programming, and help to eliminate the burden of anticipatory fear in hopes of improving well-being. This could be achieved by funding community-led initiatives and collaborating with relevant community stakeholders, such as researchers and activists interested in working alongside this group. The intersection of identities experienced by racialized SOGIE refugees must be considered when trying to make meaningful change for this group, and therefore an intersectionality-based policy analysis framework such as the one proposed by Hankivsky et al. (2014) should be adopted. This framework suggests policymakers follow a set of guiding principles including intersecting categories, diverse knowledges, and the role of power when implementing policies (Hankivsky et al. 2014). This would ensure that the community being served is more fully understood by decision-makers.

The findings also suggest that increasing opportunities for positive social experiences and community inclusion could improve mental health and well-being in racialized SOGIE refugees. SOGIE refugees often do not seek community support or local organizations out of fear of discrimination or stigma (Boles et al., 2018), and participants felt out of place upon arrival in Canada. Many did not appear to be aware of any existing social or mental health support groups and organizations. Therefore, it is recommended that policymakers support the creation and implementation of culturally-sensitive support services for SOGIE refugees – for example, a

support group run by peers, who share cultural, linguistic, and religious experiences. Logie et al. (2016) found that tailoring social support groups for LGBTQ+ newcomers can address social exclusion, in turn facilitating knowledge sharing, building friendships, and challenging stigma amongst this group. The authors suggest that tailored support groups may be significantly impactful in encouraging positive mental health and well-being across intrapersonal, interpersonal, community, and structural levels (Logie et al., 2016). It is suggested that services, such as support groups, be promoted using varied media approaches and word-of-mouth advertising, increasing public awareness of these services. Provincial and municipal organizations funded to support those who arrive based on SOGIE claims should be provided with additional resources to support this vulnerable group.

Further research may be done on the importance of preventing both proximal and distal stressors for racialized SOGIE refugees, with a particular emphasis on understanding and preventing anticipatory fear and stress. While there are many laws in place in both Canada and Ontario preventing direct acts of discrimination, the anticipation of prejudice alone was found to be highly distressing, clearly affecting well-being. It is recommended that mental health and counselling services be made more readily available and accessible for racialized SOGIE refugees, who often do not have the means to find or afford these services. It is our hope that our findings can inform service providers as well as provincial and municipal policymakers of the unique challenges and needs facing this group.

Strengths and Limitations

This qualitative study provided novel insights into the lived experiences of racialized SOGIE refugees. As such, it identified a variety of stressors that affect their mental health and well-being. The inclusion of other stakeholders allowed for more holistic insights into issues

facing SOGIE refugees. While our sample was small, it may have relevance in other similar settings, and can inform future research in different contexts.

Participants were sampled predominantly through word of mouth, community organizations, and electronic posters, therefore it is possible that only those with pre-existing access to organizations or community were recruited, and that we were unable to reach those not as well-connected. In addition, many of the participants spoke English as a second language, and in some instances, transcriptions had sections marked as unintelligible. Finally, most participants were cisgender, gay, and male, providing limited insights into the experiences of others.

Conclusion

In this study, distal stressors such as discrimination, and proximal stressors such as anticipatory fear and concealment of identity, influenced the mental health and well-being of racialized SOGIE refugees. The intersectional identities of racialized SOGIE refugees excludes them from multiple communities, inhibiting a sense of belonging upon arrival. In accordance with Meyer's (2003) Minority Stress Theory, the combination of minority stressors due to their marginalized identities and lack of social supports, led to negative consequences for their well-being. Understanding how to encourage positive mental health and well-being and remove minority stressors from the daily lives of racialized SOGIE refugees remain urgent priorities. Future studies should include a larger number of participants from a variety of sexualities, gender identities, ages, and geographical locations. Moreover, other protective factors that ensure positive mental health and well-being should be investigated, along with ways of facilitating community belonging and inclusion for racialized SOGIE refugees.

Appendix

Appendix A – Interview Guide for SOGIE Refugees

Part 1: General

1. What was life like for you in [home country] prior to coming to Canada?
    a. How safe did you feel in your home country?
2. What were the major factors in your decision to come to Canada?
3. Where do you feel a sense of belonging, if anywhere? (prompts: friendships, community organizations, social services volunteering, etc.)
    a. If they don't feel that they belong: What might help to generate feelings of belongingness?
4. How safe do you feel in Canada?
5. Where do you feel the safest? Why?
    a. What does "safe" mean to you? Safe from what?
    b. Where do you feel the least safe? Why?
6. Have you accessed support services?
    a. If yes, which kind (e.g., for newcomers, healthcare, mental health, etc.)
    b. If no, why not?
    c. Have you ever experienced any type of discrimination when accessing these support services you mentioned?
7. Are there barriers to being able to connect with others in the community?
8. Do you access any online resources where you get support?

Part 2: Integration into Society

1. How have you been spending your time since coming to Canada? Are you currently employed?
    a. If yes: How has your [insert identity here] affected your workplace experiences, if at all? How about your refugee status?
    b. If not, how are you supporting yourself?
2. Do you think your identity as [insert identity here] has impacted your job search? If so, how? Do you think your refugee status has impacted your job search? If so, how?
3. Do you feel settled in Canada?
4. Are you involved in your community [SOGIE or diasporic]?
    a. If yes, what kind of involvement?
    b. If no, are there ways you would like to be connected to/involved with your community?

Part 3: Well-being

1. How would you describe the current state of your well-being?
2. How do you think your settlement has influenced your well-being? By settlement we mean moving here and starting a new life.
3. Have you had any experiences when you felt you were treated unfairly or bad?
    a. **Follow-up:** How did you react at the time?
4. What good experiences have you had in Canada?
5. How do you think these experiences have influenced your well-being?
6. People often use activities and exercises to feel better. What do you do to maintain or increase your well-being?
    a. **For each strategy listed:**

i. Tell me about a time when you used this strategy?

ii. When did you start using this strategy?

iii. **Prompt:** How does this strategy impact your well-being? *(Use if the participant does not discuss how the strategy works for them)*

7. Who helps to increase your well-being? **Prompt:** For example, family, friends, community, etc.
8. Can you describe to me where you get social support in your life? Did you have similar support back in your home country?

Part 4: Healthcare

1. In one word, or a few words, how would you describe your experiences with accessing healthcare in Canada?
    a. ADDITIONAL PROMPT: **What sorts of characteristics do you appreciate in your healthcare professionals? (or, can you describe the characteristics of your favourite doctor or healthcare professional?)**
    b. ADDITIONAL PROMPT: **What makes you feel safe or comfortable in a healthcare setting?**
2. Now, could you tell me a bit more about your experiences accessing healthcare in Canada? (PROMPTS: What (other) kinds of healthcare do you access in Canada? Have you experienced barriers?)
3. As a [SOGIE] person, do you feel that your SOGIE status affects your experiences in the healthcare system? And how so?
4. As a refugee, do you feel that your status impacts your experiences in the healthcare system? And how so?

5. Could you pick one experience that stands out to you the most, positive or negative, and tell me about it more in depth? (PROMPT: What did you think about that? How did you feel about that? What did you do?)
6. Thanks for sharing that [negative, positive] experience. Do you have a [negative, positive] one you'd like to share as well?
7. What has helped you cope with or overcome negative experiences with healthcare if you've had any?
8. Have you had any experiences of feeling empowered or strong with regard to your healthcare? If so, what made you feel that way?

Appendix B – Interview Guide for Service Providers

1. Could you tell me a little about your role, and what you do at your job?
2. Is the term SOGIE familiar to you before this interview? Could you tell me what you know about these topics?
3. What comes to mind when you think about working with a SOGIE refugee?
4. What would you say the healthcare (or mental health) systems need to effectively provide services to SOGIE refugees?
5. Are there any policies in place at your work, your organization, or through your professional designation that apply specifically to SOGIE refugees? (e.g. diversity policy statement)

Appendix C – Thesis Proposal

Opening

Sexual orientation and gender identity are something that every person possesses, in as many variations and forms as there are human beings. However, certain genders and sexual orientations have become what many societies consider "normal", namely being cisgender (identifying with the gender assigned at birth) and heterosexual (being romantically and/or physically attracted to the opposite gender). The process of identifying only specific identities as "normal" creates a cis-normative and hetero-normative world that often persecutes many Two-Spirit, Lesbian, Gay, Bisexual, Transgender, and Queer (2SLGBTQ+) people (Mulé, 2020). Those fleeing their country of origin due to this persecution and violence – which includes but is not limited to assault, police brutality, imprisonment, and the death penalty – are known as diverse Sexual Orientation and Gender Identity and Expression (SOGIE) refugees (Ferreira & Dustin, 2017; Murray & Murray, 2020). It is important to note that the distinction between "normal" and "diverse" SOGIE is not an objective dichotomy, but rather one that was arbitrarily created due to the hetero- and cis-normative nature of many societies across the world. With Canada being one of the 42 countries that accept refugees on the basis of sexuality and gender as of 1990 (Mulé, 2020), an influx of SOGIE newcomers have entered the healthcare system over the past two decades. Moreover, Canada's mental healthcare system is an institution that often perpetuates discrimination and stigma towards SOGIE diverse people (Veltman & Chaimowitz, 2014) and negatively impacts mental health.

Within Canadian-born citizen groups – regardless of SOGIE status – those who are Black, Indigenous, and/or People of Colour (BIPOC) are more likely to experience higher levels of anxiety, stress, and depression than their white Canadian counterparts (Noh et al., 1999). The

poor mental health and wellbeing of Canadian racialized groups, in turn, puts BIPOC at a higher risk of suicide, addiction, and violence (Noh et al., 1999). While this also applies to BIPOC refugees and immigrants, those whose families have lived in what is now known as Canada for generations are affected as well – so much so that second-generation newcomers and beyond often face worsening higher rates of depression and psychosis, most likely due to combination of risk factors such as racism, colonialism, and inter-generational trauma (Hansson et al., 2012). And yet there is little pre-existing research regarding the exact rates of mental illness and the need for mental health services for the BIPOC community, despite visible racial minorities making up just under a quarter of the Canadian population (Government of Canada, 2017). This lack of literature extends to those with intersecting marginalized identities as well, with little information available regarding the mental health of those who have diverse SOGIE, are BIPOC, and claim refugee status.

The main objective of the proposed research is to examine the unique challenges and experiences of BIPOC SOGIE refugees navigating the mental healthcare system in Ontario. The purpose is to build on the missing literature surrounding the experiences with mental health and illness for those at the intersection of minority SOGIE, BIPOC, and refugee status to inform the next steps that may be taken by healthcare providers and policymakers. Given how BIPOC SOGIE refugees often face exclusion from multiple groups and communities at once, it is important to recognize how systemic structures such as racism, colonialism, hetero- and cis-normativity shape their lives and wellbeing once landed in Canada. Using a thematic analysis of the data gathered by the larger study "Innovative means for exploring SOGIE refugees life trajectories in the Canadian context" by Dr. Robb Travers, this nested study will declare the

importance of recognizing the unique positionality BIPOC SOGIE refugees hold in the Canadian context – in mental healthcare and beyond.

Literature Review

Out of the 195 countries in the world, 72 of them criminalize SOGIE diverse (2SLGBTQ+) people and their relationships, and as many as 11 impose the death penalty (Mendos, 2019). While there are currently no global estimates of how many people self-identify as SOGIE diverse, the Canadian Community Health Survey (CCHS) estimates that as many as 4% of Canadians over age 15 identify themselves as SOGIE diverse as of 2018 (Government of Canada, 2021), accounting for approximately 1 million people. These numbers are much higher when considering how census data often excludes large populations of people including Indigenous communities living in non-urban settings, and there are countless reasons why people (particularly those who are newcomers) would feel uncomfortable publicly disclosing their sexuality and/or gender to the government. Coupling this with the fact that at least 22.3% of Canadians identify as a visible, racialized minority (Government of Canada, 2017), this means hundreds of thousands (if not millions) of Canadians fall into the intersection of being BIPOC with diverse SOGIE – and yet, when analyzing the existing literature surrounding mental health, those at this unique intersection are often left out of the conversation. Moving forward, it is also important to note that there is very little information on how many Indigenous people in Canada identify as Two-Spirit (2S), since information collected by the Canadian government is done so through a colonial lens, using the English language and its definitions for sexuality, gender, and expression. Coupling the lack of sufficient data with the fact that Indigenous people are often excluded from Canada's census definition of visibly racialized (Noh, 1999; Government of

Canada, 2017), research regarding Indigenous and 2S mental health and wellbeing is severely lacking.

To address the issue of poor mental health and wellbeing of BIPOC SOGIE newcomers in Canada, we must first understand how the barriers to access are often put into place through dominating systems of power – systemic homophobia, transphobia, colonialism, and racism. The following literature review and subsequent research hopes to uncover the unique mental healthcare challenges faced by BIPOC SOGIE refugees by applying a transformative paradigm and intersectional lens. As researchers, it is important to practice reflexivity throughout our work and understand that our own unique identities and experiences shape how we collect and conduct research. The current dominant positivist paradigm set in place in society leaves very little room for BIPOC, 2SLGBTQ+, poor, disabled, and otherwise marginalized researchers to allow their voices to be heard, let alone non-academics belonging to those communities. Mertens (2003) states that within the transformative paradigm, "[t]he role of the researcher in this context is reframed as one who recognizes inequalities and injustices in society and strives to challenge the status quo, who is a bit of a provocateur with overtones of humility, and who possesses a shared sense of responsibility" (p. 212). Therefore, the purpose of research is not only to achieve social justice as an end goal, but to pursue the research as a contribution to social justice. Moving forward in this framework, applying an intersectional lens allows me to consider the numerous social determinants of mental health, such as the effects of colonialism, capitalism, globalization, and neoliberalism on the marginalized identities of those I wish to serve. Not only do BIPOC SOGIE refugees face unique barriers from each aspect of their identities, but the combination of these identities create new challenges that must be considered. In the following literature review, I will be summarizing each of these unique barriers from my established framework before using

the pre-existing literature to paint a picture of what is missing when applying an intersectional lens.

Canadian Mental Healthcare System. As of 2010, it is estimated that 22.7% of people worldwide – or 1.77 billion people – deal with mental and behavioural disorders (Becker & Kleinman, 2013). Even as public understanding of the biological nature of mental health and illness is increasing, social acceptance is not yet on the rise, and social rejection of mentally ill people has remained starkly steady over the past 20 years (Schomerus et al., 2012). Despite Canada priding itself for being a forward-thinking country with respect to mental healthcare, only 40% of Canadians with a self-reported mental illness access mental healthcare (Lesage, 2006). One of the most common reasons cited for not doing so is lack of resources, access, and support – not to mention mental healthcare is not financially covered under Canada's universal healthcare system. Even though Canada spends 5% of its total public spending on mental health (Jacobs et al., 2008), those who are less privileged consistently struggle to access mental healthcare, whether due to low SES, lack of reliable transportation, or being turned away due to their identities. Of the Canadian respondents who have not had their mental healthcare needs met, just under 20% cited language barriers and an astonishing 78.2% cited personal circumstances such as not being able to afford care (Government of Canada, 2019). Given that good mental wellbeing and positive mental health yields a higher overall quality of life (Barry, 2009), it is clear that mental healthcare being accessible only to some Canadians is a pressing issue that must be addressed.

It is also incredibly important to note that outside of the necessity for immediate care, there are countless social determinants of mental health that necessitate future care in certain groups of Canadians more than others. There have been many studies showing a direct link

between discrimination and poor mental health, particularly for those who are in the ethnic, sexual, gender, or class minority of a population (Berger & Sarnyai, 2015; Lee et al., 2016; Noh et al., 1999; Pascoe & Richman, 2009). This relationship is often exacerbated by those discriminated against in multiple ways, namely those Canadians who are Black, Indigenous, racialized, SOGIE diverse, and so on.

Mental Health of SOGIE Diverse Canadians. Those who are SOGIE diverse have higher rates of mental health problems such as depression, anxiety, and suicide when compared to their heterosexual and cisgender counterparts across the world (Collins et al., 2011; Kidd et al., 2016; Meyer, 2003; Ross et al., 2018; Steele et al., 2016). In a literature review, Kidd et al. (2016) found that both depressive episodes and suicide attempts are higher for SOGIE diverse people across a total of 27 publications. The authors also noticed that this population is less likely to note service satisfaction in mental health services, has a harder time finding spaces where one can be out, and has a higher chance of developing mental illness due to the link between discrimination and risk of poor mental health outcomes.

Similarly, Simeonov et al. (2015) found that in more ways than one, SOGIE diverse people – and transgender people in particular – are not receiving the mental healthcare they need. While it may be easy to shift blame onto patients, the lack of mental healthcare received is not necessarily due to lack of trying. Upon finally being paired with a mental healthcare provider, 23.1% and 11.4% of SOGIE diverse people were told their sexuality and gender were just a phase, respectively. As well, recently as many as 26.9% of 2SLGBQ+ and 31.4% of transgender patients in Ontario have been made to feel directly unsafe by their mental healthcare provider (Simeonov et al., 2015). These startling statistics make it clear once more that mental healthcare providers in Ontario – and more broadly, Canada – do not always have the knowledge,

education, or respect necessary to provide adequate care to marginalized populations like those with minority SOGIE identities. While some may not consider this a barrier to access because the services are *technically* being accessed, it is the lack of *appropriate* and *safe* mental healthcare that makes the experience inaccessible.

Mental Health of BIPOC Canadians. In a literature review across 229 papers, Hansson et al. (2012) found that most research conducted in Canada amongst BIPOC populations are incredibly varied, only take place in major urban cities, and often leave out non-immigrant racialized groups such as Indigenous people. These limitations mean that BIPOC mental health research (much like diverse SOGIE and/or refugee research) is not encompassing of the diverse populations that exist. Keeping this in mind, Hansson et al. (2012) found that compared to the 6.2% of immigrant and 8.3% of non-immigrant white Canadians with depression, Ethiopian, Chinese, Vietnamese, South Asian, and Latin American Canadians were all more likely to be diagnosed with a lifetime depressive disorder. These numbers were, unsurprisingly, even higher for non-immigrant racialized refugees (Hansson et al., 2012).

Fante-Coleman and Jackson-Best (2020) found that Black youth in Canada are particularly likely to develop poor mental health due to social determinants of health including racism, poverty, and social exclusion. If Black youth are unable to access the mental healthcare they need, they are also more likely to do poorly in school, face family conflict, and interact negatively with the social justice systems in ways that include higher rates of incarceration and policing (Fante-Coleman & Jackson-Best, 2020). Given that the Black population of Canada makes up 3.5% of the total population (Government of Canada, 2017), it is particularly worrying how Black youth are six times more likely to die by suicide due to depression compared to their white counterparts, and are less likely to receive adequate mental healthcare in outpatient clinics

(Williams et al., 2007). While many Canadians still believe anti-Blackness is an American problem that does not occur in Canada (P. J. Hudson & McKittrick, 2014), the over-policing of Black bodies and increased rates of undiagnosed mental illness clearly shows how anti-Blackness, colourism, and racism plays a huge role in the Canadian mental healthcare system.

While the effects of colonialism and racism on Indigenous mental health in Canada are being ongoingly reviewed, of the 370 million Indigenous people globally, disproportionately poorer mental health and wellbeing is found (Nelson & Wilson, 2017). While each population of Indigenous people is incredibly diverse, the commonality Indigenous and Aboriginal people face worldwide is the experience of colonialism. While rates vary drastically per population, Canadian Indigenous people are more likely than non-Indigenous people to experience suicidality and emotional distress – most likely due to ongoing discrimination, intergenerational trauma from colonialism and White supremacy, and the lasting effects of residential schools (Elias et al., 2012). Therefore, when discussing mental health and wellbeing, structural systems such as colonialism and white supremacy cannot be ignored.

When looking at the mental health of BIPOC Canadians – particularly those who are Black and/or Indigenous – the institutional effects of racism, colonialism, and white supremacy becomes clear. However, what many of the articles in question fail to address is how many BIPOC Canadians may also be SOGIE diverse, poor, disabled, or fall under other marginalized identities that uniquely add to worsening mental health. The lack of literature describing how one's unique identities play a large role in determining their health leads me to further believe now, more than ever, a critical intersectional lens must be considered when pursuing this research.

Refugee Mental Health in Canada. Much like BIPOC populations in Canada, newcomers such as refugees and immigrants are often marginalized in more ways than one. While Statistics Canada reports that most newcomers to Canada have better-than-average health, their overall health is shown to deteriorate greatly upon arrival (Government of Canada, 2005). Unsurprisingly, non-European and racialized newcomers have the largest rates of deteriorating health, whether they recently arrived in Canada or have resided long-term. Compared to the 16% of white Canadians and 32% of immigrants who live in the lowest bracket of health, the amount of refugees living in this same bracket is 45% (Government of Canada, 2017). When specifically investigating mental health, less than 68% of refugees self-report high mental health standing compared to 72.1% of Canadian-born respondents (Government of Canada, 2020). Those arriving from countries in Western, Middle-Eastern, and Eastern Asia report high mental health standing only 62% of the time. Hynie (2018) found that some of the most prevalent social determinants of refugee mental health in Canada were income, employment, housing, language skills, social support and isolation, and discrimination. It was found that discrimination is one of the main predictors, with persistent experiences of discrimination upon landing in Canada associated with higher levels of stress, anxiety, and depression. Moreover, there is a high prevalence of pre-existing Post-Traumatic Stress Disorder (PTSD) in refugees fleeing violence and trauma, and it has been found that elevated rates of mood disorders and psychotic illnesses are most common in refugee populations compared to other newcomers or permanent residents (Hynie, 2018).

In a systemic review of 138 studies, Mawani (2014) also found a strong relationship between experiences of discrimination and refugee mental health. When considering self-reported experiences of racism, demographic factors, SES, and pre-existing health risk factors,

they found a strong link between poor mental health and systemic, institutional, and individual discrimination. However, Mawani (2014) also points out there is a large gap in the literature regarding the *ways* discrimination influences mental health and wellbeing – whether it be direct or indirect. The author also points out how refugees often flee their countries of origin on the basis of discrimination and how facing discrimination upon landing in Canada can be a re-traumatizing experience that may or may not be the root cause of worsening mental health conditions. Given that most BIPOC refugees arrive from countries that are not white-majority, experiencing institutionalized *and* daily instances of racism upon arrival in Canada can be particularly traumatizing.

Experiences of Being a SOGIE Refugee. Many systemic barriers are currently in place that prevent both refugees and SOGIE diverse people from accessing healthcare – so much so that many SOGIE refugees face severely worsening mental health conditions when moving to Canada (Mulé, 2020). Fox et al. (2020) found that, similarly to results yielded for SOGIE diverse Canadians, SOGIE refugees have high levels of mental stress – as many as 80.2% screened positive for distress in 2020. Social isolation, being a contributing factor to poor mental health, also resulted in particularly high mental distress for refugees when coupled with minority SOGIE status. Upon arrival, refugees often live under the poverty line, do not have access to stable transportation, and struggle to land jobs since their educational or trade backgrounds are nullified. This makes it incredibly difficult to access healthcare, especially when OHIP-based services often require an English speaker. Upon the ability to be connected to a healthcare provider, SOGIE refugees are in a particularly unique situation since revealing one's sexuality and/or gender identity is often vital to both physical and mental health. However, given that SOGIE refugees are fleeing countries of origin where this is often illegal or discouraged, being

open with a primary care physician or mental healthcare provider can be far more difficult than it is for 2SLGBTQ+ Canadian-born citizens.

Instances of Discrimination for Refugees. The most common place refugees face a variety of discrimination – whether it be for their race, religion, language, or SOGIE status and beyond – is the workplace. As many as 56% of refugees are discriminated against either in the employment process or once employed (Government of Canada, 2003), which may be a huge deterrent for seeking out employment upon arrival. Given that holding a stable job is also directly linked to positive mental wellbeing (Hynie, 2018), this can be a double-edged sword for refugees. On one hand, they can seek out work in hopes of avoiding poverty and low SES, which leads to poor mental health. On the other hand, landing employment might put them in the direct face of discrimination, also leading to poor mental health. With SOGIE diverse, racialized, or refugee communities in Canada facing so many hurdles they must overcome to ensure better mental wellbeing, the lack of research on the hardships faced by those with intersections in *all* groups make it clear that work needs to be done.

In a systemic review of 138 studies, Mawani (2014) also found a strong relationship between experiences of discrimination and refugee mental health. When considering self-reported experiences of racism, demographic factors, SES, and pre-existing health risk factors, a strong link between systemic, institutional, and individual discrimination and poor mental health was found. However, Mawani (2014) also points out there is a large gap in the literature in the *ways* discrimination influences mental health and wellbeing – whether it be direct or indirect. The author also points out how refugees often flee their countries of origin based on discrimination, and how facing discrimination upon landing in Canada can be a re-traumatizing experience that may or may not be the root cause of worsening mental health conditions. The

most common place refugees face a variety of discrimination – whether it be for their race, religion, language, or SOGIE status and beyond – is the workplace. As many as 56% of refugees are discriminated against either in the employment process or once employed (Government of Canada, 2003), which may be a huge deterrent for seeking out employment upon arrival. Given that holding a stable job is also directly linked to positive mental wellbeing (Hynie, 2018), this can be a double-edged sword for refugees. On one hand, they can seek out work in hopes of avoiding poverty and low SES, which leads to poor mental health. On the other hand, landing employment might put them in the direct face of discrimination, also leading to poor mental health. With both 2SLGBTQ+ people and refugees in Canada facing numerous hurdles they must overcome in hopes of better mental wellbeing, the lack of research on the hardships faced by those with intersections in *both* groups make it clear that work needs to be done.

Experiences of Being at the Intersection of BIPOC and SOGIE Diverse. Given how members of diverse SOGIE as well as racialized populations face unique areas of discrimination and challenges, it comes without a surprise that those who are *both* BIPOC and SOGIE diverse are ostracized from not only the broader Canadian society, but their own communities as well. Giwa and Greensmith (2012) found strong evidence that racism heavily exists within Canada's SOGIE diverse communities – a fact that is unsurprising when considering how much of Canada's 2SLGBTQ+ community is predominantly white. This can result in racist interactions within the SOGIE diverse community, and "safe" spaces for 2SLGBTQ+ Canadians being filled with anti-Black, anti-Indigenous, anti-Asian, anti-Latinx, and anti-Muslim sentiments. Those who are already marginalized due to their race often have to advocate for their existence so often, leading to rampant homophobia and transphobia in BIPOC communities in Canada, particularly immigrant or newcomer communities (Balsam et al., 2011). Even in my own

experiences, it is not uncommon to hear arguments such as "you're already racialized, why make your life harder" or "you can't be BIPOC and 2SLGBTQ+, pick a fight!". Those who are BIPOC and SOGIE diverse often find their experiences of *both* is what particularly impacts the degree in which they feel a sense of belonging in communities (Hudson, 2015). The same respondents often cited the lack of intersectional awareness of *others* as one of the largest factors inhibiting their belonging in a community. By not finding safety or community belonging in either the SOGIE diverse *or* BIPOC communities, those who hold both identities are particularly ostracized, alienated, and lonely – all factors that lead to worsening mental health conditions (Giwa & Greensmith, 2012).

Experiences at the Intersection of being BIPOC and a Refugee. Canada has been one of the countries that prides itself not only in its multiculturalism, but also as one of the consistently highest countries to accept refugee resettlements (Ghahari et al., 2020). However, the global boasting of a "culture mosaic" from the Canadian government does not necessarily mean that refugees feel welcomed upon their arrival. When the Liberal government opened up Canada's borders to an influx of over 50,000 Syrian refugees in 2015, there was a large polarization in Canadians' views on refugees (McMurdo, 2016). While many Canadians were pleased with the initiative of taking in refugees fleeing war, recent attacks in Paris and Brussels led to more and more Canadians feeling uneasy towards "Muslims" entering their country, regardless of the actual religious beliefs of Syrian refugees (McMurdo, 2016). This led to the creation of a societal image of what a "good refugee" should look and behave like – vulnerable, helpless, and lacking individual agency, rather than a hyper-violent, radical, Muslim refugee (Olsen et al., 2016). Therefore, any racialized refugees coming into Canada in the late 2010s – Syrian or not – were subject to severe "othering", particularly if they were Muslim, darker

skinned, or Arabic-speaking (Oudshoorn et al., 2019). This country wide othering did not just apply to individual instances of racism or Islamophobia, but trickled down into the housing sector so much so that landlords would deny, ignore, or discriminate against potential refugee tenants (Oudshoorn et al., 2019). Given how stable housing and resettlement is key for preventing mental health challenges in refugees (Esses et al., 2017), being a visibly Muslim and/or racialized refugee in Canada leads to greater risk of developing mental illness due to discrimination, on top of the already higher-risk prevalence of pre-existing PTSD, distress, and grief (Roberts et al., 2020). Considering how many racialized Canadians – newcomer or not – are uncomfortable discussing or seeking out mental healthcare in Western environments (Hansen & Huston, 2016), refugees who *also* have language barriers, cultural barriers, or are worried about being the "good refugee" are less likely to discuss their unique feelings of distress and isolation in a new environment.

Experiences at the Intersection of being BIPOC, SOGIE Diverse, and a Refugee.

Given the unique challenges that have already been explored for those who are SOGIE diverse, BIPOC, and refugees, the next step for ensuring adequate mental healthcare for those who face *all* these intersections of marginalized identities would be to piece together gaps in the literature. So far, there have been very few studies that look at race, gender, sexuality, and newcomer status, with a few articles existing that collect this information but not necessarily as the purpose of the research. Boles et al. (2018) and the OutLook study team found that when compared to the Canadian population, only 47% of racialized newcomers and 54% of non-racialized newcomers have come out to their healthcare provider about their gender and/or sexuality – in contrast, 55% of Canadian-born participants have. Not only does this show how those with diverse SOGIE are at a disadvantage, with at least 45% of *all* 2SLGBTQ+ people in Ontario not feeling safe enough

to reveal their identity – but being at the intersections of refugee, SOGIE diverse, and BIPOC puts people at a particular disadvantage. When not directly considering SOGIE status, the OutLook study also found that 33% of both Canadian-born respondents and non-racialized newcomers have accessed a private counsellor in the last 24 months, with this number being only 11% for racialized newcomers (Boles et al., 2018). This further solidifies how holding multiple marginalized identities results in mental health disadvantages.

Although not directly investigating the mental healthcare implications, Jasbir Puar coined the term "homonationalism" to describe how the SOGIE diverse community often aligns itself with other power structures including racism, xenophobia, and Islamophobia (Puar, 2007). Paur (2007) posits that homonationalist 2SLGBTQ+ communities use sexual diversity as a tool to align with governments, states, or large power structures, taking political stances *against* immigration and diversity. The "proper homo", as she states, then becomes someone who is white, a nationalist/patriot, Christian, and other Western ideals who also just so happens to be SOGIE diverse. Rinaldi & Fernando (2019) go on to further build on this while also considering the capitalist and colonial implications of living in a homonationalist state such as Canada. By subscribing to the nuclear, capitalist queer family ideal, colonialism and white supremacy are further upheld; those who are BIPOC (particularly Indigenous) and do not live their lives in hopes to assimilate and provide for the Canadian economy can be considered "inauthentic queers" (Rinaldi & Fernando, 2019). Therefore, many BIPOC SOGIE refugees do not fit into the homonationalist mold of what it means to be a "good refugee" and an "authentic queer". This may amplify the feeling of being an outsider for BIPOC SOGIE refugees, as they do not fit into the mold of what racialized, SOGIE diverse, and/or newcomers should "look like" upon arrival. They are neither treated as "properly" sexual or racial minorities, nor are they treated as "proper"

Canadians. As said by one of my favourite scholar-activists Sara Ahmed, BIPOC SOGIE refugees are out of place, as they do not belong to Western Canadian nor queer communities (Ahmed, 2006).

Conclusion. As mentioned earlier, there are currently many gaps in the literature surrounding the unique experiences BIPOC SOGIE refugees face in accessing adequate mental healthcare. To begin, there are no comprehensive studies that clearly outline the unique experiences of being BIPOC, SOGIE diverse, *and* a refugee when accessing health – most either focus on barriers from either aspect of marginalization. It is often also difficult to survey and find BIPOC SOGIE refugees who are interested in discussing their negative experiences thus far in Canada, as newcomers are often encouraged to be grateful to the countries who grant them asylum (Schwöbel-Patel & Ozkaramanli, 2017). There have also been no policies, laws, or initiatives on the government level that provide resources for healthcare providers (include those in mental healthcare) serving BIPOC SOGIE refugee populations, and resources for BIPOC SOGIE refugees themselves. The next steps for researchers to take would be to adequately support Canadian BIPOC SOGIE refugee populations by 1) identifying barriers to accessing mental healthcare, 2) working to reduce, diminish, or eliminate those barriers, and 3) working *alongside* SOGIE refugee populations to ensure their needs are being met.

To conclude, BIPOC SOGIE refugees and the broader BIPOC SOGIE diverse Canadian population face many adversaries when facing mental health challenges, as well as attempting to access mental healthcare. Given how discrimination, lack of community belonging, stigma, and structural systems of oppression all play a significant role as social determinants of mental health (Fox et al., 2020; Hynie, 2018; Mawani, 2014), those who belong to each of these marginalized communities but feel safe in none are at a higher risk of developing mental illness or poor mental

health. Moving forward it is particularly important to keep an intersectional lens at the forefront of up-and-coming research, to ensure that unique challenges and lived experiences are considered. By doing this research for the sake of social justice and change, as done in the transformative paradigm, we can ensure moving forward that the inaccessible nature of the Ontario (and Canada) mental healthcare system will no longer be ignored, and meaningful change can be made for those who are SOGIE diverse, BIPOC, and/or refugees.

Theoretical Frameworks

To better address the unique mental health needs of BIPOC SOGIE refugees, the following theories will be used to identify the gaps in the literature moving forward: structural violence, ecological systems theory, and minority stress theory. While each of these theories can play a significant role in understanding what makes the experiences of BIPOC SOGIE refugees so specific, it is their interconnectedness that gives us the ability to understand how larger systems of power play a role on the mental, physical, and emotional wellbeing of this group of people – whether directly or indirectly.

Structural Violence. Johan Galtung coined the term "structural violence" in the late 1960's to reshape how researchers, sociologists, and social scientists critically thought about violence. Up until that point, many academics had considered violence and violent acts to be direct, and between an actor (perpetrator) and "victim". To contrast this way of thinking, Galtung (1969) proposed that social structures or systems preventing people or citizens from meeting their basic needs was a form of structural violence. For instance, police brutality, forced poverty, and hate crimes would all be examples of how violence can go beyond smaller instances. Galtung (1975) broke structural violence into four broad categories: "classical" violence (i.e. homicide), deprival of basic material needs (poverty), deprival of human rights (repression), and

deprival of higher needs (alienation). Therefore, governments or other large-scale organizations/systems that inflict avoidable impairment of fundamental human rights or needs can be thought of as structurally violent systems – including but not limited to racism, colonialism, sexism, classism, and more (Galtung, 1993).

When considering the barriers to accessing appropriate mental healthcare for BIPOC SOGIE refugees, the inaccessibility of Ontario's (and Canada's) healthcare system can be considered structurally violent based on Galtung's ideology. Even in the absence of "classical", direct violence, the system preventing those who are poor, disabled, homeless, non-English speakers, and beyond is an act of violence. While violence is often conceptualized as "physical" (even when considering structural violence – i.e. the physical implications of living in poverty in a "developed" country), Galtung (1969) goes on to describe how *all* forms of violence can also be psychological in nature. When considering how BIPOC SOGIE refugees are more likely to experience instances of racism, colonialism, and anti-newcomer sentiments from Ontario's diverse SOGIE community, homophobia and transphobia from the newcomer community, and general experiences of Islamophobia and hatred from non-newcomer Canadians, it is especially important to realize that structural violence occurs in every aspect of their lives. If the effects of structural violence and lived experiences are not considered in every step of the mental healthcare system, patients are not guaranteed to receive the best informed care necessary – another layer of structural violence in itself. Even in "developed" countries such as Canada, patients whose unique mental health needs are looked over are more likely to have a lower life expectancy than the average Canadian by as many as 15-25 years (National Academies of Sciences et al., 2017), which goes to shows how intertwined psychological and physical violence truly are.

Ecological Systems Theory. When trying to further understand the effect one's environment has on their day to day lives, the Ecological Systems Theory posited by Bronfenbrenner (1992) allows us to investigate this by applying a multilevel analysis. The Ecological Systems Theory considers every individual to be a part of a broader "ecosystem". Surrounding an individual are five systems: the microsystem, mesosystem, macrosystem, exosystem, and chronosystem *(*Bronfenbrenner, 1992*)*. When we apply this model to BIPOC SOGIE diverse people across the world, we can think of each person to be the center of their ecosystem, while considering their age and key demographics such as gender, race, and SES that may put them at an intersection of marginalization. Surrounding them would be smaller scale systems, such as family, peers, and social workers (micro- and mesosystems), gradually expanding to include many of the large-scale systems that affect their daily lives, such as stigma and discrimination (macro- and exosystems). When considering the mental health and wellbeing of BIPOC SOGIE people, we can use the Ecological Systems Theory to better understand why everyone's unique identities allow them to have a completely different experience navigating their lives.

To better understand this, we can use a (fictional) case study of someone who is SOGIE diverse in Syria and is considering moving to Canada. While our fictional individual resides in Syria, we would see that their macrosystem would be quite different than it would in Canada. To begin, societal attitudes towards SOGIE diverse people in Syria are shaped – at least in part – by the fact that Islam is the predominant religion, compared to Christianity for Canada. While homosexuality, homosexual acts, and same-sex marriage are illegal in Syria (Mendos, 2019), being transgender is legally acceptable under the Qur'an. Therefore, while living in Syria, someone who is LGBQ+ may be negatively affected by their macrosystem, while someone who

is non-cisgender may not. However, societal *attitudes* outside of the law (i.e. someone's exosystem) may be negative in both situations. Their micro- and mesosystems would most likely be unsupportive as well, however, this would be particularly dependent on the specific attitudes and beliefs of their religious center, peers, family, and so on. If our fictional individual were to seek refuge in Canada under SOGIE status, their ecosystem would drastically change. While Canada is often considered a "safe-haven" for 2SLGBTQ+ people for reasons mentioned earlier in this literature review (Mulé, 2020), individual attitudes towards being non-heterosexual and non-cisgender would still create tension between the macrosystem, exosystem, and beyond. With the fact that our individual is also now a refugee, coupled with them also being racialized, Muslim, not speaking English as their first language, and struggling with their SES as a newcomer, there may be a complete lack of support in their ecosystem due to racism, Islamophobia, classism, and xenophobia *coupled* with pre-existing homo- and transphobia.

Using Bronfenbrenner (1992) to guide our understanding of one's environment and circumstances, we can see that there is no clear "good" or clear "bad" place for SOGIE diverse people to live. Many countries will have their pros and cons, and it is up to each individual to decide (as well as their ability to decide or lack thereof) what a "safe haven" looks like to them. While Western perspectives often center themselves as being "ideal" for the wellbeing of SOGIE diverse citizens, the unique intersection of marginalization each person faces around the globe is what determines their reality – more often than not, those who are BIPOC (particularly Black or Indigenous in Canada) and not "from" Canada are not considered to be ideal at all.

Minority Stress Theory. Meyer (1995) coined the term *minority stress* to apply to gay men living in a world full of stressors caused by heterosexism, "an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behaviour, identity,

relationship, or community" (Herek, 1990). Since publishing his first paper, Meyer (2003) has since gone on to discuss how minority stress may also be applied to all people who identify as Lesbian, Gay, and Bisexual (LGB) and face heterosexism in any of its forms. SOGIE diverse people and identities are becoming more understood across the world, minority stress has begun to apply to those across the 2SLGBTQ+ spectrum, encompassing more than just cisgender, American LGB people. Minority stress theory now can be applied to those with other marginalized identities, namely race, SES, and disability.

While direct forms of violence against SOGIE diverse people have been documented and addressed by scholars for decades, Meyer argues that the stress of stigmatization, discrimination, and violence against SOGIE diverse people may lead to severe distress, even in the absence of direct interpersonal harm (Meyer, 1995). When coupling this ideology with structural violence, we can see that whether "direct" confrontation or violence is taking place, distress in itself can be categorized as psychological violence. Those who are at the intersection of marginalized identities, such as BIPOC SOGIE refugees, are even more likely to have poor beliefs on their self-identity, either from being constantly told so or believing so due to stigma, making it incredibly difficult to create any healthy peer relationships (Radkowsky & Siegel, 1997) and adjust psychologically throughout life (Hetrick & Martin, 1987).

To dive deeper into the parallels between minority stress theory and structural violence, we can visualize this combination of stressors using the Minority Stress Model by Meyer (2003). While every single person of any minority identity would face general stressors such as the death of a loved one or unemployment, or events of minority prejudice, stigma, and discrimination such as employment discrimination, those who identify as a gender, sexuality, or racial minority face further internal stressors such as internalized homophobia or colourism. While this may lead

people to place individual blame on those who deal with proximal, internal stressors, it is systems of structural violence in themselves that reinforce this belief across the globe.

Objectives

Given that the Canadian government and population are becoming more and more aware of the importance of positive mental health and wellbeing, it is crucial that populations and communities at the margins of oppression are not being left behind. The nested research project proposed would accomplish this by analyzing interviews collected by Drs. Todd Coleman and Robb Travers, under the larger project "Innovative means for exploring SOGIE refugees' life trajectories in the Canadian context". The two objectives of the broader study will be to 1) examine the diverse, intersectional life experiences of SOGIE refugees and 2) identify barriers, challenges, and opportunities at individual, community, and structural levels for SOGIE refugees to arriving in Canada.

The objective of this exploratory, nested research is to explore the mental healthcare experience specifically of BIPOC SOGIE refugee community in Ontario. By analyzing the data collected from the larger research project through a transformational paradigm, the beginning and end goal of this research is to specifically understand the mental healthcare issues experienced by this unique group of people, what barriers they may need to overcome to access mental healthcare, and what steps should and can be taken to improve the current system(s) in place. Through this project, researchers, academics, healthcare workers, and the broader community will gain a wider understanding of the impact mental healthcare has on visibly racialized SOGIE refugees in Ontario through the dissemination of any knowledge found (see below). By gaining both awareness and knowledge, improved policy and frontline service can be

put in place to protect the right to effective mental healthcare for this group, with hopes to also improve the wellbeing of Canadian citizens who are also BIPOC and SOGIE diverse.

Research Questions

Although research and literature currently exist surrounding the mental health needs of individual marginalized groups of people, there is still a severe gap in knowledge regarding the unique challenges faced by those marginalized in multiple ways. Given that SOGIE diverse, BIPOC, and refugees all experience inadequate mental healthcare on a structural *and* individual basis, work must be done to determine how layering these identities takes a toll on mental health and wellbeing. The primary research questions include: how do BIPOC SOGIE refugees describe their experiences in the Ontario mental healthcare system, and from these experiences, what unique barriers and facilitators to access can be identified? By discovering what barriers and gaps they may need to overcome to access mental healthcare services, it can be determined what steps should and can be taken to improve the current system(s) by applying intersectionality and transformative lens. Therefore, this research is significant as it is being conducted not only with the goal of addressing this lack of research, but to assert the importance of conducting research in the continuous pursuit of social justice for those intersectionally marginalized.

Methods

Study. As this study is nested under the work of the Social Inclusion and Health Equity committee, results for this analysis will come from the broader study, “Innovative means for exploring SOGIE refugees' life trajectories in the Canadian context” under principal investigation by Dr. Robb Travers of Wilfrid Laurier University’s Faculty of Science. This encompassing study collected data in four main topics: refugee experience, integration to society, wellbeing, and healthcare. To achieve this data collection, a semi-structured interview process

was implemented, where SOGIE refugees and Ontario service providers were asked specific questions. The interview process may have been tailored to each participant's needs by addressing only relevant questions if necessary, as the interviewer may stray from the set of questions if they see fit.

Setting. The present study is being conducted in Waterloo, Ontario on the traditional lands of the Anishinaabe, Haudenosaunee, Mississauga, and Neutral peoples protected by the Haldimand Tract Treaty. Waterloo is a mixed urban-rural region, 100 kilometres west of Toronto.

Sampling Procedures. Eligible SOGIE refugee research participants must: 1) have obtained refugee status in Canada within the last 10 years, 2) be over the age of 16, and 3) identify under the SOGIE umbrella in some capacity. Eligible service providers must: 1) be over the age of 18, 2) be a service provider in policy, healthcare, and/or mental health in Ontario, and 3) worked with SOGIE refugees for over one year. Eligibility was determined based on a screening form before the interviews were conducted, where participants were encouraged to self-identify in any way(s) they seem fit, i.e., ethnicity, age, sexuality, gender, and socioeconomic status. To thoroughly ensure eligibility, the researcher(s) also asked the participant(s) to self-identify during the interview process as needed. Participants were recruited through Ontario organizations that serve 2SLGBTQ+ and immigrant, newcomer, and refugee populations – such as OCASI. This method of searching for participants that are especially knowledgeable and have lived experiences within a topic of interest is known as purposeful sampling (Palinkas et al., 2015). In addition, snowball sampling, the method of using current or past participants to recruit future participants by word of mouth (Naderifar et al., 2017), and recruitment via electronic posters and social media were used as well. A total of 11 BIPOC SOGIE refugees, as well as 4 Ontario service providers, were recruited for the current study from a wide variety of ages, races,

genders, sexualities, and backgrounds. Heterogeneity of the sample ensured that the impact of intersectional identities – such as race and SOGIE status – on experiences in the mental healthcare system were effectively captured. Informed consent was collected before the interview process using an electronic consent form cleared by the Research Ethics Board (REB) of Canada, as well as at the beginning of each interview. The consent forms outline the general interview themes and processes and outline that all participants are ensured privacy.

Interview Structure. The interviews were semi-structured, with a set of questions available to the interviewer alongside additional prompts that may or may not be rigidly followed depending on the rapport built. The interviews took place over the span of anywhere from an hour to two hours and beyond, depending on how much information and data the interviewee was comfortable sharing during the process. Some sample interview questions are: 1. What are some things you look for in a healthcare provider?; 2. As someone with SOGIE status, how would you describe your healthcare experiences before moving to Canada?; 3. What can a healthcare provider do to make you feel empowered? Safe?

Interviews will have audio recorded with the consent of the participant. For the current study, only specific questions will be chosen for analysis across the four domains for BIPOC SOGIE refugees *(Appendix A).* Further, a smaller, more specific subset of questions will be chosen for analysis for service providers *(Appendix B)*.

Analysis. All interviews will be transcribed verbatim by members of the research team, research assistants, and/or an external transcription company "Transcript Heroes". Identifying information will be anonymized, and participants will only be referred to by their identification numbers pre-assigned to each participant. The audio recordings will be kept confidential throughout the process and destroyed when completed. As mentioned above, only the responses from the subset

of questions will be transcribed for analysis. These transcriptions will then be coded using QSR-International NVIVO 12 software to identify key recurring themes, phrases, and ideas. Codes will be developed based on themes in the literature regarding similar topics in qualitative research, and discussions amongst the research team. Once coding is completed, thematic analysis will be informed using a transformative paradigm. The transformative paradigm, as explained by Mertens (2007), is a metaphysical construct (in other words, worldview) that provides a framework for addressing social justice, oppression, and power in every aspect of research. From the creation of a research question, to methodological decisions, data collection, and beyond, researchers in this context must recognize inequality, injustice, and status quo in society while hoping to challenge and eventually overcome them (Mertens, 2007). The four pillars of the transformative paradigm – ontology, epistemology, methodology, and axiology – will be used throughout the analysis.

The transcribed data will be analyzed using thematic analysis and will be conducted in accordance with the six steps laid out by Braun and Clarke (2006). While these steps (also known as phases) create a general framework to be followed, it is important to note that the authors point out that thematic analysis is not a linear, but rather recursive process (Braun & Clarke, 2006). Therefore, the following phases will be followed during the analysis process, going back and forth between the six as necessary:

1. **Phase 1: Familiarizing Yourself with the Data.** As the data will be transcribed prior to the analysis, data immersion can begin immediately. While reading through the transcribed interviews, a researcher journal will be kept with notes pertaining to any important patterns and ideas that are reoccurring, as well as my own thoughts regarding the data. Once thoroughly read through and familiarized, the phase may begin.

2. **Phase 2: Generating Initial Codes.** After generating a list of ideas found throughout the data, initial codes may be produced that identify key features or categories of the raw data. Braun and Clarke (2006) point out that there is no definitive end point for producing codes, but rather the researcher may stop when they feel like they have captured codes for as many themes as possible while effectively keeping context and/or when codes no longer inform the research. As mentioned above, the software program NVIVO 12 will be used to assist during the coding process.
3. **Phase 3: Searching for Themes.** This phase requires gathering and collating codes into potential themes, while also considering how codes may be used multiple times throughout themes. The present study will identify latent themes in the data, examining underlying ideas, assumptions, and ideologies, rather than semantic themes. This may include codes and themes not explicitly said by participants, in the hopes of gaining a greater understanding into how the complex identities of participants may shape their responses and realities. Once overarching themes are identified, visual cues such as thematic maps will be used to understand the relationship(s) between codes, themes, and levels between themes.
4. **Phase 4: Reviewing Themes.** This phase of reviewing themes found in phase 3 can be conducted in two levels, one that ensures the potential themes work effectively in relation to the codes (Level 1), and one that compares the themes to the entirety of the data (Level 2). To begin, potential themes will be refined by either combining, dividing, or removing themes altogether. This ensures that each theme is not only meaningful, but uniquely distinguishable from the others. Once this has been complete, Level 1 may begin by re-reading the codes and ensuring they form a coherent pattern. Finally, Level 2 considers

the validity of each theme within a thematic map, allowing the researcher to determine the effectiveness of the chosen themes. Should they be deemed acceptable, the next phase may begin. If not, codes and/or themes may need to be reworked until the appropriate thematic map be created.

5. **Phase 5: Defining and Naming Themes.** With an acceptable thematic map complete, each theme (and potentially sub-theme) can be defined and refined by identifying the "essence" of what they're about within a few sentences (Braun & Clarke, 2006). Each theme can then have a detailed analysis written, including the story being told through each theme and how said story fits into the larger research question.
6. **Phase 6: Producing the Report.** The final phase is the creation of the larger report, ideally including vivid examples throughout. The purpose of this report is to tell a complicated – but not incoherent – story about the data that makes an argument relating to the research question.

When conducting qualitative analysis, it is important to note that many critics are reluctant to acknowledge the trustworthiness of qualitative research, particularly those who operate in a positivist framework (Shenton, 2004). However, many researchers throughout the years – most notably naturalists Lincoln and Guba (1985) – have argued that trustworthiness is possible (and highly necessary) to establish in qualitative work. One of the most important factors in establishing trustworthiness is credibility (Lincoln & Guba, 1985), and thus using well-established research methods, reflective commentary, and iterative questioning are just a few of the ways a qualitative researcher can work towards building trust. Guba (1981) also emphasizes the importance of transferability of data, dependability, and confirmability. Therefore, this study

will actively work toward building these four criteria of trust, ensuring readers, peers, and researchers alike do not feel reluctant towards the findings.

Reflexivity. While data collection will be completed by the Primary Investigator, it is also equally important to keep reflexivity in mind throughout the analysis portion within the transformative paradigm. Reflexivity, defined as "the subjectivity and social location of community psychologists in their roles as social interventionists, including the privileges that they enjoy" (Reimer et al., 2020), must be considered throughout the process to ensure social justice and equity are at the forefront of the committee's (including my) mind when conducting this research. With a deeper understanding of the multiple power structures affecting SOGIE BIPOC refugees, my methodological decisions, research questions, and data analysis will recognize inequality, injustice, and the dominant paradigm (status quo) in society, while hoping to challenge and eventually overcome them according to the transformative paradigm I will be operating in (Mertens, 2007). Particularly, when coding results of data collected by Dr. Travers, it is especially important to me to understand how the idea of a "good refugee" (Olsen et al., 2016) will most likely lead respondents to avoid speaking negatively of Canada and the Canadian experience. Moving forward, the BIPOC SOGIE refugees being interviewed by Dr. Travers may avoid specific words altogether that would deem them "inauthentically" BIPOC and/or SOGIE diverse as a refugee, for instance anything that can be read as subversive or ungrateful (Rinaldi & Fernando, 2019). Keeping this in mind, analysis will be done in a way that understands the subtle complexities of being granted asylum while also condemning systems of violence – an act that will be informed by my paradigm and theoretical frameworks, but also my own experiences growing up in a racialized immigrant household.

Knowledge Mobilization

Given the knowledge gap in the area, it would be very important for me to write a manuscript thesis that would include a peer-reviewed publication. Ideally, if funding permits, this manuscript would be published in an open-access journal that is available for free to any readers with internet or journal access. To encourage knowledge translation and mobilization, it is equally important for the findings to be spread throughout the community via an infographic fact sheet that will be shared at a roundtable discussion among agencies serving BIPOC SOGIE newcomers, as well as academic research and service providers. The hopes of this would be to encourage more widespread policy discussion in the community and broader society. The findings of this research will also be submitted to the International Peace, Global Health, and Sustainability (PEGASUS) conference in 2022, attended by refugees of all walks of life and service providers alike.

References

Ahmed, S. (2006). *Queer Phenomenology: Orientations, Objects, Others*. Duke University Press. https://doi.org/10.2307/j.ctv125jk6w

Alessi, E. J. (2016). Resilience in sexual and gender minority forced migrants: A qualitative exploration. *Traumatology, 22*(3), 203–213. https://doi.org/10.1037/trm0000077

Alessi, E. J., Greenfield, B., Yu, M., Cheung, S., Giwa, S., & Kahn, S. (2021). Family, friendship, and strength among LGBTQ+ migrants in Cape Town, South Africa: A qualitative understanding. *Journal of Social and Personal Relationships*, *38*(7), 1941–1960. https://doi.org/10.1177/02654075211001435

Alessi, E. J., Kahn, S., Ast, R. S., Cheung, S. P., Lee, E. O. J., & Kim, H. (2021). Learning from practitioners serving LGBTQ+ forced migrants and other diverse groups: Implications for a culturally-informed, affirmative practice. *Journal of the Society for Social Work and Research*. https://doi.org/10.1086/716722

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring Multiple Minority Stress: The LGBT People of Color Microaggressions Scale. *Cultural Diversity & Ethnic Minority Psychology*, *17*(2), 163–174. https://doi.org/10.1037/a0023244

Barry, M. M. (2009). Addressing the Determinants of Positive Mental Health: Concepts, Evidence and Practice. *International Journal of Mental Health Promotion, 11*(3), 4–17. https://doi.org/10.1080/14623730.2009.9721788

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117*(3), 497–529. https://doi.org/10.1037/0033-2909.117.3.497

Bayrakdar, S., & King, A. (2021). LGBT discrimination, harassment and violence in Germany, Portugal and the UK: A quantitative comparative approach. *Current Sociology*, 00113921211039271. https://doi.org/10.1177/00113921211039271

Becker, A. E., & Kleinman, A. (2013). Mental Health and the Global Agenda. *New England Journal of Medicine*, *369*(1), 66–73. https://doi.org/10.1056/NEJMra1110827

Berger, M., & Sarnyai, Z. (2015). "More than skin deep": Stress neurobiology and mental health consequences of racial discrimination. *Stress*, *18*(1), 1–10. https://doi.org/10.3109/10253890.2014.989204

Bill C-16, An Act to amend the Canadian Human Rights Act and Criminal Code (2016), 1st Session, 42nd Parliament. Retrieved from https://www.parl.ca/DocumentViewer/en/42-1/bill/C-16/first-reading#EH0. (n.d.).

Boles, R., Khalil, C., Mulholland, A., Ragonetti, T., LeFort, V., Davis, C., Coulombe, S., Coleman, T., & Travers, R. (2018). Experiences of Newcomers in the Waterloo Region. *Wilfrid Laurier University*, 1–5.

Bowleg, L. (2008). When Black + lesbian + woman ≠ Black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles: A Journal of Research*, *59*(5–6), 312–325. https://doi.org/10.1007/s11199-008-9400-z

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bronfenbrenner, U. (1992). Ecological systems theory. In *Six theories of child development: Revised formulations and current issues* (pp. 187–249). Jessica Kingsley Publishers.

Chow, H. P. H. (2007). Sense of Belonging and Life Satisfaction among Hong Kong Adolescent Immigrants in Canada. *Journal of Ethnic and Migration Studies*, *33*(3), 511–520. https://doi.org/10.1080/13691830701234830

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., Bordin, I. A., Costello, E. J., Durkin, M., Fairburn, C., Glass, R. I., Hall, W., Huang, Y., Hyman, S. E., Jamison, K., Kaaya, S., Kapur, S., Kleinman, A., Ogunniyi, A., … Walport, M. (2011). Grand challenges in global mental health. *Nature*, *475*(7354), 27–30. https://doi.org/10.1038/475027a

Crenshaw, K. (2015). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, *1989*(1). https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Cyrus, K. (2017). Multiple minorities as multiply marginalized: Applying the minority stress theory to LGBTQ people of color. *Journal of Gay & Lesbian Mental Health*, *21*(3), 194–202. https://doi.org/10.1080/19359705.2017.1320739

de Jong, J. T. V. M., Komproe, I. H., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., van de Put, W., & Somasundaram, D. (2001). Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings. *JAMA*, *286*(5), 555–562. https://doi.org/10.1001/jama.286.5.555

Elias, B., Mignone, J., Hall, M., Hong, S. P., Hart, L., & Sareen, J. (2012). Trauma and suicide behaviour histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science & Medicine*, *74*(10), 1560–1569. https://doi.org/10.1016/j.socscimed.2012.01.026

Esses, V., Hamilton, L., & Gaucher, D. (2017). The Global Refugee Crisis: Empirical Evidence and Policy Implications for Improving Public Attitudes and Facilitating Refugee Resettlement: The Global Refugee Crisis. *Social Issues and Policy Review*, *11*, 78–123. https://doi.org/10.1111/sipr.12028

Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and Facilitators to Accessing Mental Healthcare in Canada for Black Youth: A Scoping Review. *Adolescent Research Review*, *5*(2), 115–136. https://doi.org/10.1007/s40894-020-00133-2

Ferreira, N., & Dustin, M. (2017). Canada's Guideline 9: Improving SOGIE claims assessment? *Forced Migration Review*, *56*, 80–83.

Fournier, C., Hamelin Brabant, L., Dupéré, S., & Chamberland, L. (2018). Lesbian and Gay Immigrants' Post-Migration Experiences: An Integrative Literature Review. *Journal of Immigrant & Refugee Studies*, *16*(3), 331–350. https://doi.org/10.1080/15562948.2017.1299269

Fox, S. D., Griffin, R. H., & Pachankis, J. E. (2020). Minority stress, social integration, and the mental health needs of LGBTQ asylum seekers in North America. *Social Science & Medicine*, *246*, 112727. https://doi.org/10.1016/j.socscimed.2019.112727

Galtung, J. (1969). Violence, Peace, and Peace Research. *Journal of Peace Research*, *6*(3), 167–191.

Galtung, J. (1975). THE SPECIFIC CCONTRIBUTION OF PEACE RESEARCH TO THE STUDY OF THE CAUSES OF VIOIENCE: TYPOLOGIES. *University of Oslo*, 22.

Galtung, J. (1993). Kulturelle Gewalt. *Der Burger Im Staat*, *43*, 106.

Ghahari, S., Lui, J., Nagra, S., & Morassaei, S. (2020). The Life Experiences of Refugees in Canada: A Comprehensive Scoping Review to Identify Unmet Needs and Barriers.

Journal of International Migration and Integration, *21*(4), 1249–1261. https://doi.org/10.1007/s12134-019-00727-3

Giwa, S., & Chaze, F. (2018). Positive enough? A content analysis of settlement service organizations' inclusivity of LGBTQ immigrants. *Journal of Gay & Lesbian Social Services*, *30*(3), 220–243. https://doi.org/10.1080/10538720.2018.1463889

Giwa, S., & Greensmith, C. (2012). Race Relations and Racism in the LGBTQ Community of Toronto: Perceptions of Gay and Queer Social Service Providers of Color. *Journal of Homosexuality*, *59*(2), 149–185. https://doi.org/10.1080/00918369.2012.648877

Golembe, J., Leyendecker, B., Maalej, N., Gundlach, A., & Busch, J. (2020). Experiences of Minority Stress and Mental Health Burdens of Newly Arrived LGBTQ* Refugees in Germany. *Sexuality Research and Social Policy*. https://doi.org/10.1007/s13178-020-00508-z

Government of Canada, S. C. (2003, September 29). *Ethnic Diversity Survey: Portrait of a Multicultural Society - ARCHIVED*. https://www150.statcan.gc.ca/n1/en/catalogue/89-593-X

Government of Canada, S. C. (2005, February 23). *Dynamics of Immigrants' Health in Canada: Evidence from the National Population Health Survey - ARCHIVED*. https://www150.statcan.gc.ca/n1/en/catalogue/82-618-M2005002

Government of Canada, S. C. (2017, February 8). *Census Profile, 2016 Census—Canada [Country] and Canada [Country]*. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=01&Geo2=PR&Code2=01&Data=Count&SearchText=canada&SearchType=Begins&SearchPR=01&B1=All&TABID=1

Government of Canada, S. C. (2020, August 19). *Disease assimilation: The mortality impacts of fine particulate matter on immigrants to Canada*. https://www150.statcan.gc.ca/n1/pub/82-003-x/2020008/article/00001/c-g/c-g01-eng.htm

Government of Canada, S. C. (2021, June 15). *The Daily—A statistical portrait of Canada's diverse LGBTQ2+ communities*. https://www150.statcan.gc.ca/n1/daily-quotidien/210615/dq210615a-eng.htm

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, *13*(1), 119. https://doi.org/10.1186/s12939-014-0119-x

Hansen, L., & Huston, P. (2016). Health considerations in the Syrian refugee resettlement process in Canada. *Canada Communicable Disease Report*, *42*(S2), S3–S7. https://doi.org/10.14745/ccdr.v42is2a02

Hansson, E. K., Tuck, A., Lurie, S., & McKenzie, K. (2012). Rates of Mental Illness and Suicidality in Immigrant, Refugee, Ethnocultural, and Racialized Groups in Canada: A Review of the Literature. *Canadian Journal of Psychiatry*, *57*(2), 111–121.

Herek, G. M. (1990). The Context of Anti-Gay Violence: Notes on Cultural and Psychological Heterosexism. *Journal of Interpersonal Violence*, *5*(3), 316–333. https://doi.org/10.1177/088626090005003006

Hetrick, E. S., & Martin, A. D. (1987). Ego-dystonic Homosexuality: A Developmental View. In *Innovations in Psycho- therapy with Homosexuals* (pp. 2–21). American Psychiatric Association.

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., Stevenson, J., & Westermeyer, J. (2002). Measuring Trauma and Health Status in Refugees: A Critical Review. *JAMA, 288*(5), 611–621. https://doi.org/10.1001/jama.288.5.611

Hudson, K. D. (2015). Toward a Conceptual Framework for Understanding Community Belonging and Well-Being: Insights from a Queer-Mixed Perspective. *Journal of Community Practice*, *23*(1), 27–50. https://doi.org/10.1080/10705422.2014.986595

Hudson, P. J., & McKittrick, K. (2014). The Geographies of Blackness and Anti-Blackness: An Interview with Katherine McKittrick. *The CLR James Journal*, *20*(1/2), 233–240. https://doi.org/10.5840/clrjames201492215

Hynie, M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry*, *63*(5), 297–303. https://doi.org/10.1177/0706743717746666

Jacobs, P., Yim, R., Ohinmaa, A., Eng, K., Dewa, C. S., Bland, R., Block, R., & Slomp, M. (2008). Expenditures on mental health and addictions for Canadian provinces in 2003 and 2004. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, *53*(5), 306–313. https://doi.org/10.1177/070674370805300505

Kahn, S. (2015). Cast Out: "Gender Role Outlaws" Seeking Asylum in the West and the Quest for Social Connections. *Journal of Immigrant & Refugee Studies*, *13*(1), 58–79. https://doi.org/10.1080/15562948.2014.894169

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

Kahn, S., & Alessi, E. j. (2018). Coming Out Under the Gun: Exploring the Psychological Dimensions of Seeking Refugee Status for LGBT Claimants in Canada. *Journal of Refugee Studies*, *31*(1), 22–41. https://doi.org/10.1093/jrs/fex019

Kelly, P., Marcelino, L., & Mulas, C. (2014). *Foreign Credential Recognition Research Synthesis, 2009-2013*. CERIS.

Kidd, S., Howison, M., Pilling, M., Ross, L. E., & McKenzie, K. (2016). Severe Mental Illness among LGBT Populations: A Scoping Review. *Psychiatric Services (Washington, D.C.)*, *67*(7), 779–783. https://doi.org/10.1176/appi.ps.201500209

Knipscheer, J. W., Sleijpen, M., Mooren, T., ter Heide, F. J. J., & van der Aa, N. (2015). Trauma exposure and refugee status as predictors of mental health outcomes in treatment-seeking refugees. *BJPsych Bulletin*, *39*(4), 178–182. https://doi.org/10.1192/pb.bp.114.047951

LaViolette, N. (2009). Independent human rights documentation and sexual minorities: An ongoing challenge for the Canadian refugee determination process. *The International Journal of Human Rights*, *13*(2–3), 437–476. https://doi.org/10.1080/13642980902758234

Lee, J. H., Gamarel, K. E., Bryant, K. J., Zaller, N. D., & Operario, D. (2016). Discrimination, Mental Health, and Substance Use Disorders Among Sexual Minority Populations. *LGBT Health*, *3*(4), 258–265. https://doi.org/10.1089/lgbt.2015.0135

Lei, N., Velez, B. L., Seoud, J. M., & Motulsky, W. N. (2022). A Test of Minority Stress Theory with Asian Americans. *The Counseling Psychologist*, 00110000221107554. https://doi.org/10.1177/00110000221107554

Lesage, A. (2006). *Prevalence of Mental Illnesses and Related Service Utilization in Canada: An Analysis of the Canadian Community Health Survey*. Canadian Collaborative Mental Health Initiative.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

Logie, C. H., Lacombe-Duncan, A., Lee-Foon, N., Ryan, S., & Ramsay, H. (2016). "It's for us – newcomers, LGBTQ persons, and HIV-positive persons. You feel free to be": A qualitative study exploring social support group participation among African and Caribbean lesbian, gay, bisexual and transgender newcomers and refugees in Toronto, Canada. *BMC International Health and Human Rights*, *16*(1), 18. https://doi.org/10.1186/s12914-016-0092-0

Mawani, F. N. (2014). Social Determinants of Refugee Mental Health. In L. Simich & L. Andermann (Eds.), *Refuge and Resilience: Promoting Resilience and Mental Health among Resettled Refugees and Forced Migrants* (pp. 27–50). Springer Netherlands. https://doi.org/10.1007/978-94-007-7923-5_3

Mendos, L. R. (2019). *State-Sponsored Homophobia* (13th ed.). ILGA World.

Mertens, D. (2003). Mixed methods and the politics of human research: The transformative emancipatory perspective. *Handbook of Mixed Methods in Social and Behavioral Research*, 135–164.

Mertens, D. (2007). Transformative Paradigm: Mixed Methods and Social Justice. *Journal of Mixed Methods Research*, *1*, 212–225. https://doi.org/10.1177/1558689807302811

Meyer, I. H. (1995). Minority Stress and Mental Health in Gay Men. *Journal of Health and Social Behavior*, *36*(1), 38–56. https://doi.org/10.2307/2137286

Meyer, I. H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Mulé, N. J. (2020). Safe Haven Questioned: Proof of Identity Over Persecution of SOGIE Asylum Seekers and Refugee Claimants in Canada. *Journal of Immigrant & Refugee Studies*, *18*(2), 207–223. https://doi.org/10.1080/15562948.2019.1639238

Murray, D., & Murray, D. (2020). Liberation Nation? Queer Refugees, Homonationalism and the Canadian Necropolitical State. *REMHU: Revista Interdisciplinar Da Mobilidade Humana*, *28*(59), 69–78. https://doi.org/10.1590/1980-85852503880005905

Naderifar, M., Goli, H., & Ghaljaei, F. (2017). Snowball Sampling: A Purposeful Method of Sampling in Qualitative Research. *Strides in Development of Medical Education, In Press*. https://doi.org/10.5812/sdme.67670

National Academies of Sciences, E., Division, H. and M., Practice, B. on P. H. and P. H., States, C. on C.-B. S. to P. H. E. in the U., Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (2017). The Root Causes of Health Inequity. In *Communities in Action: Pathways to Health Equity*. National Academies Press (US). http://www.ncbi.nlm.nih.gov/books/NBK425845/

Nelson, S. E., & Wilson, K. (2017). The mental health of Indigenous peoples in Canada: A critical review of research. *Social Science & Medicine*, *176*, 93–112. https://doi.org/10.1016/j.socscimed.2017.01.021

Noh, S., Beiser, M., Kaspar, V., Hou, F., & Rummens, J. (1999). Perceived racial discrimination, depression, and coping: A study of Southeast Asian refugees in Canada. *Journal of Health and Social Behavior*, *40*(3), 193–207.

Olsen, C., El-Bialy, R., Mckelvie, M., Rauman, P., & Brunger, F. (2016). "Other" Troubles: Deconstructing Perceptions and Changing Responses to Refugees in Canada. *Journal of Immigrant and Minority Health*, *18*(1), 58–66. https://doi.org/10.1007/s10903-014-9983-0

Ontario Human Rights Commission. (2014). https://www.ohrc.on.ca/en/ontario-human-rights-code

Oudshoorn, A., Benbow, S., & Meyer, M. (2019). Resettlement of Syrian Refugees in Canada. *Journal of International Migration and Integration / Revue de l Integration et de La Migration Internationale*, *21*. https://doi.org/10.1007/s12134-019-00695-8

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Pascoe, E. A., & Richman, L. S. (2009). Perceived Discrimination and Health: A Meta-Analytic Review. *Psychological Bulletin*, *135*(4), 531–554. https://doi.org/10.1037/a0016059

Peleg, A., & Hartman, T. (2019). Minority stress in an improved social environment: Lesbian mothers and the burden of proof. *Journal of GLBT Family Studies*, *15*(5), 442–460. https://doi.org/10.1080/1550428X.2018.1556141

Prilleltensky, I. (2012). Wellness as fairness. *American Journal of Community Psychology*, *49*(1–2), 1–21. https://doi.org/10.1007/s10464-011-9448-8

Puar, J. K. (2007). *Terrorist Assemblages: Homonationalism in Queer Times*. https://doi.org/10.1215/9780822390442

Radkowsky, M., & Siegel, L. J. (1997). The gay adolescent: Stressors, adaptations, and psychosocial interventions. *Clinical Psychology Review*, *17*(2), 191–216. https://doi.org/10.1016/S0272-7358(97)00007-X

Ramirez, J. L., & Paz Galupo, M. (2019). Multiple minority stress: The role of proximal and distal stress on mental health outcomes among lesbian, gay, and bisexual people of color. *Journal of Gay & Lesbian Mental Health*, *23*(2), 145–167. https://doi.org/10.1080/19359705.2019.1568946

Reimer, M., Reich, S. M., Evans, S. D., Nelson, G., & Prilleltensky, I. (2020). *Community Psychology: In Pursuit of Liberation and Wellbeing* (3rd ed.). Red Globe Press.

Rinaldi, J., & Fernando, S. (2019). Queer Credibility in the Homonation-State: Interrogating the Affective Impacts of Credibility Assessments on Racialized Sexual Minority Refugee Claimants. *Refuge: Canada's Journal on Refugees / Refuge : Revue Canadienne Sur Les Réfugiés*, *35*(1), 32–42. https://doi.org/10.7202/1060673ar

Roberts, S. A., Williams, C. R., & Grimstad, F. W. (2020). Considerations for Providing Pediatric Gender-Affirmative Care During the COVID-19 Pandemic. *Journal of Adolescent Health*, *67*(5), 635–637. https://doi.org/10.1016/j.jadohealth.2020.08.018

Ross, L. E., Gibson, M. F., Daley, A., Steele, L. S., & Williams, C. C. (2018). In spite of the system: A qualitatively-driven mixed methods analysis of the mental health services experiences of LGBTQ people living in poverty in Ontario, Canada. *PLOS ONE*, *13*(8), e0201437. https://doi.org/10.1371/journal.pone.0201437

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and

operationalization. *Quality & Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, *125*(6), 440–452. https://doi.org/10.1111/j.1600-0447.2012.01826.x

Schwöbel-Patel, C., & Ozkaramanli, D. (2017). The Construction of the "Grateful" Refugee in Law and Design. In *Critical Approaches To International Criminal Law: An Introduction* (1st ed., Vol. 4, pp. 1–10). QMHRR.

Shenton, A. (2004). Strategies for Ensuring Trustworthiness in Qualitative Research Projects. *Education for Information*, *22*, 63–75. https://doi.org/10.3233/EFI-2004-22201

Shrestha, N. M., Sharma, B., Van Ommeren, M., Regmi, S., Makaju, R., Komproe, I., Shrestha, G. B., & de Jong, J. T. V. M. (1998). Impact of Torture on Refugees Displaced Within the Developing WorldSymptomatology Among Bhutanese Refugees in Nepal. *JAMA*, *280*(5), 443–448. https://doi.org/10.1001/jama.280.5.443

Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2016). LGBT Identity, Untreated Depression, and Unmet Need for Mental Health Services by Sexual Minority Women and Trans-Identified People. *Journal of Women's Health*, *26*(2), 116–127. https://doi.org/10.1089/jwh.2015.5677

Simeonov, D., Steele, L. S., Anderson, S., & Ross, L. E. (2015). Perceived Satisfaction With Mental Health Services in the Lesbian, Gay, Bisexual, Transgender, and Transsexual Communities in Ontario, Canada: An Internet-Based Survey. *Canadian Journal of Community Mental Health*, *34*(1), 31–44. https://doi.org/10.7870/cjcmh-2014-037

Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2016). LGBT Identity, Untreated Depression, and Unmet Need for Mental Health Services by Sexual Minority Women and Trans-Identified People. *Journal of Women's Health*, *26*(2), 116–127. https://doi.org/10.1089/jwh.2015.5677

The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations. (2016). Mental Health Commission of Canada.

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

Veltman, A., & Chaimowitz, G. (2014). Mental Health Care for People Who Identify as Lesbian, Gay, Bisexual, Transgender, and (or) Queer. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *59*(11), 1–7.

Wilkinson, L., & Garcea, J. (2017). *The Economic Integration of Refugees in Canada: A Mixed Record?* 31.

Williams, D. R., González, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and Distribution of Major Depressive Disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results From the National Survey of American Life. *Archives of General Psychiatry*, *64*(3), 305. https://doi.org/10.1001/archpsyc.64.3.305

Yarwood, V., Checchi, F., Lau, K., & Zimmerman, C. (2022). LGBTQI + Migrants: A Systematic Review and Conceptual Framework of Health, Safety and Wellbeing during

Migration. *International Journal of Environmental Research and Public Health*, *19*(2), 869. https://doi.org/10.3390/ijerph19020869