Digital Diaries and Documenting Queer Lives in Social Isolation During COVID-19

by

Rodney Epeli Stehr

B.A. (Hons), Simon Fraser University, 2018

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

in

The Faculty of Graduate and Postdoctoral Studies

(Interdisciplinary Studies)

THE UNIVERSITY OF BRITISH COLUMBIA
(Vancouver)

August 2022

© Rodney Epeli Stehr, 2022
The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the thesis entitled:

Digital Diaries and Documenting Queer Lives in Social Isolation During COVID-19

Submitted by Rodney Stehr in partial fulfillment of the requirements for the degree of Master of Science in Interdisciplinary Studies

Examining Committee:

Dr. Rod Knight, Assistant Professor, Department of Medicine, UBC
Co-supervisor

Dr. Danya Fast, Assistant Professor, Department of Medicine, UBC
Co-supervisor

Dr. Sereana Naepi, Lecturer, Department of Sociology, University of Auckland
Supervisory Committee Member
Abstract

**Background:** Physical distancing measures implemented to address the spread of COVID-19 between 2020 and 2021 introduced challenges for accessing mental healthcare and social support for queer youth. COVID-19 disrupted the provision of mental healthcare, social support, and in-person approaches to qualitative research. Thus, there is a critical need to understand how queer youth’s experiences of mental health have been impacted by COVID-19 and the associated with pivoting from in-person to virtual data collection methods to study these impacts. Therefore, the objectives of this thesis are to: 1) Document my experiences pivoting from an in-person to virtual data collection methods, and 2) Identify how evolving experiences with the COVID-19 pandemic impact the mental health experiences of queer youth. **Methods:** Using a social constructivist framework, I thematically analyze digital diary entries and data from semi-structured interviews collected between November 2020 and June 2021 in Vancouver, Canada, from a sample (n=15) of queer youth recruited using purposeful and snowball sampling. **Findings:** The findings of this thesis describe how digital diary methods and remote semi-structured interviews provided opportunities for exploring unanticipated areas of inquiry and opportunities for participants previously experiencing barriers to in-person research. However, this approach also featured several limitations, including instances where poor internet connectivity resulted in Zoom calls being cut off multiple times and difficulty in maintaining private space during remote interviews where guardians interrupted interviews. Physical distancing measures had unintended negative effects on the mental health experiences of queer youth by interrupting processes of identity-development, isolating queer youth and leading them to rely on limited in-person social supports and introducing barriers to virtual mental health support for queer disabled youth. **Conclusion:** These findings show how combining remote
interviewing and digital diary methods provide equity-enhancing opportunities for disabled and immunocompromised queer youth, how queer social capital plays an important role in queer youth’s ability to transition their mental healthcare and social lives online, and the necessity of accessibility being built-in at each point of virtual clinical care. Finally, they highlight how moralizing discourses around COVID-19 guideline compliance entrench existing mental health inequities by isolating them and subjecting them to discrimination.
Lay Summary

Social support plays a protective role against stigma that negatively impacts queer youth’s mental health in British Columbia. However, COVID-19 physical distancing measures have shifted in-person mental health supports and social supports virtually. Little is known about how COVID-19 has changed queer youth’s social networks and impacted their mental health, and their support-seeking strategies. To address these significant gaps in the literature, semi-structured interviews and solicited digital diaries were used to understand how queer youth’s mental health experiences during the COVID-19 pandemic. This thesis’s findings describe how combining digital diaries and remote interviewing reduces barriers to research participation and provides opportunities to explore unanticipated areas of inquiry. They also highlight how queer social capital can help youth transition to virtual forms of social connection, the importance of accessibility at each point of virtual clinical care, and how moralizing discourses around COVID-19 guideline compliance entrench mental health inequities among queer youth.
Preface

This thesis was supported by a program of research led Dr. Rod Knight, who acts as my co-supervisor. This thesis is my original and unpublished work and was completed through close collaboration with members of my supervisory committee. The design of this study and the associated research questions and objectives were designed by me with critical guidance and direction provided by my co-supervisors Dr. Rod Knight, and Dr. Danya Fast. Data collection and analysis were carried out with insight and support provided by research coordinator Anna Carson. The writing of this thesis, and the drafting and development of the constituent manuscripts, were informed by the caring mentorship provided by members of my supervisory committee: Drs. Rod Knight, Danya Fast, and Sereana Naepi. Ethics approval for this study was obtained from the University of British Columbia Behavioural Research Ethics Board (#H20-00366).
Table of Contents

ABSTRACT ........................................................................................................................................ iii
LAY SUMMARY .................................................................................................................................... v
PREFACE ............................................................................................................................................. vi
TABLE OF CONTENTS ........................................................................................................................ vii
LIST OF TABLES ................................................................................................................................... ix
LIST OF FIGURES ................................................................................................................................ xi
ACKNOWLEDGMENTS .......................................................................................................................... x
DEDICATION ......................................................................................................................................... xiii

CHAPTER 1: INTRODUCTION ............................................................................................................. 1
  1.1 THESIS OBJECTIVES ............................................................................................................. 1
  1.2 QUEER YOUTH MENTAL HEALTH INEQUITIES .................................................................. 2
  1.3 QUEER YOUTH MENTAL HEALTH AND THE COVID-19 PANDEMIC ......................... 7
  1.4 QUEER YOUTH’S VIRTUAL LIVES IN AN ERA OF COVID-19 ........................................ 9
  1.5 COVID-19, QUEER YOUTH, AND THE NEED FOR REMOTE RESEARCH METHODS .... 11
  1.6 RESEARCH CONTEXT ......................................................................................................... 13
  1.7 THEORETICAL FRAMEWORK ......................................................................................... 14
     Social Constructivism .............................................................................................................. 14
  1.8 NOTES ON LANGUAGE ....................................................................................................... 16
  1.9 POSITIONING MYSELF: STORYTELLING, RESPONSIBILITY, AND DUTY ..................... 17
  1.10 INTRODUCING THE RESEARCH PARTICIPANTS ......................................................... 21

CHAPTER 2: (IN)EQUITABLE SHIFTS: MAPPING A PIVOT TO DIGITAL DIARY AND REMOTE RESEARCH METHODS WITH QUEER YOUTH IN THE TIMES OF COVID-19 ............................................ 28
  2.1 CHAPTER 2 OVERVIEW ..................................................................................................... 28
  2.2 INTRODUCTION ................................................................................................................... 29
     A pivot from in-person to remote and digital qualitative approaches ...................................... 29
  2.3 A DIGITAL DIARY AND REMOTE INTERVIEWING PROTOCOL ................................... 33
     Identifying shifting patterns and unanticipated areas of inquiry ............................................ 37
     Limitations of digital diaries and remote interviewing: Whose voices are missing? ................. 40
  2.4 DIGITAL DIARIES AND ACCESSIBILITY: WHOSE VOICES ARE INCLUDED? ............... 41
     Technical issues ....................................................................................................................... 43
     Privacy and safety concerns .................................................................................................... 44
  2.5 CONCLUSION ....................................................................................................................... 46

CHAPTER 3: “I’M ON MY OWN”: QUEER YOUTHS’ EXPERIENCES OF NAVIGATING MENTAL HEALTH DURING THE COVID-19 PANDEMIC .......................................................... 48
  3.1 CHAPTER OVERVIEW ....................................................................................................... 48
  3.2 INTRODUCTION ................................................................................................................... 49
  3.3 METHODS ............................................................................................................................. 54
  3.4 RESULTS ............................................................................................................................... 57
     Impact of Changing Structures of Social Support .................................................................... 58
     Impact of Negotiating Public Health Guidance and Messaging ............................................. 62
     Evolving Mental Health Strategies ......................................................................................... 66
  3.4 DISCUSSION .......................................................................................................................... 70
  3.6 CONCLUSION ....................................................................................................................... 78
CHAPTER 4: DISCUSSION ........................................................................................................................................79

4.1 SUMMARY OF FINDINGS .................................................................................................................................. 79
4.2 IMPLICATIONS FOR PRACTICE AND POLICY ................................................................................................. 81
4.3 IMPLICATIONS FOR RESEARCH ....................................................................................................................... 85
4.4 SUMMARY OF STRENGTHS AND LIMITATIONS ............................................................................................... 87
4.5 REVISITING POSITIONALITY, REVISITING THE TEXT ..................................................................................... 88
4.6 POETRY ............................................................................................................................................................... 96

Not the Pacific We Know (But Still the Pacific) .......................................................................................................... 96
Diary Entry Prompts: #H20-00366 ........................................................................................................................... 105

BIBLIOGRAPHY ..................................................................................................................................................... 110
List of Tables

TABLE 1 SUMMARY OF THE DEMOGRAPHICS OF THE RESEARCH PARTICIPANTS.......................... 35
List of Figures

FIGURE 1 EXCERPT FROM "NOT THE PACIFIC WE KNOW (BUT STILL THE PACIFIC)" BY RODNEY STEHR (SEE APPENDIX A FOR FULL VERSION) ................................................................. 1
FIGURE 2 OPTIONAL PROMPTS ASKING GENERAL QUESTIONS ABOUT ROUTINES AND LIFE. NOT ALWAYS FILLED OUT BY PARTICIPANTS................................................................. 36
FIGURE 3 RECOMMENDED PROMPTS THAT CHANGE WITH EACH ENTRY AND ASK DIFFERENT THEMATIC QUESTIONS RELATED TO SUBSTANCE USE, MENTAL HEALTH, SEXUAL HEALTH, AND SOCIAL MEDIA USE. ................................................................. 37
Acknowledgments

I would like to first thank Dr. Rod Knight for his consistent, generous, and extensive support and training throughout the entirety of my graduate career at UBC. I would also like to thank Cathy Chabot and Anna Carson for the many ways that they have supported me and helped me improve as a researcher. Thank you to Rod, Cathy, and Anna for hiring me all those years back as a research assistant and providing me with the opportunity to even think about a master’s degree.

Thank you to Dr. Fast for reminding me to remain grounded in my data and not try to tell stories that were not actually reflected in the research, and for all the ways you’ve helped connect me with anthropological thought and literature.

Thank you to Dr. Naepi for agreeing to be on my committee and entertaining my strange thesis-related requests to collaborate on poetry and guiding me to find ways to make them fit. Thank you also for introducing me to an entire world of Pacific scholarship that helped me plant a bit of myself in this thesis.

Thank you to Kalani Reyes whose podcast, Deep Pacific, and friendship, helped make me feel a little more connected and a little less distant from the ocean that we share. I am grateful to learn from you and to witness and how you organize and bring together Indigenous youth from across the pacific. I am grateful to be a part of the same ocean that you are.

Thank you to my mentors (those who are here and those who are no longer with us) who helped challenge me around community engagement and community-based work.

Thank you to my friends, new and old, who helped me handle the stress of this research and kept me going when I felt like running away into the ocean.
Thank you to my parents whose sacrifice and support have allowed me to have the opportunity to step back from the world and study it.

Thank you to Margaret Christakos for your feedback that helped shape my poetry, and the many other poets whose works I have held close like Melvin Dixon, Terisa Siagatonu, Marilyn Dumont, Anna Akhmatova, and Teresia Teaiwa.
Dedication

This thesis is dedicated to the participants of this study, to my parents (Selina Stehr and Waldemar Stehr), to my grandparents (Ratu and Nau), and to my friends who helped me throughout this process.
Chapter 1: Introduction

We have been here,
We know who we are,
We are not that.
We are freshwater and saltwater,
Our kindness is our ancestors.

We have been here,
We know who we are,
We are not that.
We are freshwater and saltwater,
Our kindness is our ancestors.

We have been here,
We know who we are,
We are not that.
We are freshwater and saltwater,
Our kindness is our ancestors.

Now that you know:
You will remember what we have shared.

Now that you know:
You know a little more
About who I am.

Figure 1 Excerpt from "Not the Pacific We Know (But Still the Pacific)" by Rodney Stehr
(see Appendix A for full version)

1.1 Thesis Objectives

The aim of this thesis is to understand how queer youth mental health has been impacted during the initial waves of COVID-19 and the corresponding public health directives that limited in-person social connections. The thesis will also focus on understanding the practical and ethical considerations that arise when shifting to digital and remote methods to understand queer youth’s evolving strategies and experiences of COVID-19. Specifically, the research objectives of this thesis are to:
1) Document and address my experiences pivoting from an in-person to virtual data collection method to document the experiences of sexual and gender minority youth with the COVID-19 pandemic (Chapter 2).

2) Identify how evolving experiences with the COVID-19 pandemic impact the mental health experiences of queer youth (Chapter 3).

1.2 Queer Youth Mental Health Inequities

Two-Spirit, lesbian, gay, bisexual, trans, queer, intersex, asexual, mahu, vakasalewa, plaopa, fa’afafine, akava’ine, fakaleiti (leiti), and fakafifine (herein ‘queer’) youth experience health inequities that distinguish them from their cisgender, heterosexual counterparts. For example, previous research in our study and elsewhere identifies how queer youth (ages <25 years) experience higher rates of substance use-, mental health- (e.g., suicidal ideation; anxiety and depressive disorders) and sexual health-related (e.g., HIV; sexually transmitted and blood-borne infections – STBBIs) harms than their cisgender heterosexual peers (BC Centre for Disease Control, 2019; Bryan N. Cochran, 2002; Ferlatte, Dulai, Hottes, Trussler, & Marchand, 2015; Garcia et al., 2020; Konishi, Saewyc, Homma, & Poon, 2013; Price-Feeney, Green, & Dorison, 2020; Russell & Fish, 2016; Shearer et al., 2016; Smith A, 2015). Queer youth’s mental health outcomes are distinctly impacted by heteronormative and cisnormative social conditions that enhance homophobic and transphobic stigma (Bradford & Syed, 2019; Perez-Brumer et al., 2019). Heteronormativity can be understood as a norm where “everyone, straight or queer, will be judged, measured, probed, and evaluated from the perspective of heterosexual[ity]” (Chambers, 2003, p. 26). As a result, healthcare providers operating through a lens of heteronormativity may assume by default that their patients can only be engaged in heterosexual
sexual and romantic relationships (Knight, Shoveller, Oliffe, Gilbert, & Goldenberg, 2013). Heteronormativity frequently overlaps and reinforces cisnormativity, which maintains that “there are two and only two genders” and that “gender reflects biological sex” (Schilt & Westbrook, 2009; Worthen, 2016).

Homophobic and transphobic stigma contribute to social exclusion and discrimination that enhance external stressful events, expectation and increased vigilance of potential stressful events, and the internalization of stigma that result in mental health harms like high rates of anxiety and depression (Ferlatte et al., 2019; Ferlatte et al., 2020; Gorse, 2022; M. L. Hatzenbuehler, 2009; Mark L. Hatzenbuehler, Phelan, & Link, 2013; Meyer, 2003). For example, a recent cross-sectional survey of 25,000 queer youth (ages 13-24) in the US reported that trans and non-binary youth reported higher rates of discrimination based on sexuality and gender identity than cisgender queer youth and, across all genders, trans men reported the highest rates of depressive mood, suicidal ideation, and attempted suicide (Price-Feeney et al., 2020). Similar trends can be seen in Canada, with an online survey of 923 trans youth detailing, on average, worse mental health among nonbinary youth, and reported mental health disparities experienced among trans and nonbinary youth that are “more extreme than the disparities faced by lesbian, gay, and bisexual youth in Canada” (Veale, Watson, Peter, & Saewyc, 2017, p. 47). Existing literature has also highlighted that queer youth are more likely to experience suicidal ideation (Ferlatte et al., 2015; Marshal et al., 2011; Sutter & Perrin, 2016). For example, a meta-analysis of national-level studies on mental health outcomes of gay, lesbian, and bisexual youth found that LGB youth were more likely to attempt or ideate suicide, and 12-month prevalence of suicidal ideation and attempts among cisgender gay and bisexual men was higher than the lifetime prevalence among adult men (Lewis, 2009). Among trans youth in Canada, 65%
responded in the Canadian Trans Youth Health Survey (n=932) that they had seriously considered suicide in the last year (Colvin, Tobon, Jeffs, & Veltman, 2019).

A growing body of research also documents the impacts of multiple and intersecting forms of discrimination on queer youth health, including, for example, the multiplicative impacts of racism and homophobia and a corresponding increase in negative mental health outcomes (Buttram & Kurtz, 2014; Drazdowski et al., 2015; Sutter & Perrin, 2016; Vargas, Huey, & Miranda, 2020). Overlapping marginalized identities produce distinct mental health-related outcomes within a “matrix of domination characterized by intersecting oppressions” and there is a body of research that draws on intersectionality frameworks to interrogate health inequities (Abrams, Tabaac, Jung, & Else-Quest, 2020; Collins, 2002, p. 23; Drummond & Brotman, 2014; McCann, Lee, & Brown, 2016). The Black feminist theory of intersectionality examines how structures of power marginalize Black women along the lines of sexism and racism, and can be applied to understand how other overlapping forms of oppression (Abrams et al., 2020; Drummond & Brotman, 2014; McCann et al., 2016). Previous social scientific research has identified how these health outcomes are shaped by structural factors, including experiences of poverty, underemployment, and white supremacy (Abbas & García, 2021; Buttram & Kurtz, 2014; Mitchell & Caudy, 2015; Vargas et al., 2020).

Intersectionality highlights how the relationship between multiple, marginalized identities can be interactive and mutually constitutive in the production of inequitable outcomes (Hancock, 2007). The intersection of queerness and ableism produces unique outcomes that can be additive (double oppression) or interactive (simultaneous oppression) (Caldwell, 2010). For example, queer members of the disability community are often described as a minority within a minority and are subject to compulsory heterosexuality (i.e. heterosexuality is reinforced and naturalized,
and homosexuality is pathologized) and compulsory able-bodiedness (i.e., the notion that disability is a choice) that can render queer members of the disability community invisible, desexualized, and excluded from the planning of queer events (Caldwell, 2010; McRuer, 2022; Santinele Martino, 2017; Stoffelen, Kok, Hospers, & Curfs, 2013). Frequently missing from the literature cited are critical interrogations about how ableism also shapes inequitable health outcomes faced by queer youth, including mental health outcomes. Disabled queer individuals face discrimination based on their gender and sexuality, in addition to having to navigate ableism (Drummond & Brotman, 2014; McCann et al., 2016). Ableism is a form of discrimination that idealizes and places societal worth on ‘abled’ bodies (i.e., people who do not live with a disability) and devalues people with disabilities (Welsh, 2020). The impacts of ableism on people with disabilities take the form of barriers to health and even being subject to eugenicist approaches (e.g., deprioritizing people with severe or profound intellectual disability who have COVID-19 for ventilator support) to public health (E. E. Andrews, Ayers, Brown, Dunn, & Pilarski, 2021; Lund, 2020; Lund, Forber-Pratt, Wilson, & Mona, 2020). For example, disabled sexual minority women with multiple marginalized identities (i.e., gender, sexuality, and disability) were more likely to report decreased satisfaction in levels of social support, feelings of disconnection from other queer people, and a higher likelihood of reporting instances of discrimination and anxiety disorders (Eliason, Martinson, & Carabez, 2015; Streed Jr, Hall, Boyd, Batza, & Kurth, 2021). Therefore, it is important to address gaps in the literature and call for a better understanding how ableism impacts the mental health experiences of queer youth living through COVID-19.

Queer youth, including those impacted by intersecting forms of oppression, also often have to navigate healthcare contexts where insufficient queer cultural competency (i.e., lack of
familiarity with the healthcare needs of queer people) results in stigmatizing assumptions of need based on identity (Schuller & Crawford, 2020; Wagaman, 2014), experiences of verbal harassment and refusal of care by healthcare providers (Kattari, Bakko, Langenderfer-Magruder, & Holloway, 2020), and expectations of having to educate healthcare providers on sexuality and gender (Vermeir, Jackson, & Marshall, 2018). Other barriers to accessing mental healthcare have included lack of awareness of available services, limited geographical access, lack of insurance coverage and fear of stigmatizing encounters with service providers (Bowman, Nic Giolla Easpaig, & Fox, 2020; A. Brown, Rice, Rickwood, & Parker, 2016; Higgins et al., 2021; Shiperd, Green, & Abramovitz, 2010). Overall, experiences of stigma (actual or anticipated) and discrimination can be associated with decreased care-seeking behaviours, and disparities in geographic access (e.g., rurality) and distances travelled to access queer-specific care were also factors that influenced uptake of available healthcare supports—especially among trans and non-binary individuals (Whitehead, Shaver, & Stephenson, 2016).

To conclude, queer youth’s mental health outcomes are impacted by multiple forms of discrimination (e.g., homophobia and transphobia) that marginalize and stigmatize their sexual and gender identities, and result in higher rates of anxiety, depression, suicidal ideation and attempts (Ferlatte et al., 2019; Ferlatte et al., 2020; Gorse, 2022; M. L. Hatzenbuehler, 2009; Mark L. Hatzenbuehler et al., 2013; Meyer, 2003). Within-population disparities of mental health outcomes are a result of how these forms of discrimination impact queer youth differently along the lines of disability, gender, and sexuality (Abrams et al., 2020; Collins, 2002, p. 23; Drummond & Brotman, 2014; Lund et al., 2020; McCann et al., 2016). Furthermore, multiple forms of discrimination also materialize during queer youth’s attempts to access the mental health support they need, which take, for example, the form of verbal harassment and refusal to
provide treatment (Kattari et al., 2020). While much is known about the pre-COVID-19 mental health inequities faced by queer youth, there are gaps in our understanding of how the intersections of queer youth’s multiple marginalized identities (e.g., queerness and disability) have impacted their mental health experiences during the pandemic.

1.3 Queer Youth Mental Health and the COVID-19 Pandemic

In 2019, the global COVID-19 pandemic and the public health measures mobilized to flatten the transmission curb of the virus resulted in an online shift of social supports, mental health supports, and disruption of formerly in-person opportunities to connect with other queer people—isolating some queer youth in unsupportive home environments away from their peers and support networks (Chaiton et al., 2021; Fish et al., 2020; Glazier et al., 2021; Paceley, Okrey-Anderson, Fish, McInroy, & Lin, 2021; Rauschenberg et al., 2021). COVID-19 public health directives impacted the social networks that queer youth rely on for financial support and to provide various forms of social support (Kia, Robinson, MacKay, & Ross, 2021; Rauschenberg et al., 2021; Ross et al., 2016). For example, the shifting of post-secondary classes online to curb the spread of COVID-19 at the beginning of the pandemic forced queer students back into living environments that may be unsupportive and potentially unsafe and separating them from post-secondary-based resources like gender and sexuality alliances, affirming teachers, and subsidized or free mental health services and support (Fish et al., 2020; Salerno, Devadas, Pease, Nketia, & Fish, 2020). Previous research has also documented how this virtual shift of services and social support online has isolated of queer youth to potentially unsafe living spaces away from in-person community and social support and therefore increasing the risk for
depression, anxiety, and suicidal ideation (Fish et al., 2020; Gato et al., 2021; Salerno & Boekeloo, 2022; Salerno et al., 2020).

Furthermore, COVID-19 has caused different mental health outcomes within populations of queer youth. For example, non-binary youth disclosed higher levels of anxiety and depression and trans individuals disclosed higher levels of PTSD symptoms because of the pandemic than their cisgender counterparts (Alonzi, La Torre, & Silverstein, 2020; Gibson, Schneider, Talamonti, & Forshaw, 2021). To understand how overlapping forms of oppression (e.g., ableism and homophobia) reinforce and interact with each other to produce distinct mental health-related harms during COVID-19, intersectionality can be applied. For example, existing research details how people living with disabilities experienced higher rates of pandemic-related stressors that negatively impacted their social lives, quality of life, and employment differently from their able-bodied counterparts (Ciciurkaite, Marquez-Velarde, & Brown, 2022). However, focusing solely on disability as the “primary factor explaining lockdown experiences of disabled youth” ignores the interactions between the individual and “the complex interplay of multitude of different factors in a specific context” (Mietola & Ahonen, 2021, pp. 102,114). Thus, greater understandings of how the interplay between queerness, age, and disability informs queer youth’s mental health experiences of COVID-19 will benefit from intersectional analyses.

Physical distancing measures to address COVID-19 also introduced additional barriers to mental health care access, including disruptions to in-person counseling services, poor internet connectivity hampering access to virtual supports, and the creation of barriers for people with disability whose needs cannot be managed virtually or in a physically-distanced fashion (Bowman et al., 2020; Hawke, Hayes, Darnay, & Henderson, 2021; Richardson et al., 2020; Schormans, Hutton, Blake, Earle, & Head, 2021). Even though existing literature has
demonstrated that there exists various infrastructure- (e.g., internet access) and accessibility-based barriers to uptake of virtual mental health supports during COVID-19, there remains limited knowledge on how different populations of queer youth are impacted by these barriers and how they are adapting to meet their mental health needs.

In sum, COVID-19 and the corresponding public health measures have disrupted and transformed the lives of queer youth by moving their social and mental health supports online in ways that have unintentionally isolated youth from the social networks and in-person resources (Chaiton et al., 2021; Fish et al., 2020; Glazier et al., 2021; Paceley et al., 2021; Rauschenberg et al., 2021). As such, COVID-19-related experiences have had a significant impact on the mental health-related experiences and needs of queer youth, including those occupying intersecting positions (e.g., those living with disability). While emerging research has highlighted how mental health disparities are unequally distributed among populations of queer youth (e.g., gender and sexuality), more research is needed on the role that intersectional oppressions play in impacting how queer youth with disabilities navigate COVID-19 and mental health.

1.4 Queer Youth’s Virtual Lives in an Era of COVID-19

Queer youth have historically used virtual spaces to seek social connection. As COVID-19 ushered in a period of intense isolation for young people, many turned towards online spaces (Lopatovska et al.; Marciano, Ostroumov, Schulz, & Camerini, 2022; Salzano et al., 2021) – spaces that have been well documented as providing critical opportunities for queer youth to form social connections that they may not have access to in their existing physical environments (Ceglarek & Ward, 2016). For example, social networking sites (SNS) often represent important spaces where youth can find belonging with others who have similar identities (Ceglarek &
Ward, 2016; Spies Shapiro & Margolin, 2013), can support sexual and gender identity
development (Giano, 2021), and provide opportunities to engage in information-seeking and -
sharing practices (Fox & Ralston, 2016; Primo, Zamperini, & Testoni, 2019). However, previous
research also documents how SNS can also represent unsafe spaces for queer youth. For
example, trans individuals are subject to higher rates of digital harassment and abuse (Powell,
Scott, & Henry, 2018), negative SNS interactions can worsen pre-existing depressive symptoms
(Davila et al., 2012), and queer youth are more likely to experience cyberbullying than both their
cisgender and heterosexual peers (Elias & Gorey, 2022; Vidal, Lhaksampa, Miller, & Platt,
2020). The complex and conflicting relationships that queer youth have with SNS invite further
investigation into understanding the role SNS plays in the mental health strategies of queer youth
during the pandemic.

Given the role of the internet within many young people’s lives, early in the pandemic it was
hypothesized that the provision of virtual care, including mental health care, could reach young
people with relative ease. Unfortunately, it has become clear that the shift to virtual mental
health supports that has been documented to have both equity- and inequity-enhancing
outcomes. For example, while telepsychiatry and telemedicine have been demonstrated to be
effective interventions for depression and anxiety (Chattu, Lopes, Javed, & Yaya, 2021),
questions about who is able to access these services and how remain. Nevertheless, COVID-19-
related shifts to virtual mental healthcare have been previously tied to improved access for
neurodivergent individuals (Ameis, Lai, Mulsant, & Szatmari, 2020). However, despite
widespread shifts to virtual mental healthcare at the beginning of the pandemic (Gratzer et al.,
2021) and prevalent access to cellphones, there remains low uptake of tele-mental health services
among youth (Wood et al., 2020). Prior to the pandemic, in a study set in Ontario of youth who
identified having high mental healthcare needs between 2013-2017, only 1.5% of them accessed tele-mental health services (Toulany et al., 2021). Previously identified barriers to tele-mental health services have included poor internet service, limited or no access to private space, and lack of insurance coverage (Abramovich et al., 2021; Badawy & Radovic, 2020; Bhatti, Commissio, & Rayner, 2020; Hawke, Sheikhan, MacCon, & Henderson, 2021; Salerno et al., 2020; Wood et al., 2020). However, there remains significant gaps in our understanding of how queer youth are navigating intersections of ableism, homophobia, and transphobia during COVID-19 and how their resulting mental health experiences impact uptake of mental health services.

1.5 COVID-19, Queer Youth, and the Need for Remote Research Methods

COVID-19 has necessitated a pivot to digital and remote methods of data collection in qualitative health research work with youth, yet a variety of methodological, ethical, and practical questions remain about how to optimize these approaches. For example, while virtual methods may be helpful in documenting the experiences of diverse populations of queer youth and their evolving mental health strategies in the era of COVID-19, examples of the kinds of methodological approaches and data collection tools for doing so have yet to be assessed. This knowledge gap is particularly salient, as digital and remote methods are known to be helpful in mitigating potential cost-barriers to research engagement, allowing participants to participate from their own home, and being adapted to incorporate other elements (e.g., audio, video) to broaden accessibility (Jenner & Myers, 2019; Milligan & Bartlett, 2019; Oliffe, Kelly, Gonzalez Montaner, & Yu Ko, 2021). These benefits can allow for the participation of populations of queer youth (e.g., members of the disability community, immunocompromised individuals) who
might not otherwise be able to participate in research during COVID-19 to share their unique experiences of illness, reduced support, and isolation (Tremblay et al., 2021). Repeat points of contact can also allow for deeper insights into queer youth’s evolving experiences with the pandemic over time (Bijker, Haartsen, & Strijker, 2015; Bolger, Davis, & Rafaeli, 2003). Remote methods of data collection have been previously documented to allow for more flexibility in scheduling interviews, mitigate potential cost-barriers (e.g., transportation costs), and allow participants to engage from their own private settings (Jenner & Myers, 2019; Oliffe et al., 2021). These benefits, however, must be weighed against the limitations of the method, which often include a lack of control over the interviewee's environment and privacy, decreased ability to interpret body language, and the technical challenges related to stable internet connection (Gray, Wong-Wylie, Rempel, & Cook, 2020; Jenner & Myers, 2019).

Prior to COVID-19, diaries have been widely used in health research in a variety of forms, and have been creatively adapted digitally to meet the accessibility needs of those for whom written diaries may serve as a barrier (Milligan & Bartlett, 2019). In previous research, adaptations to broaden the accessibility of digital diaries have often taken the form of incorporating video, audio, and photographic elements to study participation (Cooley, Holland, Cumming, Novakovic, & Burns, 2014; Jacelon & Imperio, 2005; Milligan & Bartlett, 2019). The attributed strength of both written and digital diaries are in the method’s use of repeated points of interaction between the researcher and participants, which can allow for the capturing of trends and key events over time in ways that might not be possible using other methods (Bijker et al., 2015; Bolger et al., 2003). A multi-method design featuring the combination of two qualitative methods like digital diaries and remote interviewing may serve to offset each method’s individual shortcomings (O'Reilly, Kiyimba, & Drewett, 2021; Stoecker & Avila, 2021). Thus,
the application of a digital multi-method research design may fill in gaps in understanding around the equity-based implications of a shift from in-person to digital methods, and what this means for the accessibility of research. At this juncture, more research is needed to understand the challenges and opportunities that arise from a shift from in-person to virtual methods when studying the experiences of queer youth living through COVID-19.

1.6 Research Context

The research study informing this thesis was conducted in Metro Vancouver, which is a metropolitan area situated in the Canadian province of British Columbia that has a population of 2,691,343 people (Statistics Canada, 2020). Most of the participants lived in the City of Vancouver, located within Metro Vancouver, which is situated on the unceded and occupied homelands of the xʷməθkʷəy̓əm (Musqueam), and the territories of the Skwxwú7mesh (Squamish) and Səl̓ílwətaɁ (Tsleil-Waututh) peoples. Before Vancouver, there existed villages like that of c̓əsnaʔəm, which was inhabited for over 3000 years by the xʷməθkʷəy̓əm (Muntean et al., 2015). The ongoing displacement and looting of the items and remains of the ancestors of the xʷməθkʷəy̓əm represents one story of many ongoing stories of colonization (e.g., the forced relocation of the village of sən’aʔqʷ) and genocide that are inseparable from what Vancouver is as a city (Harris, 2017; Muntean et al., 2015).

Concurrent to the ongoing pandemic in Vancouver, the overdose crisis is a second, overlapping public health emergency that has claimed over 8000 lives since the provincial government announced a public health emergency in 2016 (British Columbia Coroners Service, 2021; Krausz et al., 2021). Throughout the course of the pandemic, COVID-19 public health guidelines have interrupted how youth access and consume substances (Dumas, Ellis, & Litt, 2020; Jayasinha,
Nairn, & Conrod, 2020). Additionally, COVID-19 public health guidelines have also impacted how youth practice harm reduction and access harm reduction supports (Goodyear, Mniszak, Jenkins, Fast, & Knight, 2020; Noyes et al., 2021). Access, consumption, and harm reduction strategies are further complicated by the criminalization of “illicit” substance use in Vancouver, which has also contributed to negative substance use-related health outcomes (Boyd, Fast, Hobbins, McNeil, & Small, 2017; Pan et al., 2013; Papamihali et al., 2020; Small, Kerr, Charette, Schechter, & Spittal, 2006).

Vancouver has also historically been home to the Davie Street gaybourhood—a gay-dense neighbourhood that is the center of significant celebrations (e.g., Pride), services, and businesses for members of the queer community (Ghaziani, 2014). However, beyond findings from 2015 indicating there may be between 10,000 to 41,777 men who have sex with men (MSM) living in the Metro Vancouver area, (Rich et al., 2018), there is a lack of data available to provide us with a sense of how many queer youth live in Metro Vancouver. Nevertheless, in British Columbia, there exists a variety of services and supports for queer youth ranging from school-based social support resources like gender and sexuality alliances (GSAs) (Bain & Podmore, 2020); online STBBI testing services (Dulai et al., 2021); in-person testing, counselling, and drop-in services for sexual and gender minority youth and adults (Bain & Podmore, 2021); and volunteer-based support services (Catungal et al., 2021).

1.7 Theoretical Framework

Social Constructivism

The component chapters of this thesis will be guided by the interpretative framework of social constructivism. Social constructivism argues that individuals seek to understand the world in
which they live and this process of subjective meaning-making is formed through interactions
with others and through the historical and cultural norms that individuals are embedded within
(Gergen, 1985). This implicates how researchers ought to think about their own research since
their background (formed also by historical and cultural norms) shapes their interpretation of the
research and this must be accounted for (Burr, 2015). A social constructivist epistemology
orients research objectives of this thesis to reject notions of “essential or natural givens” that
present outcomes of social processes as inevitable when they are not (Schwandt, 2007).

The ontology of qualitative research acknowledges that there are multiple realities that are
produced from overlapping phenomena, and by applying a social constructivist lens this thesis
aims to integrate within its understanding of meaning-making the multiple realities of the
participants and attempt to account for the ways that the researcher’s own interpretive bias
shapes how these realities are presented and analyzed. This thesis parts from Creswell’s
epistemological vision of qualitative research insofar that the goal is not to “get as close as
possible to the participants being studied” or “minimize the ‘distance’ and ‘objective
separateness’ between the researcher and the researched (Creswell, 2018). The epistemology of
social constructivism reminds us researchers are embedded within their own historical and
cultural norms and so the desire to attain ‘closeness’ needs to be troubled with the need to
acknowledge the power differentials between the researcher-researched, and the position of
researchers within processes of knowledge production and legitimation (Reyes Cruz, 2008;
Vandenberg & Hall, 2011).
1.8 Notes on Language

The process of selecting an ‘appropriate’ term for the purpose of this thesis is difficult with an ever-evolving vocabulary of queer experiences and identities that subjects consensus to cultural, generational, and regional distinctions when it comes to deciding how to talk about the community as a whole (Panfil, 2020). My choice of language that I use (or do not use) also has political implications because of historical power dynamics within healthcare and within the queer community that have often prioritized strict gender and sexual dichotomies that erase and marginalize everyone else who does not fall within them (Manning, 2009). For this thesis, I will be using the term “queer” as a stand-in for longer acronym 2SLGBTQ+, which stands for Two-Spirit, Lesbian, Gay, Bisexual, Trans, and Queer. “Queer” will also be used as a stand-in for the term, coined by Phylesha Brown-Acton, MVPFAFF, which stands for mahu, vakasalewa, plaopa, fa’afafine, akava’ine, fakaleiti (leiti), and fakafifine (Ministry for Pacific Peoples, 2022). MVPFAFF speaks to gender identities and sexualities that are specific to Pacific peoples (Ministry for Pacific Peoples, 2022) and my collapsing of the term into queer should not be read as queer and MVPFAFF being analogous categories. They have distinct histories but are combined for the sake of brevity in this thesis.

My choice to use queer over other alternatives, e.g., sexual and gender minorities (SGM), is not without its limitations. The process of determining ‘appropriate’ language is one of hegemonic struggle that occurs simultaneously within-population (e.g., cultural, and racial preferences on terminology among cisgender gay men) and between the queer community and the institutions they navigate and are a part of (Fairclough, 2013). By disclosing my thought process, I hope to clearly show the reader how and why I am choosing to use “queer” over other terminology and
acknowledge that this choice is being made in a complicated sociolinguistic landscape where the inclusion or exclusion of letters or the adoption of a singular term can have very serious ramifications on lives.

Throughout the course of the following chapters, I will also be using language like “disabled”, “people with disabilities”, and “members of the disability community”. The choice to use this language is informed by the decision to use a combination of identity-first (e.g., “disabled people”) and person-first (e.g., “people with disabilities”) that recognizes disability as a culture and not a deficit, and also aims to reflect language that is presently used by members of the community and scholars (E. E. Andrews et al., 2019; Best, Mortenson, Lauzière-Fitzgerald, & Smith, 2022). As such, this thesis will not use language like “differently abled”, “special needs”, “physically challenged”, and “handicapable” as these terms are described as “disability euphemisms” and are seen as problematic because they are often created by non-disabled people and are seen as “superficial, infantilizing, and patronizing” (E. E. Andrews, Powell, & Ayers, 2022).

1.9 Positioning Myself: Storytelling, Responsibility, and Duty

I am a settler who currently lives on the unceded and occupied homelands of the xʷməθkwəy’əm (Musqueam). I identify as non-binary, mixed (white/iTaukei), and queer. When I write of being of iTaukei heritage, I am connected through my mother. I am Kai Dewala from the village of Nagigi. I did not always have the words to describe what I was taught growing up, but the values that I was imbued with communicate these words that I continue to learn in Fijian. I was taught by my mother, and maternal grandmother, and observed how they spoke of leadership, duty, and of responsibility, and observed how they carried themselves in the village. My grandmother, to
whom I respectfully refer to as Nau, would describe these mannerisms as *vakamarama*—a rugged translation of this would be “lady-like”, but it is more appropriately understood as the gendered compainion to *vakaturaga*, which is to carry oneself in a chielfy manner (Nabobo-Baba, 2015). This concept of *vakaturaga* is intimately connected with kinship (*veiwakani*), and is about knowing one’s position in society and the obligations that they have to others of status similar, below, or above their own (Nabobo-Baba, 2015). The showing “love and empathy for kin” is enacted through gifting (of land, and otherwise), enacted through what Nabobo-Baba argues is:

“...*distributive justice—a form development not often discussed in economics classes in universities, where the emphasis is on individual accumulation of property and capital.*”

(Nabobo-Baba, 2015)

These obligations extend to participants in the research and understanding the responsibility that comes having stories shared with you. I have positional power in these interactions, and so I am obligated to do my best so that the findings are translated and mobilized in a way that help bring awareness of the lived experiences of those I interview, and begin to affect change in a meaningful way. The associated obligations of kinship and knowing one’s position also means that it is necessary that I am explicit with my positionality so as to not communicate shared lived experience where there is none, and not obfuscate power dyanmics where they do exist. I have a family doctor, and I have a job that pays a living wage and provides extended health benefits, and allows me to work remotely during this pandemic—a privilege that is not available to many individuals my age, nor to many others in the communities that I am a part of. My mother, for example, is a care aid and has worked throughout the pandemic—often times in full personal protective equipment. I am fortunate that the carehome she worked for was spared (until
recently) from the outbreaks that occurred at many others, and I am fortunate that she is in good health and fully vaccinated. As I write this, I also think of my family in Fiji. When I first wrote this statement, it was announced the daily COVID-19 case count has extended beyond 1000, a terrifying number for a country as small as Fiji. I am fortunate so far that my family in Fiji has not significantly been impacted by COVID-19 and I hope that remains the case.

As a Fijian academic, my values align with those taught and passed on to me by my family, and they implicate how I move through the world and how I approach research. Fijian epistemologies understand knowledge as a gift, and thus the process and protocols of “knowledge-gathering” in research contexts is infused with values of reciprocity, respect, love, mutual care, and “commitment to the researched people’s welfare” (Nabobo-Baba, 2008). There is also an understanding of the consequences of what happens when research is done poorly, and that it (especially when conducting work in the vanua) can have long-term consequences on perceptions of the researcher and their family (Meo-Sewabu, 2014). Meo-Sewabu emphasizes the importance of “cultural discernment” offered by relatives engaged in research as a means to ground the ethics of the work in community values (Meo-Sewabu, 2014). While I am not conducting research on my own people, I am guided by the experiences of my clan with researchers and the values taught to me by mother and maternal grandmother. I recall my own conversations with my mother about the researchers that come to our village, and her own resignations of how, “They come, they do their work [often researching marine life], and then they leave. We all know this. There have been many researchers like this.” I think also of the times when my own conduct has been brought into question, to which my mother will jokingly chastise me with, “Rodney, this is the Kai Valagi [white] side of you coming out”. Ultimately, I am guided by the epistemologies that have always been present in my life, and through processes
of discernment from family and supervisors I hope to continue to remain accountable to these values.

I begin the introduction of my thesis with the excerpt of a poem titled, “Not the Pacific We Know (But Still the Pacific)”. The poem was drafted and assembled from a Zoom conversation on being Pacific Islanders in the Pacific Northwest that took place between myself and two former residents of Green College who were also Pacific Islanders. The placement of the poem is intended to begin to graft Indigenous lived experience and epistemologies into the thesis through the use of poetry as a way to “disrupt sense-making and prompt sense-sensing” (Ahenakew, 2016, p. 337). Rather than end my thesis with a call to action, I want to place it at the very beginning:

“No that you know: / You will remember what we/ have shared./ Now that you know:/
You know we were here./ Now that you know:/ You know a little more/ About who I am.”

By not providing context for the placement of the poem at the beginning of the chapter, I invite the reader to sit with the disrupted sense and ambiguity of the excerpt and encourage the reader to ask who is the “we” that has been here? The “we” in this context is fungible: it can represent myself and the other Pacific Islander authors of the poem, but it can also represent the study participants and anticipates their shared stories. I wrote “Not the Pacific We Know (But Still the Pacific)” because I wanted my voice and the voices of the authors to have a platform to explain how we have struggled with being grafted into this institution—and, truthfully, I wanted to have the opportunity to exist in my own work. My use of poetry was a way to explore and name the norms that I am emersed in and how they shaped and continue to shape my research and my perspectives on responsibility and accountability, which is in line with my use of the interpretive
framework of social constructivism (Burr, 2015). Similarly, the diary entries and the transcripts of the interviews with the research participants also provide an opportunity to showcase youth’s ups and downs of their experiences of this ongoing pandemic. In this context, social constructivism and poetry pair as a way expand potential interpretations of youth’s experiences in a way that challenges assumptions of “essential or natural givens” that allow us to understand the diversity of within-community experiences of mental health during COVID-19 (Gergen, 1985). By writing, “Now that you know:/ You will remember what we/ have shared”, I envoke the sense of obligation and responsibility intrinsic to vakaturaga and kinship. Now that you know that I am a Fijian academic, I will no longer be some amorphous brown entity; now that you have heard the stories of the research participants, you will carry the memory of their experiences responsibility and with the aim to act.

### 1.10 Introducing the Research Participants

Fifteen youth took part in the research study and were recruited between November 2020 and June 2021. In a sociodemographic questionnaire digitally circulated to participants before the intake interview, I asked participants in the survey many questions, including to share what services they used in the past year, whether they had access to personal protective equipment (PPE), where most of their social interactions took place, and whether their job was impacted by COVID-19.

At the time of their intake interview, participants disclosed having accessed a variety of different mental health supports in the past year, including twelve youth accessing a counsellor or psychologist, and four participants connecting with a mental health team, or a psychiatrist respectively. When it came to physical distancing and wearing PPE, nearly all the participants
shared that they practiced physical distancing where possible and wore a mask as often as they could when they travelled outside. Two participants shared, however, that they did not have the funds to constantly purchase PPE. Additionally, ten participants indicated that their jobs did not allow them to work remotely, and five reported that they had lost their jobs because of the pandemic. Finally, participants (n=13) indicated that their social interactions predominantly took place with the people they lived with, while a smaller proportion (n=5) indicated that they interacted with a small bubble of people outside of their household. Most of the participants in this study either lived with friends or roommates, with their family, or with their partner or spouse.

Of the fifteen youth that participated in this study, the analyses carried out in this thesis focuses on the experiences of nine of them. Below, participants are introduced with care provided to using pseudonyms and the omission of potentially identifiable information.

*Chris Rose (he/him)*

Chris Rose was a 22-year-old cis man who identified as white. He shared with me how the pandemic shifted his social world using the language of how “socialization is a muscle that I have to work” and how the pandemic has made it harder to socialize with people in general— even with close friends he felt that he was “out of practice” and he accepted that he was becoming a sort of “hermit” (Chris Rose, Intake Interview). As we wrapped up study activities, he talked about how he was moving to a new city soon and had been planning on taking some of the lessons he learned in Vancouver about healthcare access with him. He described how living here he felt like he was always “running around between clinics” (Chris Rose, Follow-Up Interview) and having to constantly go through his mental health history with each new provider.
When he eventually moves, he said he will try to find a physician and therapist as soon as possible to make sure that he has “set [himself] up well” (Chris Rose, Follow-Up Interview).

*Big Mac (she/her; they/them)*

Big Mac was a 23-year-old who identified as white and as a woman/non-binary/genderqueer person. She shared how her social supports were mainly stable because she lived with her partner that she enjoyed spending time with and would occasionally hang out with friends virtually. During her follow-up interview, she described being relieved that she had the opportunity to be double vaccinated, although her medical condition meant that she may not have developed the antibodies. She was excited to start seeing friends in person but was still avoiding public transit—especially since masks were no longer mandatory. Big Mac shared some of her experiences with the practicum program she was a part of and how she was distressed that it nearly took a year of the pandemic to get anywhere near an enforcement of mask wearing, and she said she felt like she was being “gaslighted”—especially when she saw kids who are visibly sick coming to class or noticed her colleagues who are away for two weeks at a time for similar reasons (Big Mac, Follow-Up). She said that, “It feels like the Twilight Zone...like everything Bonnie Henry says, I just feel like I can’t trust it. I feel like it’s just political, you know, sweet lies” (Big Mac, Follow-Up).

*May (they/them)*

May was a 23-year-old non-binary person who identified as white. May started this study during a serious heatwave that hit the province in 2021 and they shared in their diary how the combination of this being their first summer on testosterone, combined with antidepressants and climate change, made the heat intolerable. In our discussions, they talked about how people with
disabilities effectively feel disheartened every time the province lifts restrictions and prioritizes business over people. They spoke about how CERB allowed them to be able to see a therapist, but now that that has ended, they are paying out of pocket from their savings. May and I also talked a bit about gaming and how, for May, playing games like Stardew Valley helped them get into ‘the zone’ to do mundane, repetitive tasks. Gaming also was a way that May hoped they would be able to stay in contact with their friend who had recently moved to another country. Distance between themselves and their friends was hard for May, and they described how they missed being confident that their friends still cared about them.

Victor (they/them; she/her)

Victor was an 18-year-old non-binary/genderqueer individual who identified as white. Victor shared how the provincial health orders had interrupted various aspects of their life: whether it be the disruption of their trips to the local curling club which had been shut down, or how much they missed seeing their friends, or the stress of being worried about their parent working in a nursing home where there was a COVID-19 outbreak. They were excited to start in-person classes in the fall of 2021 and were excited for the world to “open up” and have the opportunity to “start real university” (Victor, Follow-Up). In their diary entries, Victor described themselves as a medically complex human, and many of our conversations touched on the many waitlists they’re on to receive the supports they need—waitlists that, in some cases, they’ve been on so long that by the time they get to the front of the cue they may age out of eligibility. One exciting update that they shared in one of their final diary entries is that they had recently received their chest binder in the mail and would start binding soon.
ZK (they/them)

ZK is a 22-year-old non-binary individual who identifies as Chinese. ZK described how being at home for work, living, and accessing healthcare presented “an extra level of difficulty” (ZK, Intake Interview) for their day-to-day life. Being at home for everything meant that they had less privacy and space to themselves since they lived with their girlfriend. While shifts to virtual and remote care meant they were able to access the services they need, they felt conflicted about how to talk about accessibility because many of the now adopted workplace measures around remote work have been a part of the demands that many in the disability community have been making for years, however, at the same time, these requests were only implemented when the need was coming from able-bodied individuals. ZK also talked about how the lack of accessible entertainment options (e.g., streaming sites like Youtube) meant that while everyone else has been watching shows and videos to cope with the pandemic, they were not able to do so because often subtitles are not available or are poor quality.

Pancake (he/him)

Pancake was a 19-year-old cis man who identified as South Asian. COVID-19 hit Canada after “Pancake” ended his first year of undergrad and he lost contact with all his friends he used to have before COVID-19 and found it difficult to meet new people. Pancake talked about how he was often overwhelmed by the news and needing to take breaks from it and described that he would often go through loops of overconsumption followed by shutting off completely from news media. He primarily consumed news through Youtube, and at the time of our interview he explained how it’s been a month since he’s consumed any news because he was still recovering. In terms of his personal social media use, he said that he found solace in Instagram. He knows
that the image and performance around Instagram can be unhealthy, but he likes having “this image online that acts like a wall” (Pancake, Intake Interview).

Leila (she/her)

Leila was 21-year-old cis woman who identified as Chinese. Leila disclosed that she was diagnosed with depression, and we talked a lot about mental health and mental health supports throughout the course of our conversations. She shared how the formulaic approach to providing support did not make her want to access services (e.g., helplines, counselors), and dissuaded her from texting hotline services because they give you a “scripted answer and generic advice” (Leila, Diary Entry). She talked about how she usually turns to her friends for support and COVID-19 has made her talk to her friends more. She had recently returned to Vancouver from visiting family in another province and talked about how she was happy that she had the opportunity to go to the beach with a friend and watch the sunset since she had been stuck inside with her family a lot at home.

Sadie (she/her)

Sadie was a 24-year-old cis woman who identified as white. Sadie talked a lot about their work and stress around working in a pandemic, whether it be taking roles outside of their job description (e.g., transitioning the workplace into a COVID restriction-compliant one, firing employees, etc.) and dealing with regulars and customers that refused to accept shifts in dine-in policies. Sadie also talked about how hard it was to connect with other queer folks when all the places where they congregate (e.g., clubs, social spaces) were closed due to the pandemic. Sadie talked about how much she missed not having to worry about who she interacts with and how every grocery shop or friendly visit is heavily weighed and caused feelings of guilt for many
days after until she knows she was not exposed to COVID-19. One thing that brought her joy is her cat, which she had adopted from her friend and has been a steady source of a joy.

*BL (they/them)*

BL was a 23-year-old non-binary, trans, and genderfluid individual who identified as Korean. BL talked about how the queer community is spread out in Vancouver and that they are not as connected to the community as they would like to be. They said that even before the pandemic, hanging out in DIY venues, parks, and houses the queer community did not feel “concrete” (BL, Intake Interview). In their dream world, BL imagined that everyone would be gay. BL talked about how they predominantly look to their friends and family for support because they do not have a therapist or counselor because of financial barriers. The shift online was frustrating for BL because they are quite a social person, and they don’t like being on the phone too much. They talked about how online platforms make it difficult to communicate all the emotions and nuances that speaking face-to-face allows.
Chapter 2: (In)equitable Shifts: Mapping a pivot to digital diary and remote research methods with queer youth in the times of COVID-19

2.1 Chapter 2 Overview

The aim of this chapter is to document my experiences with pivoting research on sexual and gender minority young people (ages 15-29) towards an online protocol via the use of digital methods. Digital diaries presented an opportunity to conduct virtual semi-longitudinal qualitative research on how youth describe their experiences of living through the COVID-19 pandemic in Vancouver, Canada. My digital diary process, supplemented with remote interviews, allowed me to capture shifting health-related patterns and trends over time, establish capacity to identify and explore unanticipated areas of inquiry, as well as to evaluate participants’ impressions of the digital diary method itself. While going ‘digital’ allowed me to overcome some immediate constraints to participation, it also introduced new uncertainties for inclusion, including equity concerns and issues around consistent, secure and safe digital access for research participants. I describe how various features of young people’s lives, including living with chronic pain, remain crucially important factors associated with their ability to participate in digital and remote research. Finally, I offer potential solutions to some of the challenges I have faced and conclude by arguing that to counteract the inequities arising from the shift to digital methods, we need flexible, adaptive and population-tailored digital and remote approaches to data collection.

Keywords: digital, diaries, covid-19, youth, accessibility, barriers
2.2 Introduction

The COVID-19 pandemic and associated public health measures have introduced challenges to conducting in-person qualitative research. In this chapter, I examine a series of challenges and opportunities that have arisen in my qualitative research as I shifted my in-person research activities with sexual and gender minority youth (SGMY) to digital and remote methods. I discuss how digital diaries, combined before and after with remote interviewing, can generate insights into how SGMY’s health-related experiences unfold across time. I also raise several technological issues and equity concerns that may complicate digital and remote approaches with SGMY. My aim is to document and address some of the key practical and ethical implications that can arise when shifting to digital and remote methods.

A pivot from in-person to remote and digital qualitative approaches

Much has been written about how to optimize qualitative data collection activities, including via techniques to establish participant-researcher rapport and trust, maintain confidentiality, and ensure the conditions for participation are safe (Chabot, Shoveller, Spencer, & Johnson, 2012; Fast, 2016; Kirk, 2007; Knight, Chabot, Shoveller, & List, 2017). In my research involving SGMY, for example, I use a variety of strategies, including taking the time to ensure participants are comfortable and that my own body language is open, friendly, and professional. The broader researcher teams that I am embedded within have a safety protocol to ensure participants who disclose to us that they are at risk of experiencing immediate harms can be connected with support before I part ways. A critical component of my research is to create the conditions that allow participants to discuss potentially stigmatizing topics with me, including experiences with substance use-related harms and mental health challenges. It is fair to say, however, that most of
my previous work and the work of my supervisors has relied primarily on in-person interactions to establish rapport, trust, confidentiality, and safety.

With the arrival of the COVID-19 pandemic in the spring of 2020, it became clear that using in-person methods to continue conducting my research was not going to be safe or possible for the foreseeable future. Contingency planning quickly focused on how my research involving SGMY could be conducted remotely, while continuing to prioritize participant safety and well-being. This planning included considerations of equity, including whether and how a shift towards remote and digital approaches would allow me to identify and interrogate how inequities occur within and across intersecting positionalities, including with regards to Indigeneity, disability, gender, sexuality, class, and race.

After reviewing and considering various digital and remote methods, solicited digital diaries emerged as a data collection technique that appeared to meet many of my needs. Diaries have been used in both qualitative and quantitative health research for more than 90 years (Milligan & Bartlett, 2019). Solicited digital diaries go beyond traditional, handwritten forms and have been described as being more inclusive because they can be “creatively adapted to meet the skills of those for whom written diaries may prove exclusionary” (Milligan & Bartlett, 2019). Digital adaptations of solicited diaries can feature a variety of different techniques to expand accessibility, including via the incorporation of video, audio, and photography to reach populations that may face barriers to participating in traditional written diaries (Cooley et al., 2014; Jacelon & Imperio, 2005; Milligan & Bartlett, 2019; Thomas et al., 2015). An important strength associated with solicited diaries, whether completed digitally or in written form, is the emphasis on repeat points of contact with research participants – an approach that can provide
opportunities to capture patterns, trends, and key events in ‘real time’ as well as over time (Bijker et al., 2015; Bolger et al., 2003).

As I reviewed the literature in this area, I found that others have used digital diaries to understand the factors and contexts that influence various health outcomes, including with regards to substance use- and mental health-related experiences among adolescents and SGMY (Ferraz et al., 2021; Heron et al., 2019; Koning, Harakeh, Engels, & Vollebergh, 2010). Digital diaries have also been used across a variety of other substantive areas, including with regards to adolescents and food environments (Staiano, Baker, & Calvert, 2012), religious mobile apps and how they are used by Evangelical Christians (Bellar, 2017), and the experiences of midlife women with daily hot flashes (Miller, Kerr, Fischer, Zhang, & Wood, 2009). Promisingly, these and other studies have reported high levels of retention and completion rates when using digital diary-based methods (Cherenack et al., 2016). And, while opportunities to establish rapport can be disrupted or complicated when using remote and digital approaches (Oliffe et al., 2021), researchers have also described how these approaches may provide conditions in which participants are less concerned about a researcher’s social judgments (Cleary & Walter, 2011).

Based on my review of digital diary methods, I began developing a protocol intended to capture, over periods as long as three months, how substance use and mental health featured within the evolving experiences of SGMY during the COVID-19 pandemic. I divided the diary entries into two sections: one section featuring a set of repeating optional prompts that participants could use to help them get started writing their diaries (see figure 2) and a second section with a set of guiding questions that changed for each entry, including topics such as social media use, substance use, mental health, and sexual health (see figure 3). The choice to have prompts rather than an open-ended format was to help focus responses on specific areas of interest to the
researchers (Filep, Turner, Eidse, Thompson-Fawcett, & Fitzsimons, 2018), and to offer support to participants who may not normally engage with diaries and thus could benefit from guidance. However, similar to others who have used digital diaries (Milligan & Bartlett, 2019), I let participants know that they could write about any issues of importance to them, and that they could go “off topic” from the prompts provided.

I also decided to employ a hybrid approach to data collection that, in addition to digital diaries, would feature two remote semi-structured interviews that could take place by phone or via Zoom video. Before and since the emergence of COVID-19, researchers have documented several challenges and concessions around using video conferencing and phones for interviews, with challenges including a lack of control over the participant’s interview environment, and the reduced ability to pick up on body language and facial expressions (Archibald, Ambagsheer, Casey, & Lawless, 2019; Jenner & Myers, 2019; Oliffe et al., 2021). Conversely, video interviews can allow for greater efficiencies around flexibility (e.g., scheduling) and overall cost savings (Archibald et al., 2019; Jenner & Myers, 2019; Oliffe et al., 2021). Video and remote interviewing also provides opportunities for participants to join from their own private or personal settings– an important consideration in being able to discuss highly personal issues, but which can also be complicated if those personal settings are not private (Jenner & Myers, 2019).

Others have described how the technical nature of using video conferencing software for qualitative interviewing requires key considerations around having a backup plan in the face of an unstable internet connection and the need for the researcher to optimize their own internet connection (e.g., hardwiring to the internet rather than relying on WIFI) (Gray et al., 2020).
2.3 A digital diary and remote interviewing protocol

With all of this in mind, I designed my digital diary and remote interviewing protocol to include an intake interview of approximately 30 minutes and a follow-up interview of approximately 60 minutes. I gave participants the option to participate in interviews via Zoom or phone call. I carried out a total of 7 intake and follow-up interviews over the phone and 20 intake and follow-up interviews over Zoom. During intake interviews, participants were introduced to the digital diary process, and asked a series of general questions regarding their experiences regarding substance use and mental health in the context of COVID-19.

Following the completion of the first interview, participants received a semi-weekly (every 3-4 days) email invitation to fill out a total of six diary entries over a period of three (or more, as needed) weeks. I hosted the solicited digital diaries on a secure survey interface named REDCap – one of few interfaces that was free for us to use through my institutional affiliations and fully compliant with provincial and federal research regulations and privacy laws. Participants were given up to a week to complete each entry but were always provided with the opportunity to ask for an extension (participants could take as long as they needed to complete the six entries). Upon completion of the diaries, participants were invited to participate in the one-hour follow-up interview. During follow-up interviews, the diary entries were discussed, and questions were asked based on information that was shared in the diaries. I also took this opportunity to evaluate participants’ overall experiences with the digital diary process by asking them questions about their experiences with the diaries.

Data collection began at the end of November 2020. Over a period of seven months, I recruited 15 participants (ages 15 to 25). Each participant took between one to two months to complete the
study. Participants identified across a variety of sexual and gender identities, could speak and understand English, and lived in Metro Vancouver. See figure 1 for a summary of the sample socio-demographics.

### DEMOGRAPHICS

- Age range (18-25); average age: 22;

- 60% of the sample identified as white, and the remaining 40% identified as Chinese, Korean, South Asian, or Latinx;

- 46.7% of the sample identified as non-binary, and the remaining participants identified as cis or a variety of different overlapping gender identities (e.g., “female” and “genderqueer”);

- 60% of the participants identified as bisexual, 53.3% as queer, 33.3% as gay, and 26.7% as pansexual;

- 66.7% indicated that they do not have the option to work remotely for their job, 33.3% no longer had a job due to COVID;

### SUBSTANCE USE

**Lifetime**

- 100% of participants recorded experiences with alcohol, 93.3% with cannabis, 53.3% with psychedelics, 26.7% with cocaine, benzodiazepines;

**Last 30 days**
• 66.7% disclosed alcohol consumption, 73.3% disclosed cannabis use, 26.7% disclosed psychedelic use, 13.3% disclosed use of benzodiazepines;

ACCESS TO CELLPHONE OR COMPUTER

• 80% had access to a cellphone with data, and 73.3% had access to a cellphone with WIFI;

• 93.3% had access to a private computer or laptop where they live.

PROGRAMS AND SERVICES USED IN PAST YEAR

• 73.3% accessed a primary care provider, 80% a counselor or psychologist, 26.7% indicated accessing drop-in programming, psychiatrist, or mental health team, respectively.

Table 1 Summary of the demographics of the research participants.

Below, I further describe my experiences pivoting towards the use of digital diaries and remote interviews with SGMY. I examine how these techniques allowed us to develop a semi-longitudinal qualitative data set that provided important insights into health-related experiences over time, and identify and explore unanticipated areas of inquiry. I interrogate some of the ethical and practical challenges and opportunities I faced, including with regards to barriers to participation and the accessibility of digital diary and remote methods, as well as my experiences meeting privacy and safety needs.
Figure 2 Optional prompts asking general questions about routines and life. Not always filled out by participants.
Figure 3 Recommended prompts that change with each entry and ask different thematic questions related to substance use, mental health, sexual health, and social media use.

**Identifying shifting patterns and unanticipated areas of inquiry**

Multiple opportunities to share experiences over the course of two interviews alongside digital diary entries enabled us to identify and explore unanticipated areas of inquiry that may not have been possible if I had only used one method or not conducted this work semi-longitudinally. Specifically, because most participants took upwards of 1-3 months to complete their participation in the study, multiple points of engagement over time meant that: a) there were several opportunities for participants to meet the researcher and familiarize themselves with the study design, b) participants were able to revisit and reflect on their experiences over a longer period and have more control over what they shared, and c) I was able to ask individualized questions during the follow-up interview that would not have otherwise been possible. I was also able to ask participants about their experiences with the study broadly and the digital diaries specifically.
As the study progressed, I learned that digital diaries could provide important insights into how the progression of the pandemic impacted participants’ frequency of substance use and the types of substances they used. For example, I identified how participants’ patterns of substance use and calculations of risk were shaped by experiences with the pandemic. Chris Rose described in a diary entry how increased overdose deaths since COVID-19 had impacted his willingness to return to harder substances that he used prior to the arrival of the pandemic:

*Substance use during the pandemic has greatly shifted in my life. I was an occasional “hard drug” or “party drug” user prior to the pandemic. Now, with the increase of overdose and opioid deaths since covid began, I am too concerned to revert back to using those drugs. Furthermore, with parties and clubs not happening, there isn’t much incentive to do them anyway. I do consume more pot (which I had previously quit before the pandemic) and alcohol now than before COVID. I drink a few nights a week and smoke likely those same nights.* (Chris Rose, Diary Entry)

Chris Rose’s shift away from the “occasional ‘hard drug’” was accompanied by an increase in consumption of other substances—namely, alcohol and cannabis. The semi-longitudinal study design featuring digital diary and remote interviews also provided opportunities to draw clearer lines between their own lives and the impacts of COVID-19 on their experiences with mental health and substance use. For example, during the intake interviews, participants generally described that Vancouver’s overdose crisis did not directly impact them. However, over the course of successive entries and interviews, participants began providing more detail about how the overdose crisis had impacted them, including deeply personal stories about their own experiences with overdose or the loss of individuals close to them (parents, partners, friends) due to overdose. This reflects previous findings on repeat points of contact providing researchers
with deeper insights into participants’ experiences with a phenomenon over time (Bijker et al., 2015; Bolger et al., 2003).

My study design also provided the conditions to identify unanticipated areas of inquiry. For example, one of the earliest findings that emerged in the diaries was that the pandemic introduced and entrenched barriers to mental health care access among SGMY. This finding arose within Chris Rose’s diary entries and their description of struggles with accessing the medications and supports they needed:

   My ability to access health care hasn't changed too much in covid because of online clinics, but support services have been difficult to access. I stopped seeing a counsellor because I didn't like the online format. I couldn't get access to PREP because the men's clinic wasn't taking on new patients during covid. Trying to change my medication during covid has been very difficult and uncertain. (Chris Rose, Diary Entry)

The combination of intake and follow-up interviews with semi-longitudinal solicited digital diary entries allowed us to explore unanticipated areas of inquiry and pilot questions among multiple participants. In the follow-up interview with Chris Rose, I took the opportunity to ask them to expand on their challenges with medications. It became clear that their status as an ‘out-of-province’ resident and student complicated their ability to access the services they needed. It also became evident that differences in inter-provincial pharmacare coverage meant that they could not afford the medication they needed in British Columbia to address their pandemic-related mental health challenges. Upon learning this, I extended this line of questioning to the other participants and found that the topic of insurance coverage and pandemic-related interruptions to care had wide-ranging relevance for several other participants.
As such, throughout data collection and analysis, I was able to identify both shifting patterns over time, as well as unanticipated areas of inquiry. My approach allowed us to visit and revisit emergent themes (e.g., with regards to insurance coverage and pandemic-related interruptions) over the course of several months through both interview and diary formats.

Limitations of digital diaries and remote interviewing: Whose voices are missing?

An early concern with my sampling strategy was around the ability of my online ads to encourage participation among a diverse sample of SGMY. Initially, I relied primarily on recruiting through social media. I then decided to supplement digital outreach with a mixture of circulating recruitment materials among my community partners, snowball sampling, and targeted recruitment of past research participants who met my sampling criteria. While I was able to recruit a gender-diverse sample, I was unable to recruit queer and Two-Spirit Indigenous youth or Black SGMY. Furthermore, while some of the youth participants in the study had experiences with emergency housing supports, none of the youth disclosed being street-involved.

Street-involved youth and Black and Indigenous SGMY have distinct and significant experiences with the overdose crisis and COVID-19 pandemic that are missing from my data. A lack of street-involved youth and Black and Indigenous SGMY in this study means that I do not have a sense of how these individuals would experience or react to the use of digital diary methods. Street-involved youth, for example, frequently navigate digital spaces via mobile phones and publicly-accessible computers (Selfridge & Mitchell, 2021). It is likely that consistent access to public computers may have been temporarily interrupted because of the closure of public libraries and drop-in spaces at the beginning of the pandemic, thereby further restricting their ability to participate. While I was unable to generate data with and for street-involved youth and
Black and Indigenous SGMY, it is my hope that I can identify other remote methods and strategies that are more inclusive, while also acknowledging that supplementing— or altogether replacing— remote methods with in-person activities (e.g., via the spaces and places where SGMY spend time) may be a more appropriate solution for some groups of youth.

2.4 Digital Diaries and Accessibility: Whose voices are included?

Initially, I had anticipated that the extended duration of the study would be a barrier to participation. Two solicited diary entries a week for a total of six entries to be completed over the course of a month felt like it could be a lot to ask of participants. However, when consulted during the follow-up interviews, participants described digital diaries as being a low-barrier and accommodating approach, something that several participants with a disability described as being particularly novel and important. I came to realize my use of digital diaries and remote interviewing had enabled the participation of individuals who might have otherwise not participated in my research. By shifting to digital methods, I had unintentionally shifted towards an approach that was more broadly accessible for some than the in-person methods I had traditionally used. For example, one participant described how the digital, self-paced nature of the diaries was important for individuals who might not always be able to make in-person interviews due to physical and mental health challenges or other more important demands on their time:

*If I’m just having a low day, where I’m in a lot of pain or I’m too tired to really leave the house, an in-person thing is not going to really be accessible, and it’s not going to be a priority for me. Whereas something like a diary entry I can do even when I’m not feeling super well. Um, yeah, and just recognizing that a lot of people are working, you know,*
nine to five jobs, or they’re taking care of children, or they have school, and there’s a lot of reasons why it’s – it would just be really difficult I think to go and meet someone in the middle of the day. And I think it’s a lot of – it’s a bigger sacrifice that you’re asking for in research participants if it’s in person. (Big Mac, Follow-Up Interview)

Among participants who were living with chronic pain, and/or disclosed having a disability, the diaries were described as a low-barrier way to engage with the study on their own terms that allowed for ongoing, continued participation in a semi-longitudinal study design – something they described as not being possible for them via in-person approaches. Another participant talked about how the diary entry format was comfortable for them to engage with because it was a familiar mode of communication that was already a part of their online lives:

I think it’s important to mention the context, that I am – I’m autistic, and I’ve used social media and blogging forever, to communicate with people. So I feel like it felt more like blogging, or like, you know, making a sad tweet and people can – I find that generally kind of easier, because then people can approach that content at their pace, and I’m just kind of like throwing that communication out into the void, and be like, “Hey, I have these needs that aren’t getting met.” So, you know, throwing words out into the void. I’m kind of used to it. It feels pretty normal. (May, Follow-up Interview)

My conversations with participants challenged us to reflect on how my traditional reliance on in-person research activities (e.g., semi-structured interviewing, fieldwork) can exclude disabled and neurodiverse individuals from my research. My assumptions around what constitutes accessible methods of data collection can have ableist dimensions. At this juncture, carrying
forward with my research, I find myself strongly leaning towards a mix of digital and in-person approaches as a means of promoting equitable access to research participation.

Technical issues

The hybrid approach of using both digital diaries and remote semi-structured interviewing by phone call or video conferencing software also brought to light how the former method can mediate inconsistent or limited high-speed internet access – an issue documented previously by others (Archibald et al., 2019; Gray et al., 2020; Oliffe et al., 2021). Throughout the course of data collection, there were repeated instances when Zoom calls cut off multiple times throughout the course of an interview, requiring participants to repeat what they had said multiple times. There were numerous other technical issues with Zoom which made it difficult to understand what was being said and complicated the transcription process. One participant also noted their inability to access high-speed internet due to their location in Metro Vancouver:

You’d think living in Metro Vancouver, we could access high-speed Internet here. But we live in a rural part of Metro Vancouver, apparently, which whoever knew [Vancouver borough] had a rural part to it? So no Internet company has got high-speed Internet out here...So like, you know, my sister was trying to watch her show this morning, and I was trying to do a Zoom call this morning. It doesn’t work. You can’t stream and do a Zoom call at the same time. (Victor, Follow-Up Interview)

In contrast to Zoom calls, diary entries could be filled out in a self-paced manner, and participants generally found this method to be less impeded by poor or inconsistent WIFI access.
Of course, successful uptake of any digital and remote methods (e.g., Zoom calls, digital diaries) is shaped by access to information and communication technologies (e.g., mobile phone or computers) that in turn require robust WIFI infrastructure. This limitation is especially important to consider when undertaking research with those living in more rural, remote, and resource-limited settings. Despite the challenges with internet speed and video-conferencing (e.g., Zoom) to carrying out remote semi-structured interviews, participants did not indicate that quality or consistency of internet connection presented any barriers to filling out their diary entries online.

Privacy and safety concerns

In a diary entry, ZK reflected that, in the context of COVID-19, “Everything happens at home now, which means I have less privacy and less & space to myself in general.” Most of the participants in the study lived with either a partner, family member(s), or roommates. In some cases, participants were students who were attending school remotely over the course of the study. Prior to data collection, I sought to be clear with participants during eligibility screening and the informed consent process that I could not carry out a remote interview without them first guaranteeing that they had access to a private space. Living with people presented barriers to participation and complicated the guarantee of complete confidentiality. For example, one participant tried to schedule their remote interview during a time when their roommates were not home. WIFI issues throughout the conversation meant that the interview extended into the time period when their roommates returned, and the call had to be ended early. Sometimes, because many participants opted to keep their cameras off during the Zoom call, it was difficult to ascertain whether the space they were calling from was, in fact, private. I did not mandate that participants turn on their cameras because I acknowledged that many of them may have already spent a significant amount of their day on video-conferencing software and I did not want to
contribute to feelings of ‘Zoom fatigue’ (Wiederhold, 2020)—though this did mean that for a portion of the interviews I was not privy to body language or facial expressions and had to rely on tone of voice.

For younger participants who lived with family, barriers to guaranteeing privacy occasionally looked like the first author (RS) hearing a parent come into their room and make a short inquiry (e.g., “Have you eaten yet?”). Despite the relatively minor nature of the interruptions, I was worried about whether participants’ privacy and confidentiality were being breached in these instances. While participants consistently reassured us that they did not have concerns, ZK’s statement about how “everything was happening at home” during the pandemic complicated my ability to make the same kinds of promises to young people about confidentiality as if they were doing an in-person interview with us in the field office.

Conversely, concerns around privacy did not come up in conversations with participants about their experiences of using digital diary methods. Instead, participants talked about the comparative accessibility of digital diaries when compared to both in-person and remote interviews:

> I can see how it would be easier if you’re someone who can only access Internet in public spaces. It’s probably easier to do a diary entry sitting in a mall or something than it is to do a whole Zoom interview in a mall. So I think probably this sort of diary entry is still more accessible than other traditional means of surveying populations. (Big Mac, Follow-Up Interview)

In the context of my study, digital diaries seemed to allow participants to better participate across settings with variable levels of privacy and were far less reliant on strong WIFI connections. The
use of both digital diaries and interviews was a means of balancing out each method’s shortcomings. Remote interviewing was useful for getting participants to expand on sometimes sparse diary entries. Diary entries allowed for semi-longitudinal data collection that seemed to be largely unimpeded by internet connectivity and access to private space.

As I began implementing the digital diaries, I also found that this medium presented us with distinct challenges around ensuring participants’ wellbeing and safety in comparison to both in-person and remote interviews. For example, I found that the confessional nature of diary entries introduced new challenges with regards to keeping participants safe, including with regards to assessing if they were at risk for experiencing immediate harms. For instance, at times, I found it challenging to interpret tone from the diary texts when participants were discussing mental health challenges – something I can address in ‘real time’ via a team protocol when I am in-person. However, it quickly became clear that previous in-person protocols for ensuring participants safety were insufficient with regards to the digital diaries, so I quickly established procedures to review all text within 24 hours of receiving a diary submission and to determine if there were any disclosures of immediate harms that I would need to address. While I did not ultimately need to contact any of the participants out of concerns around disclosures of harm, my experiences underscored the importance of adapting and developing robust safety protocols when using digital diaries – particularly when dealing with issues such as substance use and mental health.

2.5 Conclusion

The application of digital diary methods alongside remote semi-structured interview techniques can allow us to capture SGMY’s evolving experiences during the overlapping COVID-19 and
overdose crises. My study design enabled us to revisit some of the details from participants’
diary entries during interviews, which allowed us to gain deeper insights on what was shared and
to explore unanticipated areas of inquiry and findings. My use of digital and remote methods also
provided opportunities for participants who may have been unable to access my in-person
research activities, including those disclosed living with chronic pain and/or living with a
disability. I also faced a variety of challenges, including participants’ inconsistent access to
quality internet connection and private spaces. However, because I relied on a phased approach
that employed both digital diary methods alongside remote semi-structured interviews, I found
the limitations of one method (e.g., remote interviewing interrupted by poor internet) could be
somewhat balanced by the strengths of another (e.g., the ability to submit entries at any time with
digital diaries). Additional research is recommended to understand the appropriateness of these
methods for studies with Black, Indigenous, and street-involved youth in my and other similar
settings, as these were populations not accounted for in my study sample. Future work should
also explore how digital diaries may be used as a complementary option for research engagement
alongside other in-person methods in order to increase accessibility. Overall, I found digital diary
methods to be an effective way to document the experiences of SGMY in the times of COVID-
19, and participants perceived digital diaries as a low-barrier and accessible way to participate in
qualitative health research
Chapter 3: “I’m on My Own”: Queer Youths’ Experiences of Navigating Mental Health During the COVID-19 Pandemic

3.1 Chapter Overview

The objective of this study was to identify how the mental health experiences of queer youth were impacted by the COVID-19 pandemic. Fifteen queer youth aged 15 to 25 from Vancouver, Canada were recruited between November 2020 and June 2021 to participate in semi-weekly, solicited digital diary entries and semi-structured intake and follow-up interviews about various topics including COVID-19, social distancing protocols, and mental health. Using thematic analysis, three major themes were identified pertinent to queer youth’s mental health experiences. First, participants described how COVID-19 impacted social support by describing the limitations of their existing social networks and feelings of disconnection from the queer community. Second, the mental health impacts of public health guidance and the offloading of responsibility onto the individual were described in terms of the stress associated with risk-minimization and navigating ableist public health guidelines. Finally, participants detailed evolving mental health strategies based on their changing experiences of virtual mental health support. These findings identify how COVID-19 and the associated public health guidance interrupted identity-development, offloaded risk-management onto the individual, and facilitated a shift to virtual mental healthcare. However, insufficient accessibility built-in to virtual mental healthcare highlighted distinct within-population mental health inequities that challenge the possibility of an equitable ‘return to normal’.
3.2 Introduction

Heteronormative and cisnormative social conditions produce stigma that is operationalized in the form of homophobia and transphobia (Bradford & Syed, 2019; Perez-Brumer et al., 2019). Heteronormativity assumes that sexual and romantic relationships only occur among cisgender men and women, and cisnormativity assumes that all people identify with the gender they were assigned at birth (Bradford & Syed, 2019; Knight et al., 2013). Homophobia and transphobia are used to justify social exclusion and discrimination against queer youth at structural and individual levels resulting in mental health-related harms, including high rates of anxiety and depression (Ferlatte et al., 2019; Ferlatte et al., 2020; Gorse, 2020; Mark L. Hatzenbuehler et al., 2013). For example, trans and non-binary respondents of a pre-pandemic Canadian national-level Two-Spirit, Lesbian, Gay, Bisexual, Trans, and Queer (2SLGBTQ+) survey (Sex Now) reported being twice as likely to have experienced anxiety and depression when compared with their cisgender counterparts (Rutherford et al., 2021). Existing research has also demonstrated that queer youth are more likely to experience suicidal ideation (Ferlatte et al., 2015; Marshal et al., 2011; Sutter & Perrin, 2016) and are more likely to have attempted suicide in the past year (Gorse, 2020; Hill et al., 2022; Jadva, Guasp, Bradlow, Bower-Brown, & Foley, 2021). Gay and bisexual men, for example, are four times more likely to attempt suicide over their lifetime compared to heterosexual men (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016). Among trans youth, the Canadian Trans Youth Health Survey reported 65% of the youth respondents (n=923) seriously considered suicide in the last year (Colvin et al., 2019). International research documenting the mental health experiences of youth navigating the early waves of the pandemic reflected many of the same challenges faced by youth in Canada. In countries like the UK, Spain, Italy, and China, public health measures implemented to curb the transmission of COVID-19
(e.g., social distancing) were associated with increases in feelings of despair, loneliness, and anxiety among youth (Hu & Qian, 2021; López-Sáez & Platero, 2022; O'Sullivan et al., 2021; Orgilés, Morales, Delvecchio, Mazzeschi, & Espada, 2020; Zuccolo et al.). For example, queer youth in a US-based study of pandemic experiences conducted through an online-based support program described how pandemic restrictions contributed to loss of routine and to increased isolation, which was connected to feelings of stress, frustration, anxiety, and depression (Fish et al., 2020).

Despite the high rates of mental health inequities experienced by queer youth, a large body of evidence describes how queer youth are also less likely to access healthcare – including mental health care – out of fear of discrimination and stigma (Higgins et al., 2021; Rider et al., 2019; Sefolosha, van Wyk, & van der Wath, 2021). Previously documented barriers to mental healthcare access among queer youth include a lack of awareness or geographical access to services, a fear of dismissive or pathologizing encounters (e.g., treating queer identity as problematic), and high service costs not covered by public health systems (Bowman et al., 2020; A. Brown et al., 2016; Higgins et al., 2021; Shipherd et al., 2010).

Unfortunately, COVID-19 has introduced additional challenges for accessing mental health care for all youth, including queer youth (Chaiton et al., 2021; Courtney, Watson, Battaglia, Mulsant, & Szatmari, 2020; Hawke, Sheikhan, et al., 2021). To address these challenges, during the early months of the pandemic, many services pivoted from in-person to virtual delivery strategies to reduce the spread of COVID-19 in clinical encounters (Glazier et al., 2021). Despite this pivot to virtual care, preliminary data indicates uptake was low, particularly in the early phases of the pandemic (Richardson et al., 2020). For example, a pan-Canadian cross-sectional study on the use of asynchronous virtual mental health resources (AVMH) in early 2020 found extremely low
uptake (2.8%) among those reporting adverse mental health impacts from the pandemic (Richardson et al., 2020).

The pandemic has also significantly disrupted the delivery of mental health services for youth across the world, with queer youth being uniquely impacted by additional barriers to access (Byrne, Barber, & Lim, 2021; Hawke, Hayes, et al., 2021; Ormiston & Williams, 2022; World Health Organization, 2020). Findings from a World Health Organization (WHO) survey carried out in 2020 found that 60% of the 130 member countries that responded reported partial or complete disruptions of home, community, and social services tailored for mental health and substance use support, and less than 30% reported no disruption to children and adolescent mental health services (World Health Organization, 2020). Despite the value of these preliminary data, little is known about queer youth’s experience with and perspectives of virtual mental health care services during the COVID-19 pandemic.

COVID-19 public health physical distancing measures, including the shift to online schooling during various periods in 2020 and 2021 (Fitzpatrick, Wilton, Cohen, Rosella, & Guttmann, 2022), have also had unintended effects for queer youth mental health, including prolonged experiences of social isolation. For example, previous research has documented how many queer youth in school were forced to isolate within unsupportive home environments which limited access to queer social- and school-based supports and networks, like supportive teachers and professors, gender and sexuality alliances (GSAs) or other queer youth (Fish et al., 2020; Paceley et al., 2021; Taylor et al., 2020). These public health measures also limited in-person opportunities for queer people to connect with one another—via drag shows, gay bars, and Pride events (Ghaziani, 2019), as well as by seeking out romantic, sexual, or peer relationships (Glover, Galliher, & Lamere, 2009) during different waves of the pandemic. As such, youth
increasingly turned to online communities for social support (Rauschenberg et al., 2021), which may potentially have implications on how queer youth accumulate social capital. Social capital has been previously described as an aggregate of actual or potential resources (e.g., social, cultural, or economic) linked with group membership (Bourdieu, 2018). Membership in a social network can foster belonging, security, and self-worth which can, in turn, encourage health-promoting behaviours that can improve physical health and help moderate problematic substance use (Kawachi & Berkman, 2001; Kawachi, Subramanian, & Kim, 2008). Broad changes to the social and relational lives of queer youth has revealed gaps in knowledge around how queer youth's social support networks, social capital, and corresponding experiences of social connectedness and isolation were impacted during the COVID-19 pandemic.

Since the beginning of data collection at the end of 2020, COVID-19 public health measures have evolved away from lockdowns, mask mandates have relaxed as have limitations on indoor and outdoor gatherings (CBC News, 2021a). Such shifts mark an embrace of “governance at a distance” mindsets emblematic of neoliberal public health approaches that offload responsibility for compliance and health onto the individual from the state without consideration of structural inequalities (Siconolfi, Halkitis, & Moeller, 2015, pp. 555,566). While previous research on HIV prevention and stigma have highlighted how public health directives that employ governance at a distance exacerbate marginalization among already structurally disadvantaged youth (S. Brown, Shoveller, Chabot, & LaMontagne, 2013; Crighton et al., 2013), there still remain gaps in the literature around how queer youth (especially disabled queer youth) are experiencing shifts in public health approaches towards the individualization of risk.

Finally, while disabled queer individuals experience distinct experiences of stigma based on the intersection of gender identity, sexuality, and ableism (Drummond & Brotman, 2014; McCann et
al., 2016), the experiences of queer youth with disabilities remain unaccounted for in existing calls to action (Department of Economic and Social Affairs, 2020; Lund et al., 2020) to address the differential impacts of COVID-19 on the 2SLGBTQ and disability communities. Emerging research on the experiences of disabled youth during COVID-19 have highlighted the pandemic’s differential impacts on mental health when comparing disabled youth with non-disabled youth (Hutchison et al., 2021; S. Lindsay, Ahmed, & Apostolopoulos, 2021). For example, youth with disabilities may be at a higher risk for anxiety (Hutchison et al., 2021), and have fewer social and financial supports available to cope with mental health stressors than their able-bodied counterparts (S. Lindsay et al., 2021). Furthermore, physical and social distancing protocols have added additional barriers to care for those whose needs cannot be managed virtually or by socially distanced means (Lund et al., 2020; Schormans et al., 2021). At this juncture, research detailing the experiences and perspectives of queer disabled youth during COVID-19 and the impacts on mental health are critically needed.

Taken as a whole, the COVID-19 pandemic and corresponding public health directives changed the organization of life in ways that may have both short- and long-term impacts on the mental health of queer youth. Nevertheless, there are significant gaps with regards to our understanding of how evolving social support networks have been impacted, as well as how queer youth have responded to these impacts. Therefore, the objective of this chapter is to identify how evolving social support and public health guidelines during the COVID-19 pandemic impacted the mental health experiences and strategies of queer youth.
3.3 Methods

Study Setting

The study was set in Metro Vancouver, where a significant proportion of the population of the province of British Columbia is concentrated (2,691,343) (Statistics Canada, 2020). The City of Vancouver is situated on the unceded and occupied homelands of the xʷməθkwəy’əm (Musqueam), and the territories of the Skwxwú7mesh (Squamish) and Səl’ílwətał (Tsleil-Waututh) peoples. Vancouver has historically been home to the gay-dense Davie Street neighbourhood, which has served as a hub for annual celebrations like Pride, and also 2SLGBTQ-targeted community-based services and businesses (Ghaziani, 2014). Prior to the pandemic, there existed a variety of supports for queer youth ranging from school-based social support resources, online STBBI testing services, community drop-in services specific for sexual and gender minority youth and adults, and volunteer-based support services (Bain & Podmore, 2020, 2021; Catungal et al., 2021; Dulai et al., 2021).

Data Collection

Upon receiving approval from the University of British Columbia Providence Healthcare Research Ethics Board (H20-00366), the study began recruitment on a rolling basis between November 2020 and June 2021. Recruitment took place during the second and third waves of COVID-19 infections in British Columbia, which saw the prohibition of gatherings outside of households, and the introduction of mandatory mask mandates because of record-breaking case counts and death rates (B. Lindsay, 2020). By the end of the data collection period, the Province had lifted the state of emergency along with mandatory mask mandates and limitations on indoor and outdoor gatherings (CBC News, 2021a). The study used a combination of purposeful and
snowball sampling approaches to recruit 15 youth digitally over Facebook, Instagram, and study
information and posters were circulated to community partners via email (Ghaljaie, Naderifar, &
Goli, 2017). Participants were also recruited through existing research databases, including the
Focus Survey (H20-02053), through which participants who consented to being contacted for
future research opportunities. Those who met the inclusion criteria were contacted by the
FOCUS Survey coordinator and, if interested, were then given my contact information. Inclusion
criteria included: being between the ages of 15-25; residing in Metro Vancouver; identifying as
being a sexual or gender minority, including lesbian, gay, bisexual, trans, queer and/or Two-
Spirit; and current or past substance use of any kind. Interested participants contacted by me by
email or phone and were screened for eligibility.

Upon agreeing to participate in the study, participants took part in a 30-minute semi-structured
intake interview with me and had the option to participate via Zoom or by phone. Twenty-four
hours prior to the intake interview, participants were sent the consent form via Freedom of
Information and Protection of Privacy Act (FIPPA)- and the Health Insurance Portability and
Accountability Act (HIPAA)-compliant REDCap software. Participants received CDN$20 for
participating in the intake interview, and upon completion they received an invite to fill out their
first diary entry on REDCap. Digital diary entries were solicited semi-weekly for three weeks.
Participants had a week to fill out an entry and were provided the option to ask for extensions if
needed. Upon completion of the diaries, participants were given CDN$30 to participate in a
semi-structured follow-up interview where contextualizing questions were asked drawing on
what was shared in the diaries. Participants were also asked to provide feedback on the diary
process itself. Finally, all participants were entered into a draw for a cash prize of CDN$100. All
participants were eligible to enter the draw, regardless of how many entries or interviews they completed.

Interview guides and digital diary prompts were designed to solicit participants’ mental health and substance use-related experiences during COVID-19. The semi-structured interviews that bookended the solicited digital diary process included questions that regarding participants’ experiences with substance use, the impact that social distancing measures have had on their lives, and other general contextualizing questions about social connections and their perceptions of their wellbeing, including mental health. The digital diary prompts were split into two sections: a first, optional section that remained the same for every entry asked: “How have the last few days been for you? Describe your daily routines—in what ways have they remained the same and in what ways have they changed? Tell me about anything that you have come across that has brought some joy or laughter?” The second section was required (though participants were able to move to the next question without providing a response), and the prompts changed every week. These prompts inquired about changes in substance use, experiences of COVID-19 measures, mental health, and broader experiences with social supports. Finally, the follow-up interview served as an opportunity to ask participants to reflect on their experiences and impressions of the digital diary process, in addition to asking participants to expand on their various diary entries.

_Data Analysis_

The intake and follow-up interviews were transcribed verbatim and accuracy-checked. NVivo 12 was used to manage and code the interview and digital diary data. Thematic analysis was used to identify, analyze, and report emergent themes within the data (Braun & Clarke, 2006, 2021).
Themes in the data were identified using two distinct approaches to coding: 1) inductively through observed prevalence within and across the data set and their ‘keyness’ to the research questions (Braun & Clarke, 2006), and 2) deductively through the use of a preconfigured coding schematic developed from the main topics of the interview guide. Specifically, codes were derived from the interview guides and diary prompts (e.g., “COVID-19 Compliance”, “Mental Health”) and their definitions were continually reviewed and updated over the course of the coding process. During the next phase of analysis, these initial codes were organized into potential themes to answer two guiding research questions: 1) How do participants talk about the ways that COVID-19 has impacted their mental health? And, 2) What strategies do participants use to address mental health challenges in the context of COVID-19? The codes were then organized into a “thematic ‘map’ of the analysis”, which required checking to see if there was enough data to support each theme, collapsing themes together where necessary, and organizing such that the themes and their affiliated data extracts so that they were a “coherent and internally consistent account” (Braun & Clarke, 2006).

3.4 Results

A total of 15 participants were recruited and completed the digital diaries entries and intake and follow-up semi-structured interviews. Participants were between ages 18-25. Sixty percent of the sample identified as white, and the remaining 40% identified as Chinese, Korean, South Asian, or Latinx. Nearly half the sample (46.7%) identified as gender non-binary, with the remaining gender identities being either exclusively cisgender (20%), as a man or woman (60%) or a combination of two or more gender identities. Most of the participants (60%) identified as bisexual, and many identified with a variety of different sexual orientations including queer
(53.3%) and gay (33.3%). Finally, at the time of the intake interview, only four participants indicated that they had a job that they could work remotely from while ten of the participants indicated that they could not work remotely, and five reported that they had lost their job due to COVID-19.

The findings are organized into three major themes: the impact of changing structures of social support, the impact of negotiating public health guidance and messaging, and evolving mental health strategies.

**Impact of Changing Structures of Social Support**

In both the interviews and the diary entries, participants were asked to describe what social support looked like in their lives. Participants were also asked to describe how COVID-19 has changed their perceptions and experiences of community. Participants described how COVID-19 transformed their social realities at micro (personal, interpersonal), meso (organizations, services), and macro (structural) levels and how these changes affected their lives, with a particular emphasis on mental health-related experiences. Two sub-themes emerged: discovering the limitations of existing social networks, and feelings of (dis)connection from the queer community.

**Discovering Limitations of Existing Social Networks**

Participants emphasized how their social networks are critical sources of mental health support, and played an important role in their lives throughout the various phases of the pandemic, including how social networks are critical sources of mental health support. Pancake shared an example of the importance of social networks in his life in the following diary entry:
I turn to my closest friends for support. Support to me, means that I am able to express what I am feeling without filtering it out and feel comfortable in the knowledge that it is a safe space and I can always depend on being able to talk about my thoughts. COVID-19 [...] has highlighted the importance of having a support system to me and how much it can enhance your mental health by having that feeling of 'safety' and being supported. (Pancake, Diary Entry)

Social distancing measures resulted in the limiting of social interactions to a core group of individuals with whom participants loved or those who are close biological or chosen family members (i.e., social bubbles). As important as social support systems are and, as Pancake wrote, as much as they can enhance mental health by fostering feelings of safety and support, participants described how COVID-19 introduced new stressors (e.g., fear of COVID-19 infection) as well as barriers to care. For example, sources of in-person support, which previously may have come from multiple sources (e.g., friends, acquaintances) and multiple spaces (e.g., school-based supports, in-person counseling), became drastically limited. For Chris Rose, his immediate bubble became his primary and only source of support, including within areas of his life that had previously benefited from other support structures:

Prior, I had a lot of outlets for different types of support depending on any issues I was having, e.g., relationships, academics, work, family, etc. Now my support looks very much the same all the time. Which is nice to still have a stable support system. But I don't think I get diverse support or the "right" support I need in a moment. (Chris Rose, Diary Entry)
Chris Rose’s entry reveals an increased need for mental health supports while the available supports (e.g., peer networks) around him decreased. Participants described navigating an increased amount of stress associated with properly following social distancing protocols and avoiding getting COVID, but their in-person support systems had not necessarily adapted proportionally to this increased risk. For some participants, like Chris Rose, the networks of social support available to them shrunk, leaving them with fewer support systems to address diverse needs related to different aspects of their lives.

*Feeling (Dis)connected from Queer Community*

A shift to social networking sites (SNS) and other virtual forms of social connection meant that some participants had difficulty developing or sustaining support systems within the queer community. Participants discussed how their inability to access spaces in person (e.g., drop-ins, 2SLGBTQ+ events) or connect with other queer youth impacted their ability to feel connected with the broader queer community. This was a particularly difficult experience for those participants who ‘came out’ during the pandemic or just prior to it. Victor, recently ‘out’, expressed a strong desire to connect with other queer youth:

> I've finally come out as queer to myself during the COVID19 pandemic, and I would really like to be able to go to local groups and spaces for people like myself, but that isn't possible. That has made it harder to accept who I am and get to meet people like myself [...] This has made me feel a lot more isolated and that I am alone in my feelings and challenges. *(Victor, Diary Entry)*

Victor’s entry touched on an interruption of their identity-formation as a recently out queer person. Isolated and unable to attend local groups and spaces in-person, Victor wrote about not
getting a sense of how their experiences fit with those of other queer youth and how this also impacts their ability to feel connected to a community. For participants who disclosed recently being out, COVID-19 represented not only an interruption in what they expected the process of coming out to look and feel like, but a sort of stasis. In Victor’s entry, they wrote about feelings of isolation, longing, and frustration because they were not able to progress and engage in processes of identity-formation that are part of being initiated into queerness. Instead, they were stuck at home with their “feelings and challenges” to process on their own.

Conversations with other youth who had been out longer, or expressed a firmer sense of self, reflected a very different relationship between senses of connection to self and community and the impacts of COVID-19. As Leila, who described having a more secure sense of self, shared:

> I guess those things [e.g., the ability to go to queer events] to me are like fun, but it doesn’t impact like my own sense of identity, I suppose […] Like I don’t need to have that many other queer friends. It doesn’t make that much of a difference to me. I guess I’m like very secure in my sexuality and stuff like that. (Leila, Follow-up Interview)

Leila had the time pre-COVID to cultivate a network of queer friends, which meant that social distancing measures did not significantly impact her sense of queerness or community connection. Victor, by contrast, did not have the same opportunity to build social capital. They were and not able to access queer spaces negatively impacting their identity-formation processes prior to the pandemic. Having had the opportunity to build queer forms of social capital pre-pandemic (e.g., making queer friends and having time to explore sexuality and gender identity)
represented an important distinguishing factor in terms of how connected participants felt to a broader queer community during the early phases of the pandemic.

Impact of Negotiating Public Health Guidance and Messaging

The mental health impacts of negotiating public health guidance have manifested in the experiences of participants in two ways: first, in the challenges of managing the stress of COVID-19 risk-minimization; and second, through experiences of ableism and distress.

Managing the Stress of COVID-19 Risk-Minimization

Participants discussed how the COVID-19 pandemic and corresponding public health guidelines forced them to constantly evaluate COVID-19-related risks. Navigating COVID-19 risk fundamentally changed how and whether participants interacted with friends in-person, and generated significant experiences of anxiety and stress. Participants described how the process of risk navigation largely hinged on the question of whether meeting in-person with someone new (e.g., a peer not part of their bubble, or a new prospective sex partner) was worth the risk of being exposed to COVID. In Sadie’s entry, she tried to reconcile the need to see her friend with public health measures that, at the time, instructed her that she should not do so:

*I'm still struggling to find my balance again. It is compounded by the fact, that while the conditions I chose to see my friend in were calculated with precautionary measures, I am reluctant to reach out for support because of fear of being judged for seeing a friend while cases are so high.* (Sadie, Diary Entry)

I was struck by the extent to which narratives of assessing COVID-19 risks reflected the tremendous burden placed on participants to simultaneously manage individual risk and a deep
desire to connect with others. The burden of self-managing risk meant that participants moralized their own compliance, describing feelings of shame for ‘wrong choices’ that are more ‘risky’ rather than ‘risk-adverse’. These wrong choices, however, were choices made in response to and to address feelings of intense isolation and loneliness.

Connecting shame to these choices meant that some participants delayed or altogether avoided seeking help from service providers. For example, Sadie was reluctant to seek support for “anxiety and shame spirals” triggered by going out and seeing a friend and drinking because of fear of judgment (Sadie, Diary Entry).

For others, the ‘right choice’ to stay in and avoid contact with others was further complicated by the fact that the household or bubble in which they confined to was insufficient for meeting their social support needs. As Sadie noted:

*I find, a particular stigma towards – maybe not a stigma, but a – almost like a collective shaming, of people who do go out. I’m fortunate that I do live with people, but sort of everyone I would call in my immediate community, or in my bubble, has partners. So they – they, you know, if they want to leave the house for a weekend, so they can go to their partner’s place, and it’s still technically within the bubble…But someone who’s single, or like lives alone, and their community is the bar they go to, like by themselves on a Tuesday night, like that’s shamed. (Sadie, Follow-Up Interview)*

As someone who was single at the time of this study, Sadie did not have the same approved access to community as her roommates. If she wanted to connect with others in the same way that was permissible for her roommates she worried she would be “shamed”. Sadie had to pick between being risk-adverse and lonely, or choosing to “go out” to sate her social needs and be
subject to shame for wanting to meet people outside of her limited bubble. The simultaneously flexible/inflexible definition of a social bubbles based on relationship status highlights the unequal application of the burden of responsibility for limiting risk on Sadie versus her roommates.

Experiences of Ableism and Distress

Participants who identified as disabled and/or immunocompromised described how ableism in the implementation and policing of public health directives impacted their mental health. In addition to concerns around the social impacts (e.g., impacts on social connections) of physical distancing measures, disabled and immunocompromised participants also had to contend with ableist public health measures that impacted their safety. One participant who identified as disabled described how visual cues and signage may seem like helpful enforcement tools to ensure physical distancing, but for some may be a source of stress and result in discrimination.

As Victor, a participant with limited vision, pointed out in their interview:

Social distancing measures are like really impossible for the visually impaired community to follow, because they rely on vision. In the early days in the pandemic, before like mask wearing was a big thing, and I could wear a mask everywhere I went at that point in time, if a store had a sign on it that said like “masks mandatory,” depending upon, like for me, how big of a print it was in, I necessarily couldn’t read it, and then people would get mad at me because I don’t have a mask on, and they say mask mandatory, but I can’t read it. (Victor, Follow-Up Interview)

For Victor, the ableist assumption that everyone can see the markers, or the signs, places those who cannot in a position where their perceived lack of compliance subjected them to harassment.
For example, Victor frequently experienced people yelling at them to the point that they had to make a special mask with “I have low vision” written on it to avoid harassment (Victor, Follow-Up Interview). This stress placed on Victor to mitigate the impacts of ableist public health guidelines was amplified by their belief that the government was not doing anything to protect the lives of disabled and immunocompromised individuals.

As Victor’s narratives underscore, COVID-19 public health measures can foster different experiences of ableism, including the distress of witnessing others around you comfortably drop mask-wearing, while you have to continued to mask and social distance for your own safety. ZK discussed this in their recapping of a conversation they had with their girlfriend about perceptions of upper middle-class white people not wearing masks in a neighbouring ocean-side park in Vancouver:

White people just don’t believe or don’t think that they or their family or their loved ones will get sick. They just like have this sense of immunity, and oftentimes maybe it is intersected with a lack of care for others. [...] It seems like they just don’t believe that it’ll be them that gets sick. (ZK, Follow-Up Interview)

As someone who is racialized, living with a chronic illness, and caring for a loved one with a disability, ZK’s frustration juxtaposed their vulnerability to COVID-19 with the white, unmasked, and able-bodied surroundings in the park. In this moment, ZK had to perhaps navigate perceived binary oppositions of non-white/white, masked/unmasked, and disabled/able-bodied resulting in different forms of distress. First, the distress arising from conflicting cultural norms with ZK’s lived experience of growing up and wearing a mask with SARS and H1N1
outbreaks in their birth country versus in Vancouver where it was “unusual” to wear a mask (ZK, Follow-Up Interview); and second, the distress of having to take abundant precaution for the sake of their own health and their girlfriend’s while the white, wealthy people around them returned to being unmasked. While by March 2021, the BC government had relaxed rules around outdoor gatherings (CBC News, 2021b), ZK could not understand why the government would “lift anything” if “we were on the upswing” of cases (ZK, Follow-Up Interview). The distress of knowing cases were increasing while observing those around them taking fewer precautions had two primary impacts on ZK: first, managing feelings of “paranoia” and active attempts to “avoid everyone” when going outside ultimately resulted in them discontinuing their weekly walk (ZK, Follow-Up Interview). By consulting their diary entries, I was also able to see, secondly, how ending their walks also meant losing an opportunity to talk to friends over the phone privately, and that these walks started out of a recommendation made by their physiotherapist (ZK, Diary entry). By being forced to navigate the distress of increasing case counts and decreased safety measures and ultimately stopping their walks out of concern for their own safety, ZK had reduced opportunities for social interaction and potentially impacted their own physical health.

_Evolving Mental Health Strategies_

COVID-19 interrupted a variety of different daily norms in the lives of participants, including the migration of social activities, work, and school from in-person to online, and changes in access to healthcare and community supports. Descriptions of these shifts were often accompanied by discussions of evolving mental health strategies to address negative mental health outcomes.
Changing Experiences of Mental Health Supports

COVID-19 required many services to move online for them to continue to safely operate—including counseling services. Participants shared experiences and perceptions that explained their affinity (or lack thereof) for online and remote counseling options. Their stories can be organized into two thematic subcategories: 1) concerns about quality of care, and 2) navigating accessibility. Together, both subcategories help us understand why some queer youth may opt to include virtual services in their mental health strategies, and while others have not.

The primary concern around quality of care expressed by participants had to do with the rapport they either established or felt they could not establish online. In-person sessions were often viewed as more legitimate and helpful because they were in the same room as the counselor whereas the feeling of distance from the counselor during an online session acted could be a deterrent for some. As Leila wrote:

*I have never tried those free online counseling sessions but I feel like they won't be helpful because doing a quick zoom call with a stranger doesn't seem like something I'd like to do even though I feel like they are heavily promoted especially right now.* (Leila, Diary Entry)

Across the sample, participants’ views on the shift of counseling services to virtual or remote forms often reflected concerns regarding the ability to build or maintain rapport with an existing provider or form rapport with a new one. Leila’s language of “doing a quick zoom call with a stranger” reflects a view communicated by a number of participants; namely, that in-person services are more intimate and genuine, whereas there is a sort of immutable distance virtually that cannot be reconciled. Participants in the study who either actively or had accessed
counseling supports in the recent past shared a skepticism regarding the effectiveness of
online/remote counseling. These attitudes either stopped them from seeking supports, or led them
to actively delay seeking them out.

For other participants, however, concerns around rapport had less to do with modality and more
to do with queer competency. BL shared an example of their therapist’s lack of queer
competency in their appointment over the phone:

   He’d call me, and he would always misgender me, and use my dead name, even though
I’d ask him not to. And he’d kind of make a stink about it [...] I think he tried to call me
once a week, but whenever he called, I was just so detached. Like I said because we
weren’t in person, but also because he was kind of a shitty therapist. And we weren’t able
to like have a deeper connection, even – even with our challenges with him [Laughs] not
really being trans literate [...] I hate online services. (BL, Intake Interview)

BL’s mention of feeling “detached” over the phone from their therapist complements other
participants’ descriptions regarding the challenges of building rapport outside of in-person
settings. They describe this detachment as a product of the phone being a hindrance to the
potential development of a “deeper connection”, and how it made it harder for them to address
their therapist’s lack of trans literacy. This was the only therapist available to BL because they
could not afford to pay for these services out-of-pocket. Thus, despite needing mental health
support and being able to secure a free therapist through a local hospital, BL ultimately felt
“detached” from the therapist, in addition to having to navigate transphobia and being subject to
additional stress and frustration as a result.
There were some benefits to online care; namely, increased convenience. ZK, for example, talked about how much easier “things going virtual” made it for them to book a counseling appointment:

*The issue that I have is that you have to basically walk in and ask them to put you like on the list for the day, and they’re open X hours, Monday to Friday [...] it was really a chore if you wanted to go to walk-in counseling. “Okay, okay. I really need it today. I’m going to go in.” Whereas this way, it was virtual – it’s virtual, so I can, you know, stay home. And most importantly, the hours have really expanded. And I definitely believe that things going virtual allows for stuff to be accessible at more times of the day.* (ZK, Follow-Up Interview)

Despite these clear benefits, ZK carefully acknowledged potential drawbacks:

*With everything being so last-minute put online [...] there’s just not always accessibility built in mind over just like having it up there, you know?* (ZK, Follow-Up Interview)

ZK made an important point that just because something moves online does not necessarily mean that it is more accessible. The “last-minute” nature of the shift online in reaction to the pandemic meant, as ZK noted, that these new services may not always have “accessibility built in mind”. ZK’s points prompt important questions around the design of online services and whether they take into consideration whether the text is compatible with screen readers and other key considerations that can facilitate broader, more equitable access. Overall, participants provided a composite perspective of counseling services as being structurally inaccessible in terms of cost, and the lack of queer and disability competency. However, when queer competency and
disability are taken seriously and are “built with accessibility in mind”, online mental health services do have the potential to provide greater access to mental healthcare beyond cisgender, heterosexual, able-bodied individuals who can afford counseling.

3.4 Discussion

The advent of the COVID-19 pandemic has disrupted social- and service-based strategies that queer youth draw on to address negative mental health outcomes. Queer youth’s experiences of shifts to virtual modalities of social connection were mediated through their pre-established queer forms of social capital. For those who did not have pre-existing queer connections or networks and who were coming to terms with their queer sexual identities, this meant a delay in coming out and was associated with negative mental health outcomes (e.g., isolation). Positive experiences of shifts to virtual mental healthcare were determined by whether these services were perceived as effective, accessible, and queer competent. Negative experiences along these lines resulted in some youth delaying access to or avoiding virtual mental healthcare. Finally, participants described how ableism, the moralizing of compliance, and the burden of risk-management impacted their mental health and generated barriers to seeking support and addressing their mental health needs. Below, the implications of these findings are discussed, with a focus on four areas: 1) implications for the disruption to identity-formation and social capital 2) the burden of individual risk-management, 3) the ableism of public health guideline compliance/non-compliance, and 4) future considerations for virtual mental healthcare.

Implications for the Disruption to Identity-Formation and Social Capital

Coming out is a lifelong, non-linear identity development process (Sodhi, 2017). Within the current study, social distancing protocols and concerns about COVID-19 interrupted this process

70
for some participants. Coming out can be associated with negative mental health outcomes like depression (Charbonnier & Graziani, 2016; McGarrity & Huebner, 2014; Pachankis, Cochran, & Mays, 2015) and positive mental health outcomes like increased self-esteem, self-acceptance, and increased opportunities for identity support (Beals & Peplau, 2005; Cox, Dewaele, van Houtte, & Vincke, 2010; Ong et al., 2021). The inability to move forward and connect with their peers meaningfully was a source of frustration and isolation, resulting in a potential delay of potential positive health outcomes associated with coming out. Participants’ belief that connecting with other queer youth was integral to coming out reflects D’Augelli’s “Life Span” model of sexual identity development that includes interacting with other LGB individuals to develop long-lasting social support and to challenge “internalized myths” about “non-heterosexuality” (Trickett, 1994).

The study’s findings also affirm the role that time, intimacy (e.g., trust), and emotional investment in relationships in SNS can positively contribute to building greater social capital online (Cserni & Talmud, 2015). The benefits of integration into a social network are related to senses of belonging, security, and self-worth which may positively influence health-promoting behaviours (e.g., physical exercise, moderation of alcohol consumption) (Kawachi & Berkman, 2001; Kawachi et al., 2008). Even though SNS usage has previously been tied to queer identity development (Bates, Hobman, & Bell, 2019), participants’ challenges with making queer friends online indicate there are unique experiences of intimacy and connection associated with face-to-face interactions that may be challenging to replace with virtual strategies alone (Parent, Dadgar, Xiao, Hesse, & Shapka, 2021; Twenge, Spitzberg, & Campbell, 2019). In the era of COVID-19 and during the early phases of the pandemic, these experiences also highlight some critical limitations in the “poor-get-richer effect” where online resources are theorized to offset “reduced
social resources offline” (Winstone, Mars, Haworth, & Kidger, 2021, p. 11). Conversely, participants who were already ‘out’ prior to the pandemic and had established queer forms of social capital experienced less severe impacts on their ability to feel connected to a queer community and therefore relied less on virtual strategies for doing so. At this juncture, there are important questions about how these different experiences will have knock-on effects for the next phases of the life course among queer youth, including with regards to inequitable impacts within and across queer youth populations.

*The Burden of Individual Risk-Management*

The social pressure (both actual and perceived) of following COVID-19 public health guidelines acted as a significant source of anxiety and stress for research participants. Findings from the current study begin to expose how some forms of COVID-19 public health directives relied heavily on various forms of governance at a distance. For example, findings highlighted situations in which public health directives were underpinned by individual behaviour change and individual- and community-level policing of non-compliant behaviour (Ayo, 2012; Siconolfi et al., 2015). While these public health approaches were implemented with limited resources, the effect of offloading risk-minimization onto the individual results in the disciplining of bodies and behaviours enforced by moralizing discourses that can result in the further marginalization of structurally disadvantaged youth (S. Brown et al., 2013; Crighton et al., 2013), including both queer and disabled youth. Experiences of public health policies that conflicted with participants’ needs to connect with others frequently resulted in difficult individual-level risk-management processes—processes that were frequently moralized by youth themselves as they grappled with how to best manage this dissonance. These findings begin to delineate how stress related to social bubble parameters uniquely impact queer youth, a population that uses and relies on social
supports differently than their cis heterosexual counterparts (Moore, Wierenga, Prince, Gillani, & Mintz, 2021). The fear of judgment for breaking the prescribed social bubble meant that some participants had to pick between the right choice of being risk-adverse and limiting themselves to small or potentially unsafe or limited social networks or making the wrong decision and going out and being judged by others (and themselves) for non-compliance.

These findings also echo previous literature on HIV prevention and stigma, which demonstrates that shifts towards neoliberal approaches to public health interventions impact individual-level perspectives around personal responsibility and blame. Research around pre-exposure prophylaxis (PrEP) and seroconversion has highlighted a “responsibilization discourse” (Knight, Small, Carson, & Shoveller, 2016, p. 7) that sees seroconversion as the sum of a series of ‘wrong’ choices made in the individual governance of risk. Responsibilization discourses are similarly mobilized in the context of COVID-19 compliance at the individual-level through the association of youth non-compliance with “antisocial potential”—namely with low acceptance of moral rules and low self-control (Nivette et al., 2021, p. 2), negative influence on the compliance of peers (J. L. Andrews, Foulkes, & Blakemore, 2020), and narcissism (Zajenkowski, Jonason, Leniarska, & Kozakiewicz, 2020). Using responsibilization discourses like antisocial potential to understand youth COVID-19 guideline non-compliance is highly problematic. Literature critical of the use of at-risk discourses has shown how binary categorizations that result in youth being labeled by the state as either good/bad, responsible/irresponsible can result in stigmatizing labels that “stick” alongside their “associated disadvantage [accrued] over the life course” (S. Brown et al., 2013, p. 340; Shoveller & Johnson, 2006). While little is known how the potentially stigmatizing framing of COVID-19 non-compliance of youth may result in long-term negative mental health outcomes, the findings from the current study underscore the extent to which queer
youth’s experiences of (non)compliance to COVID-19 measures – packaged within binaries of antisocial/prosocial, responsible/irresponsible risks – are shaped by heteronormative (e.g., public health guidelines not taking into account chosen families) and ableist discrimination. For example, participants were differentially impacted based on their previously established social capital and whether they lived with a disability or not. Within-community inequities manifested in participant descriptions of increased social isolation, delayed queer identity-development, and decreased feelings of safety—whether it be safety from COVID-19 infection or from harassment.

The ableism of public health guideline compliance/non-compliance

Participants described policy decisions and public health guidance as being ableist in terms of lack of consultation or concern for the well-being of people with disabilities and people with immunocompromised conditions. These concerns regarding the devaluing and de-prioritization of the lives of disabled individuals by policymakers during COVID-19 is supported by research detailing ableist, international triage approaches around ventilator access (Orfali, 2021). This chapter identified ableist dimensions of social and physical distancing protocols that have made it difficult for queer members of the disability community to comply with COVID-19 measures and is congruent with a growing body of literature that points to the role of ableist physical and social distancing protocols in exacerbating inequities during COVID-19 (Lund et al., 2020; Schormans et al., 2021). Participants did not discuss how intersections of queerness and disability may have additionally shaped their experiences of ableist COVID-19 measures. However, while the study findings may not have specifically described how disability, queerness, and youth contribute to distinct experiences of COVID-19 public health guidelines, the existing literature has pointed to how overlapping marginalized identities (e.g., disabled and queer) produce unique experiences, and consequently unique mental health-related harms, within
a “matrix of domination characterized by intersecting oppressions” (Abrams et al., 2020; Collins, 2002, p. 23; Drummond & Brotman, 2014; McCann et al., 2016). This is consistent with the Black feminist theory of intersectionality which was developed to examine how structures of power marginalize Black women along the lines of sexism and racism, and has been used as a critical theory to examine other identities (Abrams et al., 2020).

A corollary set of findings also identified experiences of distress by disabled and immunocompromised individuals navigating a loosening of public health restrictions (e.g., on outdoor gatherings) at times during the pandemic when cases were increasing. This distress can be contextualized through theoretical constructions of the “normate” citizen as white and able-bodied cast opposite to people with disabilities (Jenkins, 2021, p. 2). This binary opposition is further enforced in public health messaging where the normate body is aligned with minimal risk, as opposed to non-normate, disabled or immunocompromised body, producing a psychological distancing that can be theorized as a justification for non-compliance (Arcieri, 2021). Non-critical approaches to public health guidance and perceptions of guideline compliance are thus inherently ableist in the ways that they define ‘risk’ as the domain of non-normate bodies and fashion guidelines where compliance is possible only for the able-bodied.

*Future Considerations for Virtual Mental Healthcare*

A final, significant finding of this chapter is the need to balance the utility of virtual mental healthcare with an awareness of the inequities experienced by diverse queer youth. Among participants, the shift from pre-pandemic drop-in to virtual mental healthcare increased convenience and improved access to counseling services — a sentiment shared by both able-bodied participants and those living with chronic pain. This finding is in line with literature that
has tied shifts online to improved access to therapeutic support for neurodiverse individuals (Ameis et al., 2020) as well as literature that has reported on the efficacy of telepsychiatry and telemedicine as interventions for depression and anxiety (Chattu et al., 2021). However, this shift online was not always experienced by participants as a shift to modalities with accessibility ‘built in mind’. Concerns were voiced about the ability of vision-impaired and neurodiverse youth to navigate the myriad of webpages and phone calls necessary to book appointments, and to navigate the appointments themselves. Thus, these findings also contrast emerging literature around potential of greater accessibility with virtual modes of mental health care (Ameis et al., 2020) and affirm findings that call for greater attention to structural barriers (e.g., anti-black racism, anti-trans policies) that prevent queer youth from accessing mental healthcare (Roulston, McKetta, Price, Fox, & Schleider, 2022). Additional findings on accessibility of virtual mental healthcare include concerns around the high cost of counseling, and limited queer competence within the government subsidized services that presently exist, which is consistent with existing research that has demonstrated a lack of queer competency of service providers and resulting barriers to care and resources for queer youth during COVID-19 (Chaiton et al., 2021).

**Strengths and Limitations**

The strengths of this chapter include an approach to data collection which employed a mixture of solicited digital diaries and remote semi-structured interviewing techniques. This hybridized approach facilitated the collection of rich, somewhat semi-longitudinal data on the evolving experiences of diverse queer youth during the COVID-19 pandemic. The remote and digital methods also allowed participants who might not have otherwise participated (e.g., participants who lived with chronic pain) to participate at their own pace and from a comfortable, private setting. The participation of research participants who disclosed being neurodiverse,
immunocompromised, and/or being disabled generated many of the unexpected findings of this chapter around ableist dimensions of public health guidelines, and the barriers to virtual mental health supports.

There are several limitations to this study. First, the study findings are highly contextualized and reflect the lived experiences of queer youth living during the early stages of the COVID-19 pandemic, during which they had to follow a specific set of public health guidelines that may no longer exist. Second, the extent to which participants disclosed experiences of not following public health guidelines in their diaries and in the semi-structured interviews may have been informed by a social desirability bias. Reporting an action that “violates existing social norms” (e.g., attending an unmasked gathering when it was forbidden to do so) and the fear of judgment by me may have dissuaded participants from sharing some of their COVID-19 experiences (Krumpal, 2011). Third, the eligibility criteria of the study did not include being a member of the disability community or being immunocompromised and so the recommendations formed from these findings are limited to the needs of the research participants. Furthermore, critiques of the inaccessibility of healthcare or queer spaces for members of the disability community are not new, and therefore, findings related to these inequities must be understood in the context of a broader disability justice movement that has advocating for awareness and policy for decades prior to the COVID-19 pandemic. Finally, more research is required to understand how the identity development of queer immunocompromised individuals and queer members of the disability community has been impacted by COVID-19.
3.6 Conclusion

COVID-19 has disrupted the social support networks of queer youth. This chapter details their mental health experiences during shifts to virtual social connection and mental healthcare. Beyond adapting to virtual forms of social support and service delivery, queer youth have also had to contend with the increasing offloading of risk-management onto the individual and ableist public health measures that further isolate queer youth. This has impacted processes identity-development, placed pressure on already limited in-person support networks, and moralizes already difficult decisions as ‘good’ or ‘bad’ public health choices. However, the virtual shift has also been marked by perceptions of increased accessibility to mental health supports and added convenience for youth who cannot travel or prefer to attend appointments from a familiar space. The findings of this chapter point to the need to greater understand the impossible positions that moralizing approaches to public health discourse and policy place on queer youth, and to the ways that queer individuals who are immunocompromised and/or disabled have been specifically impacted by COVID-19 and ableist public health measures. Finally, the findings also point to the importance of having accessibility ‘built in’ to virtual mental healthcare at every point of interaction from appointment-booking to the therapeutic encounter.
Chapter 4: Discussion

This thesis documents my experiences of pivoting from in-person to virtual data collection method while studying the experiences of queer youth with COVID-19 and identifies how queer youth’s mental health experiences have been impacted by the initial waves of COVID-19 and the corresponding public health directives. The previous chapters outline the utility of hybrid approaches in the study of sexual and gender minority youth (SGMY) experiences of COVID-19, and the evolving mental health experiences of queer youth navigating the virtual shift of mental healthcare and social connection during COVID-19. Chapter 2 discussed how the application of digital diary methods and remote semi-structured interviews are an effective way to document queer youth’s experiences of COVID-19 and how they can be perceived as a low-barrier and accessible way to participate in research. Chapter 3 discussed how COVID-19 has disrupted queer youth’s support networks and details their mental health experiences as COVID-19 impacted identity-development, the moralization of ‘good’ or ‘bad’ public health choices, and the impacts of the virtual shift on mental healthcare in terms of accessibility. Below, this section will outline how these chapters advance policy, practice, and research related to queer youth, COVID-19, and mental health.

4.1 Summary of findings

Chapter 2, “(In)equitable Shifts: Mapping a pivot to digital diary and remote research methods with queer youth in the times of COVID-19”, described how the use of digital diary methods alongside remote semi-structured interview techniques can help capture SGMY’s experiences of COVID-19 and the overdose crisis. This hybridized method of solicited diary entries book-ended by semi-structured interviews allowed for the exploration of unanticipated areas of inquiry and
provided opportunities for deeper insight into experiences shared during different phases of the data collection. The digital and remote nature of the methods also provided opportunities for participants who disclosed living with chronic pain and/or living with a disability the opportunity to participate in research activities that they might not have otherwise felt comfortable doing in-person prior to COVID-19. Despite these associated benefits, the chapter identified two important considerations when using these methods: first, that remote interviewing was not always possible due to limitations related to poor internet connectivity; second, that participants were not always able to secure a completely private space to participate from when using Zoom. The chapter also recommended additional research to be carried out to understand the appropriate of these methods when working with populations not accounted for in the research—namely Black, Indigenous, and street-involved youth. Overall, the chapter found that combining remote and digital diary methods can present equity-enhancing opportunity to not only include a more diverse set of participants, but also provide deeper, semi-longitudinal insight into evolving experiences of overlapping public health crises like COVID-19 and the overdose crisis.

Chapter 3, “‘I’m On My Own’: Queer Youths’ Experiences of Navigating Mental Health During the COVID-19 Pandemic”, details participant experiences of how COVID-19 has disrupted the social support networks of queer youth. The chapter discusses how ableist and neoliberal approaches to public health were deployed in response to COVID-19, including approaches that resulted in the offloading of responsibility of risk-management almost entirely onto the individual. For queer youth, this means that they have had to evolve their mental health strategies with limited in-person supports while contending with public health measures that further isolate them, and subject them to harassment. The chapter also describes the virtual shift to online social interaction and mental healthcare in reaction to COVID-19 and how it has had both positive and
negative impacts on queer youth. First, participants described that virtual mental healthcare increased the convenience and accessibility of counseling supports. However, my analysis also revealed how the rapid shift online meant that accessibility was not necessarily ‘built in’ to these interfaces, and so considerations around potential barriers to disabled individuals at various important points of interaction (i.e., from appointment-booking to therapeutic encounters) were not necessarily made. Second, the virtual shift of social interaction also meant that participants living with chronic pain and/or with a disability were able to participate in more community events. However, for those who were recently ‘out’ and did not have pre-established connections in the community, this virtual shift impacted processes of identity-development negatively (i.e., coming to term with queerness and feelings of community connectedness). Overall, the chapter identifies the need for a greater understanding of how COVID-19 has impacted the identity development of queer immunocompromised youth and queer members of the disability community, and how queer youth’s mental health and social supports uniquely impacted by public health approaches to offloading of risk-management onto the individual by public health and the resulting moralization of ‘good’ and ‘bad’ public health choices.

4.2 Implications for Practice and Policy

Drawing on the findings from Chapter 3, “‘I’m On My Own’: Queer Youths’ Experiences of Navigating Mental Health and During the COVID-19 Pandemic”, I will summarize below key recommendations for healthcare practice and policymaking. The goal of these recommendations will be to enhance the potential for more equitable experiences in healthcare and in day-to-day contexts for queer youth during COVID-19.
It is important for clinical and community-based providers to integrate into care provision and program-development an awareness of how the ongoing pandemic may continue to delay identity-development and negatively impact social connection among populations of queer youth. The findings from Chapter 3 indicate that pre-pandemic access to social networks of queer youth, and disclosure of disability or being immunocompromised were important contextual factors that influence the ability of youth in this study to transition their mental healthcare and social lives online. Paired with this study’s findings that affirm existing literature on motivations behind low uptake of virtual mental health resources (Richardson et al., 2020), there are important implications for service provision. Firstly, virtual mental health supports may not be a viable alternative to in-person provision of care for participants in this study who expressed negative previous experiences of online services. Secondly, other participants indicated that online interfaces that do not have accessibility built in at all points of the encounter present barriers to access for queer members of the disability community. Taken together, low uptake of virtual mental health supports means that queer youth with limited pre-existing networks of queer friends prior to the pandemic and disabled and immunocompromised youth have even fewer social and healthcare-based resources available to them. Therefore, care provision, program-development, and future interventions need to consider pandemic-entrenched disparities in social connectedness. Youth who do not feel safe attending events or accessing care or resources in-person will be left behind if healthcare provision and community-based programs do not maintain virtual or hybrid options. However, the provision of accessible, virtual mental health services may not be sufficient to curb negative mental health outcomes among recently ‘out’ queer youth with limited in-person social resources and are living at home in unsafe living arrangements and/or are disabled or immunocompromised. Furthermore, providers must also
consider how ‘return to normal’ strategies that marginalize disabled individuals and the immunocompromised may continue to interrupt and delay processes of identity-development among queer youth who are not able to develop in-person social connections due to concerns around COVID-19. This may pose the potential for the entrenchment of within-population disparities in mental health outcomes for disabled and immunocompromised queer youth.

A second implication for practice is the importance of built-in accessibility at each point of a virtual clinical care. People with disabilities are at a greater risk for becoming further isolated during COVID-19, and this isolation makes it difficult to seek digital technical support (Cho & Kim, 2022). Therefore, this study’s findings around the experiences of queer youth navigating the digital shift to virtual mental healthcare encourages service providers to consider how diverse experiences of disability impact uptake of virtual-based supports. Thus, when taking into consideration the accessibility of a program or service’s website a substantive framework must be applied. For example, the World Wide Web Consortium’s (W3C) POUR framework. The acronym stands for Perceivability, Operability, Understandable, and Robust, with each letter representing a criterium that is used to evaluate whether web content is accessible for people with disabilities (Mason, Compton, & Bhati, 2021). Attention is paid to the compatibility of web content with various assistive technologies like screen readers, but also calls to attention easily remediable accessibility failures like low contrast, empty links, or a lack of an accessibility policy statement (Mason et al., 2021).

Third, the study’s identification of moralizing discourses and the negative mental health implications of offloading risk-management onto the individual has important policy implications for public health. Moralizing discourses around ‘right’ and ‘wrong’ choices aligned with protocols (e.g., social bubbles, social distancing) that do not take into consideration queer
lived experience and disability entrench existing mental health inequities by isolating queer youth and subjecting them to additional discrimination based on perceived non-compliance. Non-critical approaches to moralizing discourses of right and wrong choices assume equal access to social supports, healthcare, and that social distancing measures are accessible and possible for everyone. As seen in the literature around HIV/AIDS and responsibilization, shifts to models of individual responsibility are problematic in contexts where there are significant inequalities in terms of poverty, disease, and unequal and diminishing access to state healthcare (Beckmann, 2013). For disabled participants in this study, their experiences of COVID-19 public health guidelines demonstrated that disability was not considered in pandemic planning and resulted in experiences of ableism while attempting to comply with the guidelines. These experiences are reflected in the broader literature, with discussions of ableism featured in the lack of guidance for people who are blind or with low vision navigating social distancing protocols (Goodley, Lawthom, Liddiard, & Runswick-Cole, 2022), pervasive ableism that frames disabled lives as disposable and “ungrievable” (Thorneycroft & Asquith, 2021), and shifts from in-person to remote support framed with fears of the responsibility of care being increasingly shifted to family and close social supports—i.e., “carers of last resort” (Shakespeare et al., 2022). Second, in this study, participants’ critique of heteronormative dimensions of public health guidelines highlighted how the exclusion of queer lived experiences from policy can unintentionally isolate and reduce the social supports available to queer youth. In other contexts, COVID-19 restrictions described as “largely centered on heteronormative family and household structures” have been associated in Australia with a perceived decrease of public acceptance of the LGBTQ+ community (Grant, Gorman-Murray, & Briohny Walker, 2021). Heteronormative approaches to COVID-19 restrictions raised concerns among some queer individuals around being targeted by
authorities enforcing physical distancing measures for non-compliance based on assumptions of appearance that they did not belong to the same ‘household’ (Grant et al., 2021). Therefore, it is key that the slogan “nothing about us without us” is invoked as a necessary reminder that the lived experiences of queer and disabled individuals must be taken into consideration in policy responses to a disaster or pandemic. For example, the recent international outbreak of Monkey Pox has raised concerns around how queer individuals are being targeted by potentially stigmatizing public health measures and messages what barriers this may have on early detection and treatment (Schmidt-Sane, Abbas, Karam, & Palmer).

4.3 Implications for Research

Drawing on the findings from Chapter 2, “(In)equitable Shifts: Mapping a pivot to digital diary and remote research methods with queer youth in the times of COVID-19”, I will summarize below key recommendations for ethics and future research. The goal of these recommendations will be to enhance the potential for more equitable experiences in research for queer youth.

First, findings from my pivot to digital diaries and remote interviewing methods have important implications for future approaches for qualitative research. The study found that digital diaries and remote methods provide opportunities for disabled, immunocompromised, and other participants who might not have otherwise participated in research in-person pre- or peri-pandemic. This highlighted a significant, ableist gap in my previous approaches to qualitative research methods that did not take into consideration the barriers that prevent queer members of the disability community from engaging in research. Digital and remote methods should not only be used when they are convenient or safer (e.g., in the context of a pandemic) for able-bodied
researchers but should be implemented perennially as an equity-enhancing approach to any qualitative research endeavour.

This study shows successful uptake of these methods is mitigated by access to information and communication technologies and a consistent and quality internet connection; furthermore, privacy cannot always be guaranteed given that participants may live in crowded environments where confidentiality may not always be guaranteed. The detailing of barriers to uptake and privacy of these methods in my study complement existing research that has detailed concerns around the limited ability to control participant’s interview environment and difficulties posed by unstable internet connections (Archibald et al., 2019; Gray et al., 2020; Jenner & Myers, 2019). However, study findings have also shown how issues with unstable internet connections during data collection can be overcome by a hybridized approach to digital methods where asynchronous methods (e.g., digital diary methods) are employed. These digital, asynchronous methods can be used to supplement remote interviewing where internet connectivity interferes.

Overall, more research is needed to gain a better understanding of what uptake may look like across diverse geographies (e.g., urban versus rural or remote) and across different populations of youth (e.g., among street-involved youth).

The study’s discussion of the importance of accessibility at every point of the clinical encounter extends significant questions around how accessibility can be addressed in the research process. The finding from this study on the potential equity-enhancing capabilities of hybridized remote interview and digital diary methods to reach populations (e.g., members of the disability community) that otherwise might not engage with in-person research beg additional questions around what considerations could be taken to improve the inclusion of queer members of the disability community within research. Drawing from the broader literature, this chapter
wishes to continue to entrench the message that the research process must continue to strive towards the meaningful inclusion of queer members of disability community within research in ways that involve action- and politically-led research that does not end up “gathering dust on a library shelf” (Kitchin, 2000). At the level of the research encounter, considerations around screen-reader compatibility with digital interfaces, accessibility of informed consent forms and other study materials to improve research literacy, and not making assumptions about another individual’s “competence to participate in research” are examples from the broader literature that can strengthen the equity-enhancing potential of digital and remote methods (Carey & Griffiths, 2017; Mason et al., 2021). Over the long-term, developing relationships with community-based organizations and advocacy groups that are operated by and for people with disabilities to help guide and develop research can begin to address power differentials that frequently make people with disabilities feel “medicalized, scrutinized, and surveilled” during the research process (Banas, Magasi, The, & Victorson, 2019).

4.4 Summary of strengths and limitations

The detailed outline of each chapter’s strength and limitations can be found in Chapters 2 and 3 of this thesis. To begin, a summary of this thesis’s strengths lies in its application of digital methods alongside remote semi-structured interview techniques to allow for the collection of rich, semi-longitudinal data on queer youth’s experiences of overlapping public health crises. Furthermore, the combination of digital diaries and remote, semi-structured interviews can allow for deeper insight into the experiences and the exploration of unanticipated areas of inquiry. Finally, the hybridization of both methods allowed for two things: a) for participants (e.g., queer members of the disability community) who might not have otherwise participants in in-person
research to participate; and b) for participants to participate in research at their own pace in a familiar and private setting.

The limitations of this thesis include that findings of the study are specific to the lives of queer youth living during the early stages of the COVID-19 pandemic, and thus cannot be extrapolated to the experiences of all queer youth at other times during the pandemic when the public health guidelines being observed by the participants had ceased to exist. Furthermore, these disclosed experiences may have been influenced by a social desirability bias based on the fear of judgment for the perception of non-compliance to public health guidelines and thus impacted what may have been shared with the researcher. Third, the findings around experiences of queer members of the disability community were unanticipated given the eligibility criteria did not intentionally seek out individuals who disclosed a disability. Therefore, the findings are limited to the specific needs of the research participants who disclosed experiences with disability. Finally, limitations with the use of digital diary methods and semi-structured remote interview techniques include the barriers associated with internet connectivity and whether these hybridized methods are appropriate for working with populations (e.g., street-involved youth) who navigate different systemic barriers than most of the research participants involved in this study.

4.5 Revisiting Positionality, Revisiting the Text

These hybridized methods also generated a significant amount of text, which included transcripts from the intake and follow-up interviews and diary entries. In this thesis, the analysis of this text was guided by the following research questions: 1) How do participants talk about the ways that COVID-19 has impacted their mental health? And, 2) What strategies do participants use to address mental health challenges in the context of COVID-19? The desired academic output of
this thesis will be a book chapter and a published manuscript. Beyond these academic goals I am challenged by the vakaturaga, i.e., knowing my position and my responsibilities and obligations to everyone I work with, vested in me with the stories shared and selected for print, and those that were ultimately excluded from processes of analyses (Nabobo-Baba, 2015).

Strega and Brown write about the importance of uncomfortable reflexivity that focuses not only on personal struggles with the research, but also the unresolved political struggles faced by researchers (L. A. Brown & Strega, 2015). In this thesis, participants have shared how members of the disability community are routinely overlooked when it comes to public health policy both prior to and peri-pandemic. In the years that it has taken me to carry out this research and write about it, I have witnessed how governments have confirmed participants’ fears of a return to normal that leaves disabled and immunocompromised queer youth to fend for themselves without mask mandates. Even at my own research institution, despite warnings from its own academics about the arrival of a seventh wave (Harnett, 2022), mandatory masking has not been reinstated since regulations were relaxed on June 30th, 2022 (Ono, 2022).

In my own thesis work, I have highlighted in Chapter 2 of this thesis the benefits of using a hybridized approach that can allow for participants who would not otherwise be able to participate in in-person research (e.g., members of the disability community) to participate. Challenged by vakaturaga, I think of Dr. Charles Menzies’s (Gitxaala) writings on consultations with Indigenous people in research, he writes:

“Some researchers master the form of respectful research, but do not follow it through in any meaningful way. For such researchers, being able to solicit a letter of support is to
them sufficient proof they have “consulted” and included community interests...[which] does much to continue the legacy of colonialism.” (Menzies, 2004)

An important implication of the hybridization of remote and digital methods is not solely to expand the inclusive potential of qualitative research methods during the ongoing COVID-19 pandemic. Methods that open opportunities for the inclusion of experiences that may have otherwise been excluded must also be accompanied by expanded and ongoing commitments made by the researchers that use them. Respectful research, whether you are working with Indigenous peoples or settlers, cannot be a process of simply checking off boxes (e.g., getting a letter of support, meeting research ethics board requirements, including an accessibility statement), but must also be lived. For me, this means that outside of my research work I need to carry forward these stories with me and integrate them into how I organize future community events (e.g., provide livestream options), make policy and program recommendations for local non-profits (e.g., reformulating or developing equity mandates at the board-level), design research studies for future graduate work, or how I facilitate spaces in my friendships and relationships for people who I care about who are members of the disability community and/or immunocompromised.

To do justice to the stories left on the cutting room through my processes of thesis-writing, I sought to revisit the text of the diary entries one last time. In Chapter 1, I start my thesis with the ending of “Not the Pacific We Know (But Still the Pacific)” (see section 4.6) and discuss the fungible “we”. In the poem, “we” represents both my voice and that of the Pasifika co-authors who share stories of how we grappled with clashing against the constructs of the graduate residence we all lived at different times over the last three decades. However, I also note how my
use of the excerpt expands the context of the lines from their original structure to a new destination: the lived experiences of the participants of this study on the experiences of queer youth navigating COVID-19. By nesting of the poem at the beginning of this thesis, I invite myself and the readers to not only think about what it means to be a Fijian researcher on the shores of a familiar and unfamiliar Pacific, but also what it means for the lines to say “Now that you know: / You will remember what we/ have shared” in the context of this research. I was not initially sure how justify my use of “Not the Pacific We Know (But Still the Pacific)”, but committee member Dr. Naepi (Fijian/Pakeha) suggested that I write another poem working with the experiences of the participants. Using the diary entries of all fifteen research participants, I drew out unaltered segments and sentences from their entries to form a poem: “Diary Entry Prompts: #H20-00366” (see section 4.6).

In “Not the Pacific We Know (But Still the Pacific)” (see section 4.6), the original structure of the poem is separated into four columns: the first is the voice of the narrator who guides the direction of the poem, and the other three each represent a deidentified voice. The poem was written to be read by a group, mimicking the dynamics of the Zoom conversation whose words make up the poem. “Diary Entry Prompts: #H20-00366”, named after ethics-approved document whose prompts participants answered, is structured differently. It is a single column comprising of different segments of diary entry text that are occasionally separated by line breaks for flow and breath. If the poem included staging instructions, I would write that the poem should be broken up into as many speaking parts as there are people are in the room. The goal of the poem is to revisit the text of the diaries in a different way that can draw on moments and feelings shared by participants that I was not able to include in Chapters 2 and 3. In “Not the Pacific We Know (But Still the Pacific)”, I struggled with my own silence both in how I fit in my own poem
alongside the accomplished community leaders and academics who joined me, and in my own life, I write: “Just sinking./ I have to give myself/ space—can’t just be all/ silence.” I wrote the poem to create space for myself to contend with the parts of my life that are sometimes silent and to give myself permission to identify as a Pasifika academic and ending the poem with “Now that you know:/ You know a little more/ About who I am.”

In assembling “Diary Entry Prompts: #H20-00366”, I wanted to continue in my thesis-long exercise of attempting and re-attempting to describe complex and contradictory humanity beyond the disservice of essentializing participants (intentionally or not) as either “victim” or “superhuman agents” (Gordon, 2008, p. 4; Thulien et al., 2022). In Chapter 1, for example, I draw on the work of co-supervisor Dr. Fast (Thulien et al., 2022) and introduce nine of the participants whom I quote in Chapter 2 and Chapter 3 in short paragraphs drawing on my fieldnotes to contrast traditional approaches to sociodemographic summaries that focus only on characteristics like ethnicity, gender, sexuality, and age. In this chapter, “Diary Entry Prompts: #H20-00366” provides the opportunity for more complexity to be added to participants’ experiences by facilitating space for different, sometimes contradictory, experiences and emotions to live beside each other. By placing complementary and conflicting experiences recorded in the diary entries beside each other in the poem, I revisit social constructivism to represent multiple realities of COVID-19 and how each participant’s process of meaning-making around their mental health experiences is different. My use of poetry is also guided by vakaturaga, which helps me engage with social constructivism me and the rejection of the reification of particular health outcomes as inevitable by presenting multiple realities of mental health and COVID-19 (Schwandt, 2007) by adding an additional challenge of now that I am
aware, what will I do to ensure that the stories that are shared with me are honoured. In the poem, the participants write:

**Diary Entry Prompts: #H20-00366 [excerpt]**

The constant rhetoric of only  
The old and sick will die  
As one of the so-called “sick”  
I resent that my life  
Is disposable and worthless.

I began watching more TV shows,  
More frequently  
Began consuming alcohol  
Beyond social settings

COVID-19 has highlighted  
The importance of  
Having a support system  
How much it can  
Enhance your mental health

I told my friend I was  
Feeling suicidal  
That was a little victory

I usually don’t tell people  
Because I either expect  
A response that takes away  
My autonomy and safety  
Or no response at all.

I’m getting my second vaccine soon  
Hoping to try getting out more  
And hooking up more  
I just want to feel hot  
And desired.

Online gatherings  
Difficult and draining  
I miss hugging friends

People dying for no reason  
Other than negligence  
From people in power
I remind friends to
Get their drugs tested
Attended one funeral
Through webcam
Wanting to numb out more.

I miss people
As someone who
Navigates the world by touch
Having to stay away
Not touch anything
Is hard.

I'm trying to let myself
Make mistakes
Talked to some close friends,
Feel loved.
I'm trying to be more open
With all of my struggles

I'm not allowed
To use my pain meds
Anymore so everything
Is torture.

Having friends that support me
Means [they] want me
To get better.

I've tried therapy
I've tried drugs
Tried a lot of stuff
To not feel so alone.

Some days are more
Productive than others
Virtual communication
Doesn't even feel real.

Difficult to not be able to
Hug, be close.

Out of the house, out on my own
During the quieter hours.
I certainly hold a lot of anger
The pandemic and how others are treating it
I will definitely not forget, post-pandemic
The friends who just
Blatantly put others at risk.

In good spirits
I made a calendar
The times of the sunset
Each day of the month
It’s nice to remember
That it’s only getting
Brighter every day.

The inclusion of poetry aims to supplement the thesis’s existing approaches to describing complex humanity by presenting participants’ diary entries in a way that does not explicitly guide the reader to identified outcomes as one would in a results section. By collapsing fifteen participants’ experiences into a column of text that does not demarcate whether the fragments are arranged chronologically or whether each line break represents a change in participant, I argue, using the language of Ahenakew (Cree) previously discussed in Chapter 1, that the process of sense-making is disrupted (Ahenakew, 2016, p. 337). In the previous chapters, one taking the form of a methods chapter and the second a manuscript, there are clear sections that guide the reader to my conclusions based on the study’s findings. This disruption using poetry allows for two potential outcomes: 1) the creation of space for “other possibilities of knowing and being” that are frequently subjugated in sense-making processes that feed “desires for security, certainty, control, comfort, and autonomy” (Ahenakew, 2016, p. 336); and, 2) in this opening up of other possibilities of knowing, the encouragement of a “variety of possible readings...beyond the control of any single authority” (Clifford, 1988, pp. 52,53). In this thesis, I have both guided the reader in my interpretation of the participants’ experiences of mental health during COVID-
19 and, through my use of poetry, hope that I can expand my descriptions of complex
personhood in a way that aligns with the responsibility and obligations that are tied to my
understandings of vakaturaga.

4.6 Poetry

In the section below are the two poems, “Not the Pacific We Know (But Still the Pacific)” and
“Diary Entry Prompts: #H20-00366”, that are referenced in Chapters 1 and 4 of this thesis. The
version of “Not the Pacific We Know (But Still the Pacific)” represented below has been
restructured to fit the formatting rules prescribed for theses.

Not the Pacific We Know (But Still the Pacific)

Narrator

Write slower.

Between pauses of paperwork.

Do the words breathe; how do they hold room?

Can you find traces,
Sleeping kinship,
Ties lingering to connect the next…

Press record.

Everyone [Laughter]

Speaker 2

Sunlight spilling in from the
Corner of a Zoom screen in Aotearoa.

Speaker 3

Winter sky, infinite line of prairie grass
Stretching beyond the length of sight;

Speaker 1

Stony pacific, gradient of wet gray cloud
Tankers grazing on cold ocean;

Speaker 3
These horizons feel familiar,

Narrator
Bodies of water, seas of grass
Salt and freshwater; mixing.

Speaker 3
That cold gray ocean we feel
Not quite the Pacific we remember

Speaker 2
At the bottom of those stairs (huffing and puffing)

Speaker 3
Eventually circles around to those we love:

Speaker 2
And it is wonderful and warm.

Speaker 3
As I look back, the
Ocean was actually home
I could go down there
I could tell my mom,
“I’m going down to the ocean.”

And i’d be imagining she was there.

Speaker 1
*Isa na makubuqu, noqutagane*

Speaker 2
When my uncle died. I told my cousin…

Speaker 3
I’d say to my brothers,

Everyone
Look up.

look up to the stars,
and
i’ll be down by the ocean

Speaker 3
Look up
And i’ll be looking at the moon.
Narrator  Bodies of water, seas of grass  
Salt and freshwater mixing.

Speaker 1  
I’m all mixed up. 
Don’t really know 
Words, just  
Sinking.

Speaker 2  
More than the Pacific Academy’s saltwater.  
More than scholarship shaped by Polynesia.  

My bubu was calling me back to say,  

No, it’s freshwater. Remember, You’re a river girl.

Speaker 3  
Pedaling along  
Lake Taupō,  
Waimakariri  

Speaker 1  
Just sinking.  
I have to give myself space—can’t just be all silence.

Everyone  
Three

Narrator  
Three feels like a small number for 30 years.  

For a College by the Pacific.

Everyone  
Three?

Speaker 2  
Four.  
Margaret Mutu: up on a wall.  

Said to myself,  
“Ah, okay, people do come through here.”

Speaker 3
Counting partners?

**Speaker 2**

Niue?

Five.

**Speaker 1**

Still not enough for a rugby team.

**Everyone**  
[Laughter]

**Narrator**  
Sleeping kinship:

**Speaker 1**

Corner of a Zoom screen  
I shuffle  
Try to be seen  
(I can’t believe my eyes)  
I google her name.

Airini.

I text my friend (screaming in caps).

We have been here!  
Here!

**Narrator**

It can be lonely on this side of the Pacific if you’re floating through.

Lonely even if you’re born here, the product of other people’s floating.

**Speaker 1**

Found Sereana on LinkedIn, ran to my mom, “She’s from Fiji!”

I wanted to tell her about the cassettes I grew up with, cutting my fingers  
On tin meat cans;  
Do you like tin biscuits?

**Narrator**

Away from home, away from  
Family, away from so much
Everyone

Away from

Speaker 2

We’ve always had
Family fallback in Aotearoa
We’ve always had

Away from—

That fallback wasn’t there.
We had to grow.
Being able to claim Pacific academia

Narrator

Anger

Speaker 2

Articulate—
In a way that you don’t have to in Aotearoa.
Articulate—

Narrator

Why do your ideas matter?

Speaker 2

You don’t have to justify
Talanoa in Aotearoa.

Narrator

“It’s just part of another group.”

Speakers 1 & 2

Anger

Speaker 2

Articulate—
I was real angry.
Having to justify it
Made me strong

But I was
Really angry.

Everyone

Anger

Speaker 1
I think sometimes
She doesn’t want to tell me,
Teaching requires memory
Language is home,
Is fish, is family
Remembering is too painful
Speaking what she left behind.

Narrator
Away from memory,
Away from warm currents
Away from understanding.
We have been here.

Speaker 2
You notice when things have
“Pacific” in their name (that aren’t)

Speaker 3
The attempts at categorization (failed)

Narrator
But,

Everyone
We have been here
We know who we are
We are not that.

Speaker 3
Being in Vancouver
I was free
Of others reading
Who I am
Who I should be because

They looked at,
And saw and my name being a
different kind of name

Speaker 1
My version…
My version…

Narrator
In New Zealand:

Speaker 3
Spokesperson for every pacific person on the planet!

**Narrator**
In New Zealand:

**Speaker 3**
If even more confused:
every Maori person on the planet!

**Narrator**
In Vancouver,

**Speaker 3**
Mexican.

**Everyone**
[Laughter]

**Speaker 1**
There’s something missing.

**Narrator**
In Vancouver,

**Speaker 3**
Not fighting
because you're
not being irritated
because people aren’t asking you to do things
all the time
is a little bit empty.

**Narrator**
Missing.

**Speaker 3**
you miss the gentleness the caring
even the rough and tumble that comes with
the cultural things that that you do.

**Narrator**
Missing.

**Speaker 3**
Absence of ritual and ways of showing respect.

How can people exist without an awareness of how to show respect?

**Speaker 1**
How can people exist without an awareness of how to show respect?

**Speaker 2**
How can people exist without an awareness of how of how to show respect?

**Speaker 3**
How can people exist without an awareness of how to respect?

If I stood up
Rushed over
To get tea, to fill a plate of food for somebody
Who is visiting—

**Narrator**
“Why is she doing that?”

**Speaker 3**
People would be puzzled

**Narrator**
“Why is she doing that?”

**Speaker 1**
This mischaracterization of this act of giving, you’re responsible—

**Speaker 2**
Oxford model, mimic?

**Speaker 3**
What do you know of worlds

**Speaker 2**
Whom do you greet?
Distinguished fingers
Distinguishing fingers
Figures in the shadows—
Do you know what mana is?

**Speaker 1**
—is the kind of person who’d give the shirt off his back

**Speaker 3**
I felt the obligation to be as generous as possible
Speaker 2: almost stressful for some of our friends, calculating when they would repay.

Speaker 3: The shirt off your back is a reflection of a millennia of upbringing.

Speaker 1: Caught between

Speaker 3: The calling to share, and my resentment that I have to share…

Speaker 2: The shirt off your back is a reflection of a millennia of upbringing.

Speaker 1: I am not subservient.

Speaker 3: Why did I have to be a teacher instead of others sorting out their own learning?

Speaker 1: I am falling for it.

Speaker 2: It’s the whitest place he’s ever lived.

Speaker 1: Generosity will dig me out of this hole. Sinking

Speaker 2: This idea of community

Speaker 1: Lacks a sense of accountability to

Speaker 2: Fundamentally different from our idea of community.

Speaker 3: “It’s not the Pacific you think it is.”

Speaker 1: But, it is still the Pacific.

Speaker 3: But, kindred elements, shared elements. Puzzle it out together—
Speaker 2  Not a breakfast, though.

Everyone  [Laughter]

Speaker 3  Regard for history

Speaker 2  Regard for knowledge keepers

Speaker 1  Regard for knowledge-makers.

Narrator  Bridges across, bridges over.  
Ends of the pacific tied together by kinship, circling currents of thought and motion.

Everyone  We have been here,  
We know who we are,  
We are not that.  

We are freshwater and saltwater,  
Our kindness is our ancestors.

Speaker 3  Now that you know:  
You will remember what we have shared.

Speaker 2  Now that you know:  
You know we were here.

Speaker 1  Now that you know:  
You know a little more  
About who I am.

Diary Entry Prompts: #H20-00366
Ups and downs
I left abruptly
With a duffle bag
I’d packed in under
An hour.

The poorer you are
The worse it is for affirmation
Sucked into services web.

Not being able to see
My family much

Being stuck at home
With my mother
Highlighted how unhealthy
Our relationship was.

How little attention
The overdose crisis gets
I am always shocked
At how often opioids
Are prescribed to patients.

I’m scared I won’t be able to
Find an appointment
I missed a birth control
Refill because the appointments
Were all booked

Just smoking weed these days
Being trapped indoors
Muscles ache more
Fewer emotional spoons
Staying literally away from humans
Everything happens at home.

Cope with my boredom
And loneliness and grief.
Need to shrink circles
Socially anxious and
Emotionally distant.

I have often crossed the road
When I saw someone walking
To put more distance between
Myself and other people walking

I miss not having to worry
Overdose deaths are rising
Not seeing anyone at all
Worried about friends who are
Still using.

Remembering
That this won’t
Last forever and
Focusing on the future.

My friends or peers
Who have died from overdose
You wish you could have
Done more.

The government has a lot
Of power to change things
And save lives.

I’ve always used alone
Because none of my
Friends or family know.

I don’t really text my friends
Except to send memes occasionally
“Have you seen today’s
Case numbers?”

The constant rhetoric of only
The old and sick will die
As one of the so-called “sick”
I resent that my life
Is disposable and worthless.

I began watching more TV shows,
More frequently
Began consuming alcohol
Beyond social settings

COVID-19 has highlighted
The importance of
Having a support system
How much it can
Enhance your mental health

I told my friend I was
Feeling suicidal
That was a little victory

I usually don’t tell people
Because I either expect
A response that takes away
My autonomy and safety
Or no response at all.

I’m getting my second vaccine soon
Hoping to try getting out more
And hooking up more
I just want to feel hot
And desired.

Online gatherings
Difficult and draining
I miss hugging friends

People dying for no reason
Other than negligence
From people in power

I remind friends to
Get their drugs tested
Attended one funeral
Through webcam
Wanting to numb out more.

Turning inwards
I miss people
As someone who
Navigates the world by touch
Having to stay away
Not touch anything
Is hard.

I’m trying to let myself
Make mistakes
Talked to some close friends,
Feel loved.
I’m trying to be more open
With all of my struggles
I’m not allowed
To my pain meds
Anymore so everything
Is torture.

Having friends that support me
Means [they] want me
To get better.

I’ve tried therapy
I’ve tried drugs
Tried a lot of stuff
To not feel so alone.

Some days are more
Productive than others
Virtual communication
Doesn’t even feel real.

Difficult to not be able to
Hug, be close.

Out of the house, out on my own
During the quieter hours.

I certainly hold a lot of anger
The pandemic and how others are treating it
I will definitely not forget, post-pandemic
The friends who just
Blatantly put others at risk.

In good spirits
I made a calendar
The times of the sunset
Each day of the month
It’s nice to remember
That it’s only getting
Brighter every day.
Bibliography


Vancouver, Canada: an ethno-epidemiological study. *Harm reduction journal, 14.*
doi:http://dx.doi.org/10.1186/s12954-017-0159-9


Fox, J., & Ralston, R. (2016). Queer identity online: Informal learning and teaching experiences of LGBTQ individuals on social media. *Computers in Human Behavior, 65*, 635-642. doi:https://doi.org/10.1016/j.chb.2016.06.009


Harris, D. C. (2017). Property and sovereignty: an Indian reserve and a Canadian city. *University of British Columbia law review*, 50(2), 321. Retrieved from http://ubc.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwdV1LT8MwDl5gLgg3owByo1TWdc2SYOEpqmYQNqBw-5THI7apRtdB9q_x-5aGI04tpaj1o0_O7UMxZHD2Gw5RPAhzQSx4aRjRMIZu8yYwrxQ8TCh9Zuleo8Na0xVe7ucrKaZv5fNH1M9cdYJye6EQ12R2N-xujNJYPS-toW9spBkJ7RF6lm66--teC0nJNIS4xfUjQ7PVI1MHVqD18ZAdlOMgHa_sdsR3lj9nuHydsP4bnZX5Ypjs8XVGpJQzTLIT1e4K85GZZT81DxCZW14Q3VAHYeYW5-y8fB5_PgS1OMOgvdUv8BjkkrDo5yF1KnUeE00nz2pPMRRFibeZh4A4dYA0cZBD11DzyTaWMiElz4-Y618lsMF40kEJJExCl0aM6dQPQPeQwvCZ-FNrm53TI0_oGv4L4yY_r7PNNv_eMXWRPuolnqjJYE0Y8fSzaczv3ou_12hw_YjQsbgfO0KtepICdCv5FCNZadv-Tqfeg


Knight, R., Shoveller, J. A., Oliffe, J. L., Gilbert, M., & Goldenberg, S. (2013). Heteronormativity hurts everyone: Experiences of young men and clinicians with...


Schmidt-Sane, M., Abbas, S., Karam, S., & Palmer, J. CURRENT KNOWNS, UNKNOWNS, AND PERCEPTIONS ABOUT MONKEYPOX.


Intersex Youth-Inclusive Primary Health Care by Nurses. *Journal of Homosexuality, 68*(8), 1298-1319. doi:10.1080/00918369.2019.1696106


and Disability by Sexual and Gender Minority Status. *LGBT health, 8*(8), 563-568. doi:10.1089/lgbt.2021.0075


