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Critical self-reflection as an intervention tool for health and psychosocial service practitioners working with LGBTQI+ migrants

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Résumé : Les personnes LGBTQI+ migrantes évitent souvent de solliciter les soins de santé et les services psychosociaux dont elles ont besoin, en raison de leur méfiance à l'égard des professionnel.le.s et de leur crainte d'être victimes de discrimination. Ces dernières années, de nombreuses approches d'intervention antioppressives ont été développées pour répondre à cet enjeux et améliorer la qualité globale des soins reçus par les membres de diverses populations marginalisées. L'une de ces approches, l'autoréflexion critique, permet aux intervenant.e.s de prendre conscience des facteurs susceptibles de nuire à leurs relations avec les utilisateur.trice.s de services, tels que les biais inconscients et les dynamiques de pouvoir. À ce jour, peu d'études ont examiné l'utilisation quotidienne de cette approche avec les personnes LGBTQI+ migrantes. Cette étude vise à explorer l'utilisation de l'autoréflexion critique comme outil d'intervention par les intervenant.e.s travaillant dans une clinique interdisciplinaire pour les personnes LGBTQI+ migrantes. Les données de 13 entretiens menés auprès de professionnels de la santé et de travailleur.euse.s psychosociaux.ales ont été analysées selon une méthode d'analyse thématique réflexive. Les résultats et les implications pour la recherche et la pratique clinique sont présentés.

Mots clés : Autoréflexion critique, antioppression, justice sociale, migrant.e.s LGBTQI+, soins de santé, services psychosociaux, préjugés, relation thérapeutique, psychologie clinique

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Abstract: LGBTQI+ migrants often avoid seeking the healthcare and psychosocial services they need due to distrust of professionals and fear of facing discrimination. In recent years, many anti-oppressive intervention approaches were developed to address this issue and improve the overall quality of care received by various marginalized groups. One of these approaches, critical self-reflection, allows practitioners to become aware of the factors that may negatively impact their relationships with service users, such as unconscious biases and power dynamics. To date, few studies have examined the daily use of this approach with LGBTQI+ migrants. The purpose of this study was to explore how critical self-reflection is used as an intervention tool by practitioners working at an interdisciplinary clinic for LGBTQI+ migrants. Data from 13 interviews with medical professionals and psychosocial workers were analyzed using a reflexive thematic analysis method. Results and implications for research and clinical practice are discussed.

Key words: Critical self-reflection, anti-oppression, social justice, LGBTQI+ migrants, healthcare, psychosocial services, biases, therapeutic relationship, clinical psychology

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Abbreviations

CIUSSS	Centre Intégré Universitaire en Santé et Services Sociaux
CM	Clinique Mauve
LGBTQI+	Lesbian, gay, bisexual, trans, queer and intersex

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Introduction

Migrant and racialized populations encounter barriers when attempting to access health care and social services (Campbell et al., 2014; Kalich et al., 2016), barriers which were accentuated by the destabilization of the Quebec health care and social services system during the COVID-19 pandemic (Hamila et al., 2022). LGBTQI+[1] migrants[2] face particular difficulties due to the intersection of their migratory status, ethno-racial identity, sexual orientation and/or gender identity (El-Hage & Lee, 2015). As part of these barriers, LGBTQI+ migrants face bias and discrimination by health care professionals and psychosocial workers, which can greatly damage the relationship between providers and service users (Ackerman & Hilsenroth, 2001). Recent studies have called for improvements in LGBTQI+ migrants' access to quality culturally-informed health and psychosocial care (Chávez, 2011; El-Hage & Lee, 2016).

This article aims to present the results of an exploratory study that documented health and psychosocial practitioners' use of critical self-reflection, in order to understand how this tool is applied in practice with LGBTQI+ migrants. Although this term will be more fully explored in the subsequent section, critical self-reflection can be briefly defined as a tool for practitioners to develop a deeper self-awareness of their relationship with service users, and as individuals whose experiences and perspectives are informed by a particular social, cultural and historical context. This process entails not only examining one's biases, values and assumptions, but also challenging

[1] The acronym "LGBTQI+" refers to the terms lesbian, gay, bisexual, trans, queer and intersex. The term "queer" may be used as an umbrella term for members of sexual and gender minority communities (Barker et al., 2009), while "trans" is a shorter version of the word transgender and refers to individuals whose gender identities deviate from traditional expectations based on the sex assigned at birth (Lindqvist et al., 2020).

[2] The present study uses the term "migrant" to refer to forced migrants, voluntary migrants, refugees, and asylum seekers. More specifically, refugees are people who flee their country of origin due to high risks of persecution or human rights violations. Similarly, asylum-seekers seek protection and safety in another country, but haven't been legally recognized as refugees yet (International Organization for Migration, 2018).

and questioning the power imbalances present in helping relationships and in society as a whole (Alessi & Kahn, 2017; Ash & Clayton, 2009; Brookfield, 1995; Kumagai & Lypson, 2009).

Background

Health and psycho-social care provision for LGBTQI+ migrants

Due to their intersecting identities, as well as the various forms of violence they face both in their countries of origin and in Canada, the realities of LGBTQI+ migrants are complex (Lee et al., 2020; LaViolette, 2009). After arriving in Canada, LGBTQI+ migrants still bear the weight of the traumatic experiences from which they escaped, while also facing various social barriers, such as challenges surrounding employment, housing, education, and systemic racism (Cowen, 2011; Lee & Brotman, 2011). As a result, this population often experiences high levels of mental health difficulties, as well as social isolation (Fox et al., 2020). According to Kahn et al. (2018), LGBTQI+ migrants have a difficult time finding mental health providers who are culturally sensitive, LGBTQI+ affirmative, and who are qualified enough to understand the complexity of their intersecting identities. Many practitioners are frequently unprepared to adequately care for the unique needs of LGBTQI+ migrants, and even risk perpetuating harm against them often due to their own internal biases (Alessi et al., 2021; El-Hage & Ou Jin Lee, 2015).

Bias is a term which refers to stereotypes and prejudices based in the negative evaluation of one group compared to another (Blair et al., 2011; FitzGerald & Hurst, 2017). Stemming from conscious or unconscious bias (Williams, 2020), professionals may harm marginalized communities through microaggressions, defined as daily commonplace behaviors toward others that communicate derogatory insults based on race/ethnicity, gender, sexual orientation, etc. (Sue, 2010). In a clinical context, these phenomena can harm the therapeutic relationship between service provider and service user by compromising trust, undermining practitioner-client

communication, and making clients feel devalued and disrespected (Ackerman & Hilsenroth, 2001). In the case of clinicians working with LGBTQI+ migrants, Alessi et al. (2021) reported that unexamined biases can have a similar negative impact on clients. Moreover, the damage caused by exposure to microaggressions and biases is cumulative; in the long term, it can contribute to physical illness, decrease self-esteem, and affect mental health (Turner et al., 2021).

The role of critical self-reflection in health and psychosocial care provision

A variety of trainings, frameworks and strategies have been proposed in recent years to help reduce practitioner biases and microaggressions (Davis et al., 2016; Fisher-Borne et al., 2015; Foronda et al., 2016; R. D. Goodman & West-Olatunji, 2009; Hook et al., 2016; Owen, 2014; Stone & Moskowitz, 2011; Tummala-Narra et al., 2018; White et al., 2018). The present study focuses on one approach in particular: critical self-reflection. According to Ash and Clayton (2009), without reflection, experience alone can reinforce our biases – especially since our social environment tends to reflect the existing power structures established in society. Thus, critical self-reflection prioritizes awareness of practitioner's thoughts, feelings, beliefs, behaviours, experiences, assumptions, biases, and social positions (such as gender, sexual orientation, ethno-racial identity, social class, religious orientation, etc.), and how these factors can influence their relationship with service users (Kumagai & Lypson, 2009; Pieterse et al., 2013).

However, the literature is not uniform in the ways that it defines and applies critical self-reflection, and this concept has been theorized in relation to various associated and overlapping terms, such as reflexivity, reflective practice, critical self-awareness, reflectivity, critical reflectivity, critical consciousness, etc. (D'Cruz et al., 2007; Rosin, 2015; Piererse et al., 2013; Sakamoto & Pitner, 2005). Notably, "decentering" (or decentration) is an approach similar to critical self-reflection consisting of "distancing ourselves from ourselves" (p. 76) through

reflection and introspection (Cohen-Émérique, 1993). Decentering stems from the literature on intercultural intervention, and helps practitioners become aware of their own subjective frames of reference (Cohen-Émérique, 1993).

Although some authors have explored critical self-reflection as a theoretical concept (D'Cruz et al., 2007; Sakamoto & Pitner, 2005), others have conceptualized critical self-reflection as an intervention in and of itself (Fook & Askeland, 2007; Heron, 2005). It has also been defined differently according to the lens through which it is elaborated (i.e., social work, education, counselling psychology, etc.). For the purpose of this study, critical self-reflection is understood as an intervention tool for practitioners belonging to various health and psychosocial fields, which is intended to bring about social change through concrete improvements to professional practice (Fook & Askeland, 2007). Indeed, it is the emphasis on structural power which makes the reflective process "critical" in nature (Brookfield, 1995). By considering one's own role within the practitioner/service user relationship in health and social services, it allows for an understanding of the ways in which power relations operate (Lee et al., 2017; St-Amand, 2003). These characteristics make critical self-reflection a valuable tool for practitioners working with marginalized communities, where power relations between provider and service user are prone to exist, but to be left unexplored. As part of a process of critical self-reflection, awareness and exploration of one's biases was found to be significant in preventing service providers' harmful microaggressions with diverse clients (Dovidio & Fiske, 2012). Owen et al. (Owen, 2014) recommended that therapists working with diverse populations engage in continuous reflection on how their presence, words, and actions could impact their clients, especially because this process could help them recognize and prevent microaggressions.

Critical self-reflection can also be a tool that is integrated into other existing medical and psychosocial approaches, such as cultural competence and cultural humility (for ex: Lewis et al., 2018; Ortega & Faller, 2011; White et al., 2018). Although an in-depth presentation of these approaches is outside the scope of this article, the following are brief definitions of each. Cultural competence was developed to increase capacity to provide safe and quality care to individuals of different cultural backgrounds, by equipping professionals with knowledge and skills to work more effectively with marginalized groups in a culturally sensitive manner (Betancourt et al., 2003; Cai, 2016; Tummala-Narra et al., 2018). Cultural humility aims to address power imbalances in therapeutic relationships through commitment to self-reflection and life-long learning (Lewis et al., 2018; Tervalon & Murray-García, 1998). These brief descriptions reveal the overlaps with critical self-reflection. Interestingly, a study by Olson et al. (2016) demonstrated that the cultural competence approach can be improved by the incorporation of self-reflection to existing trainings. In fact, more recent notions of cultural competence tend to involve the concepts of reflection and critical thinking, which are also key components of cultural humility (Danso, 2018; Foronda et al., 2016; Hammell, 2013; Tervalon & Murray-García, 1998).

As such, this article focuses on critical self-reflection as a tool that can be integrated into broader approaches. Most of the literature suggests that critical self-reflection has the potential to be an effective tool for practitioners working with marginalized populations. It could also contribute to build safer and more trusting relationships between service providers and service users by encouraging providers to reflect on their biases and mitigating microaggressions. Alessi et Kahn (2017) underlined in their framework for practice with LGBTQI+ asylum seekers that professionals should use self-reflection with their service users. However, critical self-reflection has yet to be explored as a tool to reduce biases against LGBTQI+ migrants in particular.

Moreover, critical self-reflection has mostly been explored theoretically, or in the context of academic and professional training. As such, the ways in which practitioners concretely apply the critical self-reflection process to their everyday practices with this population remain unclear.

Theoretical frameworks

This research project adhered to the *social constructivist* interpretive framework. By adhering to social constructivism, this study sought to understand the subjective experiences and perspectives of the service providers working at the CM, which are informed by social, historical, and cultural influences (Creswell, 2012). However, a constructivist lens does not explicitly examine the power structures at play, nor does it aim to challenge these structures (Abes, 2012).

As such, this study also engaged with *intersectionality*, a concept rooted in Black feminist thought which not only supports the notion that individuals living at the intersection of multiple axes of oppression can experience different forms of discrimination at the same time, but also focuses on challenging and transforming systems of power, as well as eliminating the societal inequalities they perpetuate (Crenshaw, 1989; Moradi & Grzanka, 2017). Moradi & Grzanka (2017) called all researchers to use intersectionality as a comprehensive methodological framework rooted in action, and recognize the influence of their subjectivity on knowledge production. Viewing LGBTQI+ migrants' identities through an intersectional lens was helpful for the present study, as this framework considers the complexity of this population's individual realities. In the case of LGBTQI+ migrants, it is principally the intersecting of race/ethnicity, migratory status, sexual orientation, and/or gender identity that creates unique challenges and barriers. Intersectionality also helped with the selection of approaches, methods, data collection and analytical strategies that are more sensitive to the realities of participants, which may produce more nuanced findings (Abrams et al., 2020).

Research context

This article shares the results from an exploratory sub-study that was part of a larger research project titled *Clinique Mauve: Évaluation du point de services pour les personnes LGBTQI+ (lesbiennes, gaies, bisexuelles, trans, queer, intersexes) migrantes à Montréal*. This larger project's main objective is to evaluate the implementation of the Clinique Mauve (CM), the very first health clinic providing integrated health care and psychosocial services destined for LGBTQI+ migrants in Montreal. The clinic aims to reduce inequalities in healthcare access for LGBTQI+ migrants, particularly in the context of the COVID-19 pandemic. To achieve this goal, the CM adopts anti-oppressive, intercultural, intersectional, trans-affirmative, and trauma-informed approaches, while also advocating for harm reduction strategies and informed consent processes, with a strong emphasis on user empowerment.

Although the larger research project used a mixed-method strategy, this exploratory study drew solely from its qualitative data, more specifically a set of semi-structured interviews with health care and psychosocial service providers affiliated with the CM. The main research project was approved in March 2021, by the Psychosocial Research Ethics Committee of the CIUSSS of West-Central Montreal Research Ethic Board, and subsequently by a Research Ethics Committee at the Université de Montréal. An amendment request was approved for this particular sub-study by the same committees in order to add questions pertaining to critical self-reflection to the existing interview guide for practitioners.

Method

This exploratory study's main goal was to document the ways in which critical self-reflection is used as an interdisciplinary intervention tool in health and psychosocial service delivery to LGBTQI+ migrants at the CM. Indeed, the process of critical self-reflection is central

to existing intervention approaches that are used at the CM, such as cultural humility and cultural competence, and closely related to others, such as intercultural intervention and decentering. As such, practitioners working at the CM commonly engaged with these approaches, which were also discussed during weekly or bi-weekly interdisciplinary group supervision meetings.

This study's objective was to ask service providers to discuss their potential integration of critical self-reflection in their respective practices at the CM, to understand the relevance, advantages and challenges related to its use. The following research questions draw from the main goal and objective of this study: "1) How do practitioners working with LGBTQI+ migrants describe, conceptualize, and apply critical self-reflection to their individual practices?; and 2) What are some of the organizational constraints to applying a critical self-reflection process?" Based on these preliminary findings, this study aimed to offer recommendations for practitioners to use critical self-reflection with LGBTQI+ migrants in the future.

Sample and data collection

In total, 13 interviews were conducted with service providers and included the following types of workers: peer navigator, social worker, psychologist, mental health worker, nurse, and family doctor. The 90-minute interviews mostly explored practitioners' general experiences working at the CM as part of the main evaluative project. However, they also included a section on practitioners' use of the critical self-reflection approach, as well as related approaches commonly used by practitioners at the CM, such as cultural humility, cultural competence, decentering, etc. Interviews were semi-structured, which allowed for questions to be modified, added, or eliminated. Due to the iterative nature of social constructivist methods, all new questions were also informed by previous interviews.

The interviews were conducted both in French and English by the author of this paper and two other researchers, between July and September 2021. These individual meetings were conducted through Zoom, due to the restrictions imposed by the COVID-19 pandemic, and were recorded after obtaining participant consent. Audio recordings were then transcribed in their original language, and all French quotes included in the results section were translated to English by the author, who is bilingual. All identifying information of participants was removed from transcriptions to preserve confidentiality.

Data analysis

This study was guided by Braun & Clark's reflexive thematic analysis strategy (2021), which allows researchers to identify, analyse, describe and interpret patterns within data, without being theoretically bound, while the reflexive component encourages researchers to critically reflect upon their own role, practice and processes. Rather than seeking a universal and objective truth, this approach teaches how to seek situated, multiple and partial truths (Braun & Clark, 2021). As such, subjectivity is seen as an asset which should be interrogated, explored and acknowledged, rather than eliminated. Not only was this strategy selected because it fits with the study's exploration of critical self-reflection, but its flexibility and accessibility give it the capacity to generate unanticipated insights, which aligns with the study's exploratory nature.

Using the coding software "Dedoose," the author applied a content analysis to find codes and then uncover principal themes in the verbatim data from interviews. Although analysis focused on questions pertaining to critical self-reflection, the entirety of each interview was investigated. Indeed, themes related to critical self-reflection could emerge throughout discussions of practitioners' general experiences working at the CM. In terms of coding strategies, elements of the *inductive* approach were adopted, including the fact that practitioners' subjective experiences

were the focus, and as such, codes were not chosen beforehand. However, this study's coding took on a mostly *deductive* orientation, meaning that the analysis is shaped by existing theoretical constructs, which provides the "lens" through which to read and code the data and develop themes. Indeed, coding was explicitly guided by principles of social justice, as well as the goal of creating better care conditions for members of the LGBTQI+ migrant community. Moreover, the coding strategy was developed following a constructivist perspective, which allowed an exploration of the influence of societal discourse on participants' unique realities (Braun & Clark, 2021).

Results

Overall, four main themes were identified based on the data: reflections on social location and power dynamics, decentering, recognizing the potential to cause harm, and the process of applying critical self-reflection. The specific numbers of participants who mentioned each theme is specified in the appendix.

1. Reflections on social location and power dynamics

Almost all interviewed practitioners engaged in some form of reflection pertaining to their social location. Participants underlined the importance of identifying their own social identities, such as their ethno-racial identity, their gender identity and their sexual orientation, as well as their individual experiences, perspectives, values and privileges. Out of all interviewees, 5 participants identified as not belonging to the LGBTQI+ migrant community, 6 identified as belonging to the LGBTQI+ migrant community, and 2 did not directly discuss their identities.

1.1 Power dynamics

In total, 5 participants perceived themselves as not being a part of the LGBTQI+ migrant community. These participants recognized that the differences between their own and their clients'

social location (including notably ethno-racial identity, gender identity, and sexual orientation) could create power dynamics within the therapeutic relationship. As part of the process of critical self-reflection, practitioners underlined the importance of recognizing these power dynamics.

Many white participants, such as Participant 4, noted that they made the effort to think about how their ethno-racial identity might impact their role: “ It's important to make sure I'm like, reflexive about my social position and also the power dynamics, especially as a white person.”. Similarly, Participant 9 mentions that since some of his clients’ countries of origin were colonized by his own European country of origin, this colonial heritage could shape their power dynamic. These dynamics could impact the trusting relationships he had with his clients, as he felt as though some participants shared (and refrained from sharing) certain information with him.

Since personal identities are complex and multifaceted, practitioners who did not belong to the LGBTQI+ migrant community sometimes shared some identities with their clients. Indeed, some of them identified as either an LGBTQI+ person, or as a racialized/migrant person. For example, Participant 7, who does not identify as a member of the LGBTQI+ migrant community, explained that although his whiteness and experience as a Canadian citizen created a divide between him and his clients, as a gay man, he could relate to some of his client’s experience, if they had this identity in common.

1.2 Intervening as an LGBTQI+ migrant

According to the 6 practitioners belonging to the LGBTQI+ migrant community, sharing social location with their service users impacted their relationships in various ways. Half of them expressed that having more proximity to the LGBTQI+ migrant community made it easier for them to relate to their clients’ lived experiences, especially when they come from similar cultural and/or regional backgrounds. These participants explained that having gone through similar experiences,

they understood what their clients were going through, including the challenges associated with arriving in a new country, such as feelings of isolation and loneliness.

Despite having shared identities, half of the participants who self-identified as LGBTQI+ migrants admitted that it was impossible to share all their identities with every client and to relate to all of their clients' experiences. For example, Participant 6 recognized that despite the similarities, their own experiences were ultimately different than their clients' experiences. Thus, it was essential to continue to reflect on their biases and not assume that sharing identities would be sufficient. Participant 5 explained: "[…] even though I am from that community still I have blind spots, because I can never know how it feels and all the different, you know, communities and all the different things. I have to keep my eye open even." Similarly, for another participant who belonged to the LGBTQI+ migrant community, it was important to recognize that his position as a cis gay man meant he unconsciously made certain assumptions about a trans client, which led to a misunderstanding:

> "…the person took it badly and I had forgotten that she was a trans person, and she told me 'it's not that, it's because people don't like the way I look, and it's the same Latinos who don't like me because they always make fun of me, and they say "faggot", they say "*tapette*" to me….' I'm homosexual, but I'm not trans, so it's not the same thing and I forget that, you see. It's that I have a privilege [...],'it's intersectionality, but on the inside, but it's complicated because we take it for granted." – Participant 10

2. Decentering

More than half the participants made a conscious effort to decenter themselves in relation to their LGBTQI+ migrant service users. Having reflected upon their own social location, participants pointed out the necessity to see things through their clients' perspective, even if as humans, we have a natural tendency to rely solely on our own experiences, knowledge, and values to make sense of the world. For example, Participant 4 noted: "But I think that, like, what I try to

do is to decenter myself in relation to my own values. Identify my own values in the situation, that can come into play."

2.1 Considering 'culture'

Almost half of participants discussed the importance of considering the similarities and differences between their own culture(s) and their clients' cultures. In order to better understand their service users, practitioners noted that it was helpful for them to reflect upon those differences, rather than ignoring them. This could help them prevent viewing their clients' situations through the lens of their own culture(s), since this can create misunderstandings. For example, Participant 4 wondered how they were going to help service users navigate the health care system without imposing their own perspectives on service users, considering that different cultures have different values when it comes to medical care: "And we find ourselves in the psychosocial team working as mediators between the Western healthcare system and the person who doesn't have much power within that system, with all their expectations, values and cultural background."

Moreover, a few participants noted that thinking about culture could be a challenge, notably due to the fact that culture is a complex concept. This participant states:

> "Yes, and I think that's probably the aspect that was the most, that was the biggest question mark in relation to all this, where I think there's something in the culture, that even if I were asked to describe my own culture, it wouldn't necessarily be that easy. Because a culture is something you embody and live every day, it's not always easy to be able to capture the cultural references with which your clients come to you. Of course, I was trying as much as possible to say that we don't necessarily have the same culture, but sometimes there are things we totally miss, especially when we're working with clients who are suffering more, who don't necessarily have the words to explain that culture to us, who aren't necessarily aware of how that culture has influenced the person they are, their expectations of people, how they interact in relationships. So, I find that this is actually a very complicated aspect of multicultural intervention" – Participant 12.

A few participants, including Participant 12, also underlined that even when two service users come from the same origin country, their experiences could still be completely different:

"...sometimes we're talking about subcultures too, where you may have three Mexican clients, well, it's like, depending on the region of Mexico, sometimes there are things that are extremely different". Moreover, Participant 9 suggested that this idea is particularly true in the case of LGBTQI+ migrants, who can hold many different "cultural universes" at once, due to their intersecting identities:

> "And to keep in mind the importance of culture, without... I think it's all the more important for LGBTQ people, who – for some of them anyway – have this capacity to have many cultural universes, and to want to value certain aspects or others [...] To see how people want to present themselves every day, a little bit, in their identities, in their representations" – Participant 9.

2.2 Humility and willingness to learn

A little less than half of the participants mentioned the fact that decentering themselves can also look like adopting a stance of humility. Participants tried to position themselves not as "experts" who know everything, but rather as practitioners who are willing to listen to, collaborate with, and learn from their service users. When service providers weren't sure whether they understood what their clients were trying to express or explain, rather using their own perspectives to fill in the gaps, many of them simply asked. As Participant 4 explained, "…[the important thing is] to ask questions to understand how the person perceives the situation, what values of theirs play a role, and then we try to discuss it openly to make sense of the situation together." This was particularly useful for practitioners who had difficulties understanding and navigating the complexities of their client's culture. Participant 12 described such a situation:

> "Sometimes it's things I'd say in my own perception, it would look like this, the relationship blah blah blah. Let's say the man/woman relationship or how men/women are perceived in a culture. Is that how you'd understand your culture, or is it... Sometimes I'd try to check with the client. [...]Then sometimes, I'd just go and check with the client, does it make sense when I talk to you like that? In your experience, is that important?" – Participant 12.

A few participants mentioned that decentering themselves could also entail trying not to take things personally when a client says something that they perceive as offensive or hurtful.

> "My thought process is to be with, with the person in front of me. Because the thing is, we're humans. And all of that is very, very, very important not to mix what's in your head with what you're feeling with what your client is feeling. And I fear that this thing is something that I always work on and developed a lot. If someone is reacting in a certain way, it's not necessarily about me. And most of the time it's not about me. They're going through something, and it is what it is, and I just have to listen to that person in front of me" – Participant 5.

They also explained that decentering oneself by not taking things personally is particularly important for the practitioner to take into consideration when their social position can create a power dynamic in the relationship.

3. Recognizing and acknowledging harm

Almost half of participants discussed how causing harm in helping relationships, including through biases, knowledge gaps, and mistakes, is almost inevitable. They noted the importance of accepting that harm will occur, and not only being able to learn from it, but also to tolerate the discomfort that stems from this inevitability. Notably, Participant 9 expressed that "critical self-reflection is also accepting our own violence in the system, it means not denying our place in it, not to side with the good guys, in a political sense".

3.1 Knowledge gaps and biases

First, participants recognized that due to their social positions, there were often gaps in their knowledge when it came to understanding clients' different cultures, identities and lived experiences. These knowledge gaps could create additional challenges for practitioners when it came to intervening with LGBTQI+ migrants with complex realities. One particularly challenging aspect about knowledge gaps, according to Participant 12, is that recognizing them doesn't actually eliminate the challenge they pose:

> "So, there are also all these issues that can sometimes be difficult to think about, because in the end, it's still an unknown. You might think, oh yes, there are things I don't know, but you don't know them all the same. There's something that's a great challenge, I think, where it's interesting, but it's a great challenge because it's unknown factors" – Participant 12.

This participant also mentioned that one way they tried to mitigate the negative impact of these knowledge gaps was to discuss these topics with other team members, who might come from different cultures and who could share information with them. However, it may not always be possible to fill certain gaps, especially when we are not aware of there being a gap. Indeed, biases can be ingrained in the ways we think and perceive the world around us. Participant 7 shared: "...I think we all have a certain homophobia and transphobia in us that we've developed [over] the years that is often also difficult to change in ourselves. [...] I think it scares us to a certain degree."

3.2 Making mistakes

These biases and knowledge gaps can lead to practitioner mistakes, which can impact service users. Two participants discussed the fact that they made mistakes while working at the CM, with members of the LGBTQI+ migrant community. Participant 10 explained that their social position led them to make a false assumptions about a client's linguistic abilities:

> "I felt that I hadn't listened properly and that I had taken a lot of things for granted, and that was due to my position, because I think the person, so she showed me – I'll give an example – she showed me the health insurance sheet, and she didn't ask, but I started translating it from English to Spanish and she said, "I understand English", you see? So, it was me who had assumed that I knew more English than she did. Why was that? Because of my position, perhaps?" – Participant 10.

They also noted that although they sometimes feel guilty after having made a mistake, they recognize that reflecting upon these mistakes after the fact can help them improve their practice. As such, they explained that it is important to "…minimize our expectations, because we are not perfect people." Participant 4 shared that not only is making mistakes bound to occur in helping

relationships, but that service providers may not even be aware of making them, notably due to knowledge gaps.

4. Organizational constraints to applying a critical self-reflection process

Not only did participants discuss what elements of critical self-reflection they applied in their practices (reflecting on their social positions, decentering of the self, recognizing the potential to cause harm), but almost all of them shared thoughts regarding the process of applying this approach. As such, they highlighted both the strategies that helped them adopt critical self-reflection, as well as the challenges that prevented them from doing so efficiently.

4.1 Implementing the process of critical self-reflection in a practice setting

Almost half of participants discussed the strategies that help them implement critical self-reflection in their daily practice with clients. First, two participants mentioned that they kept a journaling practice to facilitate the implementation of critical self-reflection. Most of them highlighted the necessity and usefulness of regular supervision meetings, which gave them a shared space to reflect on their interactions and challenges with clients, as well as other elements related to critical self-reflection. For example, Participant 12 explained that supervision helped them become aware of certain biases and knowledge gaps by discussing them with others.

Some practitioners received individual support, where they could benefit from the one-on-one attention of an experienced colleague, while all team members, including the medical team and the psychosocial team, took part in group supervision sessions. The latter facilitated the reflective process amongst fellow practitioners, who were able to exchange thoughts and ideas together. It seems that this team support was useful when it came to learning from everyone's unique experience, not only because the clinic is an integrative space with practitioners of different disciplines, but also because they all had different cultural backgrounds and experiences.

According to Participant 12, who is not a part of the LGBTQI+ migrant community, this diversity was particularly useful when it came to dealing with their own knowledge gaps:

> "And I think that supervision was also very important in this sense, because, in a way, we saw more cultures, we were in contact with more cultures, we had other ideas, we had access to things, so we can share them with each other as well. [...] So to have support from other people, to have other people – because we were also people from different cultures. Basically, to have this exchange on a cultural level, I think to have these exchanges on a personal level, to be able to talk about them, I think it becomes extremely useful." – Participant 12.

4.2 Challenges when applying critical self-reflection

Taking the time during the workday to sit down and focus solely on reflection could be difficult, if not impossible, for the service providers working at the busy CM. Indeed, resources were already lacking, and participants said that they were already stretched thin as it is. For example, Participant 4 explained that they don't have time to hold a journal, as opposed to their colleague: "Because that's it – I admit that like, I don't always have time to like, sit down, and think, and write in a journal, to be able to like really unpack situations. Because the workload is really high." All participants highlighted that LGBTQI+ migrants face multiple barriers when accessing care. As such, the CM's unique role as the primary provider of care to this community likely contributes to the heavy workload experienced by practitioners. Moreover, as Participant 8 shared, service users' more urgent needs (such as mental health crises, gender affirming care, etc.) often took priority, which left little time for practitioners to explore themes related to power dynamics, decenter themselves, or adequately identify and address instances where harm had occurred.

Participant 11 also noted that other than the lack of time and resources, there is also a "lack of training" pertaining to critical self-reflection, as well as other intervention approaches. Moreover, Participant 9 shared that critical self reflection is a very theoretical concept, which can

be difficult to put into practice. Indeed, there aren't many guidelines regarding concrete steps one can take to apply the approach in a feasible and effective way.

> "In critical approaches, there's the critical phase, which is fairly well theorized, but after that, practical application is always a little more difficult. You have to invent because there's no recipe. I think – maybe I'm wrong – but I don't think there's a complete recipe. So, the challenge was in the application" – Participant 9.

Discussion

This study sought to explore how practitioners working within one specific practice site use and apply critical self-reflection in their interventions with LGBTQI+ migrants. Findings show that all participants engaged in some form of critical self-reflection, whether explicitly or implicitly, and that critical self-reflection was interwoven with other intervention approaches used at the CM. According to practitioners, this process included reflecting upon the impact of social location on their role as practitioner, decentering themselves, and grappling with causing harm to the individuals they provide care to. Moreover, participants shared challenges they encountered while applying critical self-reflection, as well as the strategies they employed to overcome them.

Reflections on social location and power dynamics

Participants reported using critical self-reflection to reflect upon their social location. More specifically, they tended to reflect on their perceived proximity to the LGBTQI+ migrant community. Indeed, results show that depending on their social location, some practitioners perceived themselves as belonging to the LGBTQI+ migrant community, while others did not. In the research literature, these positions have been described using the terms "insider" and "outsider", meaning that researchers can hold either insider or outsider postures when conducting research with certain marginalized groups (Caron et al., 2020). These terms can also be used in an intervention context; for example, Staples (2001) explores the impact of these outsider/insider positions on the roles of social workers intervening with various populations. For the purpose of

clarity, practitioners who are in proximity to the LGBTQI+ migrant community will be referred to as "insiders" in the following section, while those who don't identify as belonging to this community will be referred to as "outsiders."

However, it is important to note that these positions were found to be complex and fluid, rather than binary and fixed. According to Naples (1996), "'Outsiderness' and 'insiderness' are not fixed or static positions, rather they are ever-shifting and permeable social locations that are differentially experienced and expressed by community, members" (p. 84). Similarly, Caron et al. (2020) explains that, "although social workers are often described as people with an outsider position helping marginalised people (insider position), it is often much more complex than this binary framework" (p. 309). To illustrate the fluidity of these positions, results show that being an insider or outsider can also depend on the context and the specific situation. For example, in a context where a service user was experiencing difficulties related to their transness, a gay cisgender practitioner who is from a similar ethno-racial background as their service user (and identifies as an LGBTQI+ migrant) felt more like an outsider in relation to gender identity, and felt more like an insider while addressing issues related to migration.

Moreover, these positions seemed to be formed based on practitioners' perceived proximity to not only the LGBTQI+ migrant community as a whole, but also with the LGBTQI+ community, the migrant community, and various ethno-racial communities. Interestingly, practitioners mostly based their position of insider/outsider on their ethno-racial identity. For example, regardless of their sexual orientation or gender identity, white practitioners tended to consider themselves to be outsiders. This may indicate that their whiteness distances them from the LGBTQI+ migrant community, due to having less shared experiences.

In contexts where practitioners in this study associated more like "outsiders", most of them tended to be particularly aware of the ways in which their social position could create power dynamics that could be tied to poorer relationships with clients. According to Heron (2005), simply listing one's social location does not necessarily lead to an interrogation of power relations. Sakamoto and Pitner (2005) contend that critical "consciousness" (a synonym of critical self-reflection) entails that social workers become cognizant of power differentials in client-practitioner relationships, especially ones where the practitioner holds more power due to their social identities. These power differentials can often create an oppressive environment for clients belonging to marginalized groups, as well as foster distrust of service providers (Sakomoto & Pitner, 2005). Indeed, this study's results indicate that participants were aware that power dynamics and lack of trust could dissuade service users from sharing certain parts of their stories with them, which could be associated with negative treatment outcomes.

On the other hand, practitioners who felt more like "insiders" shared that their perceived proximity to their service users' identities afforded them an advantage when it came to creating trusting relationships. These results align with Staples' (2001) assertion that "insiders" are less likely to hold biases about service users due to being equipped with more knowledge about the group's history, culture, political background, etc. However, there is still a risk that this advantage can lead them to make false assumptions about service users. Holding the belief that one "knows it all" might make them complacent and less likely to dig deeper, ask questions, and challenge assumptions. It is thus always necessary to reflect upon one's biases and knowledge gaps, and acknowledge that sharing similar identities does not eliminate the need for critical self-reflection. Similarly, participants admitted that it was impossible that all their identities and experiences align

with their clients', meaning that power dynamics will exist in any given therapeutic relationship, even when practitioners hold an "insider position".

Decentering

This study also found that almost all participants engaged in a decentering process. As such, they recognized the need to become aware of their own subjective frames of reference, which shape their understandings and perspectives of the world they live in. These frames of reference can be informed by culture, familial experiences, relationships, professional and academic models, as well as institutional norms and discourses (Cohen-Émérique, 1993; Heron, 2005).

Notably, participants underlined the importance of decentering their own culture(s), one of the most influential shapers of our subjective frames of reference. Participants noted that culture is a complex concept that is sometimes hard to grasp, because while it is deep rooted in the ways we perceive the world, culture is not tangible. This also involves the inability to represent ourselves within cultures that are different from our own, which leads us to instinctively interpret situations based on our own cultural references, which are considered universal (Cohen-Emerique, 2015). While considering the person's culture is important, many participants also note the importance of not making assumptions based on that culture, since each user has a unique and complex personal story. Even participants who came from a similar cultural background as their service users ("insiders") employed cultural decentering strategies, since, according to them, cultural differences are always present.

In order to decenter themselves, participants also emphasized the importance of positioning themselves as "learners" rather than "experts", by adopting principles of humility, open-mindedness and curiosity. Indeed, rather than relying on limiting categorizations and generalizations informed by their own preconceptions, they tried to accept the limits of their own

knowledge and perspectives and prioritized an honest and curious exploration of service users' complex and unique subjective experiences (Tummala-Narra et al., 2018). Adopting a "learner" role also meant soliciting advice from colleagues during group discussions and supervision when necessary.

These findings align with the principles of the cultural humility framework (Tervalon & Murray-García, 1998), which seeks to shift away from mastery and expertise in order to focus on self-reflection and life-long learning (Lewis et al., 2018). Tervalon & Murray-Garcia (1998) explain that culturally humble practitioners should be "flexible and humble enough to say that they do not know when they truly do not know and to search for and access resources that might enhance immeasurably the care of the patient as well as their future clinical practice" (p.119). Indeed, the importance of being informed and educated not only on the realities of cultural, sexual and gender minorities, but also on the impacts of oppressive systematic structures such as racism, cisnormativity and heteronormativity, should not be ignored. Some scholars agree that provider competence and continuing education play a critical role in establishing a genuine relationship with a client, as it should not be the service user's role to educate their providers on matters surrounding their own identities (Alessi et al., 2021; Berke, 2016). Participants also underlined that simply acknowledging that one doesn't know something isn't always helpful – what is unknown remains as such.

Thus, some authors argue that the concepts behind cultural competence and cultural humility often overlap, and that these approaches should be combined (Alessi et al., 2021) in order to understand the balance between "knowing" (cultural competence) and "not knowing" (cultural humility). According to Alessi et al., (2021), "training is not about becoming an expert on a client's

culture, but rather being able to recognize the nuances within and between groups and how these nuances are shaped by particular historical, social, and political contexts" (p. 16).

Furthermore, Ross (2010) underlines the importance of developing empathy and patience for the mistrust some community members might present towards helpers and institutions. Similarly, participants said they tried not to "take things personally" by considering that the service user's mistrust often stemmed from power dynamics in the therapeutic relationship.

Recognizing and acknowledging harm

Not only can these aforementioned frames of reference shape our values and beliefs, but they can also generate harmful biases and prejudices. As such, study participants shared that an important aspect of critical self-reflection consisted of bringing into awareness the biases that come from their unique combination of identities and experiences (Kumagai & Lypson, 2009). In accordance with existing studies (Dovidio & Fiske, 2012; Owen, 2014), practitioners explained that reflecting upon these biases could help them avoid imposing their own views and perspectives on service users and prevent the perpetuation of harmful microaggressions.

Moreover, participants acknowledged that microaggressions, prejudice and mistakes did inevitably occur when working with LGBTQI+ migrant service users, despite their efforts to utilize tools such as critical self-reflection to mitigate them. These events can sometimes lead to ruptures in the therapeutic relationship, consisting of "a breakdown or tension in momentary therapeutic collaboration and a deterioration in the quality of relatedness" (Mylona et al., 2022). Ruptures can arise from a multitude of factors, including when practitioners implement interventions that clients may not be ready to accept, or when service user and practitioner disagree about treatment goals (Goldsmith, 2012).

However, in the case of the present study, participants focused specifically on ruptures arising from practitioner mistakes, notably microagressions and misunderstandings due to biases. Some authors have coined this specific type of rupture "cultural rupture" (Gaztambide, 2012; Mosher et al., 2017; Owen, 2014). As such, given the significant influence of the therapeutic relationship on treatment outcomes across various disciplines, including psychotherapy, medicine, nursing and social work (Fuertes et al., 2007; Hartley et al., 2020; (Riki) Savaya et al., 2016), CM practitioners emphasize the importance of identifying and addressing cultural ruptures rather than avoiding them. However, study participants underlined the challenge of recognizing when a cultural rupture in the alliance had happened. Indeed, cultural ruptures in particular tend to go undetected and unaddressed due to therapist discomfort, as well as the complex, subtle, and unconscious nature of both microaggressions and biases (Owen, 2014; Sue, 2010). Most importantly, conflict, mistakes, and ruptures can be transformed into opportunities for connection, trust building, healing, and justice between service users and service providers (Chang et al., 2021). Indeed, research indicates that when therapists and clients effectively handle challenging situations, they tend to achieve better outcomes (Goldsmith, 2012; C. L. Stevens et al., 2007; Stiles et al., 2004).

According to study results, critical self-reflection can be a helpful tool to identify, recognize and repair therapeutic ruptures. Some of the strategies used by participants to repair ruptures include owning up to their mistakes, apologizing to their clients, and learning from their mistakes to avoid making similar ones in the future. In accordance with these results, Tummala-Narra et al.'s (2018) findings on psychologist cultural competence suggest that practitioners should recognize having engaged in a microaggression with a service user, as well as explicitly acknowledge their role own within systems of oppression, since this can foster trust. In another

study on repairing the therapeutic alliance following microaggressions, practitioners' effective repair strategies included openness, empathy, flexibility and, most importantly, collaboration with the service user (Yeo & Torres-Harding, 2021).

Moreover, participants highlighted the need to accept the discomfort that occurs during and after a rupture. In accordance with these results, Gaztambide (2012) underlines the importance of therapists becoming aware of their discomfort and avoidance when a cultural rupture occurs. Similarly, Tummala-Narra et al.'s (2018) study mentions the idea of being "optimally uncomfortable" when a microaggression occurs, suggesting that discomfort can motivate practitioners to take accountability and be more open to difficult conversations. Regardless of the repair strategy used, it was shown that when practitioners actively attempt to repair ruptures in the therapeutic relationship by engaging and collaborating with their service users, trust can be restored and the overall relationship improved (Spatrisano, 2019).

Participants also mentioned that they tried to tolerate the uncertainty that comes with having knowledge gaps, as well as the discomfort of being in a position of power in helping relationships, especially as an "outsider". Indeed, they recognized that power dynamics are inherent to relationships. According to Walker (2008), "every relationship, including the therapy relationship, bears the complexity of multiple social identities. That is, the bodies that we bring into relationship with each other have been formed by multiple sociocultural agendas" (p. 90).

These findings align with studies that suggest that service users often regard health and mental health care professionals as both adversaries to be approached with suspicion, and allies who can offer them valuable help (Alessi et al., 2021; Kelly & Chapman, 2015). Thus, they conceptualize these practitioner/service user relationships as "paradoxical adversarial alliances". Although this concept may simplify matters into a binary framework, it does offer insight into the

reality that service users must often receive care from individuals and institutions that hold power over the, while underscoring the fact that help and harm go hand in hand and cannot always be detangled from one another (Kelly & Chapman, 2015).

Organizational aspects of the critical self-reflection process

Participants encountered some challenges when implementing critical self-reflection and related strategies to their individual practices, including a heavy workload, lack of training, as well as unclear procedures. The challenges related to a heavy workload seems to accurately reflect the limitations of our current society, where helping professionals often feel overworked and drained. When practitioners don't have enough time to reflect and introspect, or are burnt-out, this could have a direct impact on their individual practices, as well as on treatment outcomes (Delgadillo et al., 2018; M. Stevens, 2008). In fact, a study by Salyers et al. (2015) on the effects of professional burnout on clinical work and patient outcomes found that "clinicians' ability to provide care with enthusiasm, patience, empathy, effective communication skills, attention, and creativity was influenced by burnout" (p. 204). Moreover, participants shared that critical self-reflection can be difficult to use as an intervention tool, since there are no specific guidelines on how to apply it "practically". As such, they also underlined the need for more training pertaining to critical self-reflection.

Although participants did not share a specific set of rules, protocols, or procedures to apply critical self-reflection to their practices, they did share the strategies they used to facilitate the use of the approach. A few participants mentioned that journaling helped them detangle their thoughts by putting them on paper. Critical reflective journaling and similar strategies are part of student training programs in various fields, including nursing, (Isaacson, 2014), medicine (White et al., 2018), and social work (Taiwo, 2022). However, most participants were too constricted by time

and their heavy workload to commit to a regular journaling practice, which concords with other findings regarding critical reflective journaling practices (Allen & Farnsworth, 1993).

Instead, study findings show that group discussion and supervision were seen as the most helpful tools to facilitate practitioner critical self-reflection. As there are no manuals or "recipe books" to guide them, participants found that debriefing with peers and experienced supervisors helped them detangle their feelings, thoughts, perceptions, and interactions with clients. They were able to use this space to reflect upon their social identities, power dynamics, decentering strategies, and mistakes, in a safe and non-judgemental environment. In fact, many researchers agree that dialogue amongst peers is essential to critical self-reflection and other anti-oppressive approaches (Kumagai & Lypson, 2009; E. Lee et al., 2017; Motoi, 2016). According to Motoi (2016), since thoughts and reflections are expressed narratively through language, team dialogue can facilitate the elaboration of complex critical thoughts.

These peer discussions can also help practitioners gain new perspectives on their own practices, as they are confronted with new ideas and values from individuals of different backgrounds (Motoi, 2016; Tummala-Narra et al., 2018). In fact, participants in the study discussed the benefit of having people of various cultural backgrounds on the team. Moreover, group supervision has long been a crucial component of training programs for students and workers (Winstead et al., 1974). It is not surprising, then, that discussion groups and supervision sessions are also used as a support tool when training service providers in other critical intervention approaches, such as reflexive anti-racism training for individuals working with Indigenous populations in Australia (Kowal et al., 2013), social justice training for counseling psychologists (Goodman et al., 2004), and trans-affirmative training for counsellors working with transgender and gender non-conforming youth (Case & Meier, 2014).

Although there is no clear formula on how to apply critical self-reflection, results show that in order to improve their clinical practice and provide better care to LGBTQI+ migrants, it is essential for practitioners to continuously reflect on themselves, their practice, their relationships with service users, and their mistakes. Not only does this process require humility, curiosity, and a commitment to social justice, but enough time and resources are needed to allow for these reflections to develop, ideally in a group setting where many ideas can be exchanged and explored.

Positionality

As the author of this paper, I engaged in my own reflexive process throughout the course of this research, which stemmed from the reflexive thematic analysis methodology. This process allowed me to become aware of my own subjective frames of reference, biases, and preconceived notions and think about how these can influence my research. As such, I reflected upon my motivations to choose this research topic, such as my lived experience as a queer person, which motivated me to engage in research that aims to improve the well-being of my own community. My positionality as a non-migrant, white, cisgender person might have informed my analyses, as well as created power dynamics with racialized and/or migrant interviewed participants. Moreover, as a clinical psychology doctoral student, I tried to be aware that my perspectives are informed by my knowledge of psychology and the institutional norms related to this field. My personal and professional interest in critical self-reflection and other anti-oppressive approaches is informed by my desire to use them in my own future clinical practice.

Limitations

One of this study's limitations is that it was conducted as part of a larger project (*Clinique Mauve: Évaluation du point de services pour les personnes LGBTQI+ (lesbiennes, gaies, bisexuelles, trans, queer, intersexes) migrantes à Montréal*). Thus, the study parameters, which

were determined by this larger project, created some constraints in terms of data sample, data collection, questionnaire questions, and interview time accorded to the exploration of critical self-reflection. For example, sociodemographic data concerning participants was not obtained, which may have limited the analysis.

Conclusion

LGBTQI+ migrants often avoid seeking the care they need due to distrust of practitioners and fear of discrimination. The CM aims to remediate these issues and improve the overall quality of care provided to LGBTQI+ migrants in Montreal, by providing them with health and mental health services in an interdisciplinary context, using a variety of anti-oppressive intervention approaches. Literature shows that critical self-reflection has the potential to be an effective tool for practitioners working with marginalized populations, notably by reducing microaggressions and improving trust in the therapeutic relationship between service provider and service user. However, the approach has mostly been explored in a theoretical manner or in a training capacity.

Thus, as part of the larger CM evaluation project, this study's goal was to explore the ways in which practitioners working at the CM, including medical professionals and psychosocial workers, utilize critical self-reflection as a tool when working with LGBTQI+ migrants. Data from 13 interviews with practitioners was collected and analysed according to reflexive thematic analysis, and informed by a constructivist and intersectional framework. Multiple themes were developed and explored in relation to existing literature. Based on these findings, the core features of the critical self-reflection process include the following: reflecting on social location and power dynamics, decentering, and recognizing and acknowledging harm. Moreover, organizational constraints to applying a critical self-reflection process include a heavy workload and lack of clear guideline, while group discussions facilitated the critical self-reflection process. Although critical

self-reflection is a complex concept related to many other approaches, it can be applied to practice with LGBTQI+ migrants.

Implications for future research and clinical practice

In the following section, implications for future research and clinical practice are discussed. First, this research focused on the perspectives of practitioners, and not those of LGBTQI+ migrant service users. Indeed, it was pertinent to understand how practitioners conceptualized and applied this approach, in order to offer concrete, practical, and useful recommendations for clinical practice. However, an important next step involves examining the influences of critical self-reflection on the practitioner/service user therapeutic relationship, as well as on trust, communication, and treatment outcome. Future studies should also assess the impact of the approach on perceived microaggressions in health and psychosocial service delivery to LGBTQI+ migrant. This study also revealed certain constraints related to the practice setting's interdisciplinary context, notably the fact that all 13 participants come from different academic and professional backgrounds. As such, participants had different training experiences and knowledge, which may have affected the ways critical self-reflection was understood and applied. Notably, the extent to which critical self-reflection is integrated into curriculum and literature differs significantly across disciplines. While medical, psychological, and nursing literature increasingly incorporate such approaches, critical self-reflection has long been ingrained in social work standards, as recognized by the Canadian Association for Social Work Education (2021). Therefore, if all participants had been social workers, their understanding of critical self-reflection might have been more comprehensive compared to practitioners from other disciplines, potentially leading to different study outcomes.

Consequently, future studies could focus on understanding how critical self-reflection is shaped by different disciplines, including medicine, nursing, social work, and psychotherapy. Moreover, study participants mainly discussed the relation between their roles as practitioners and the aspects of their identities related to migration, gender identity and sexual orientation. However, more research is needed to explore certain aspects of intersectionality that are often overlooked, such as social class, ability, education level, body size, age, etc.

Secondly, based on study findings, it is suggested that practitioners in healthcare and psychosocial services who work with LGBTQI+ migrants engage in an ongoing and life-long process of critical self-reflection, in order to improve the quality of care received by this community. To be able to implement this approach, an appropriate workload that allows practitioners time to practice self-reflection is essential. Practitioners are also encouraged to discuss reflections in the context of a safe and diverse group setting, such as was the case at the CM. Critical self-reflection should include recognizing power dynamics that may exist within the therapeutic relationship and are influenced by the practitioner's proximity to the LGBTQI+ migrant community through their social location. In order to enter the service user's subjective world, practitioners are encouraged to decenter their perspectives by recognizing their subjectivity, and can generate biases and knowledge gaps. When harm inevitably occurs, it is important for practitioners to recognize and address it rather than to ignore it to avoid discomfort, which helps foster trust and repair ruptures in the therapeutic relationship.

Engaging in any type political practice, including using anti-oppressive approaches such as critical self-reflection, can present challenges for practitioners. Notably, the traditional ethos of healthcare emphasizes neutrality, making it difficult for clinicians to navigate their practitioner-advocate role without compromising their perceived "impartiality". Moreover, bureaucratic

structures within healthcare systems often limit the autonomy of individual practitioners, constraining their ability to advocate for broader political change. The demanding nature of clinical work, as observed at the CM, can also limit the available time and energy for clinicians to actively participate in political activism.

Despite these obstacles, study findings support the idea that in order to create solidarity with service users belonging to marginalized groups – including LGBTQI+ migrants – health care providers and psychosocial workers should adopt a more political *practitioner-advocate* role. In other words, practitioners should not attempt to remain neutral, but rather adopt a role rooted in advocacy, activism and social justice (Motulsky et al., 2014). In fact, many authors have explored how mental health professionals, physicians, nurses and social workers often face pressure to remain neutral in political matters, but argue that this neutrality is a myth, as their work inherently intersects with political and social issues ((Dickman & Chicas, 2021; Hamilton, 2013; Hoehner, 2006; Jones, 1998). Ignoring political and social context may appear to confer neutrality, but in reality, it often perpetuates and reinforces existing power dynamics and inequalities. Indeed, workers in helping professions are not only responsible for individual changes, but also are agents of social change (Fook & Askeland, 2007; Motulsky et al., 2014). This role requires professionals to engage in actions "designed to change societal values, structures, policies and practices, such that disadvantaged or marginalized groups gain increased access to tools of self-determination" (Goodman et al., 2004, p. 795). As pointed out by Kumagai & Lypson (2009), critical self-reflection is only "critical" insofar as it involves "a shifting of one's gaze from self to others and conditions of injustice in the world" (p. 783).

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Appendix

Number of participants per theme	
Themes	Number of participants
1. Reflections on social location and power dynamics	• All participants except for 2 of them
• 1.1 Power dynamics	• 6 participants, including participants 4, 7, 9, 10, 12, and 13
• 1.2 Intervening as an LGBTQI+ migrant	• 6 participants total, including participants 1, 2, 5, 6, 8, 10
2. Decentering	• 8 participants total, including participants 1, 3, 4, 5, 6, 9, 10 and 12
• 2.1 Considering 'culture'	• 7 participants total, including participants 1, 3, 4, 5, 6, 9 and 10
• 2.2 Humility and willingness to learn	• 6 participants total, including participants 1, 3, 4, 5, 6 and 12 • 3 participants mentioned trying not to take things personally, including participants 1, 5 and 6
3. Recognizing and acknowledging harm	• 6 participants total, including participants 4, 5, 7, 9, 10 and 12
• 3.1 Knowledge gaps and biases	• 6 participants total, including participants 4, 5, 7, 9, 10, 12
• 3.2 Making mistakes	• 2 participants total, including participants 9 and 4
4. Organizational constraints to applying a critical self-reflection process	• 9 participants in total, including participants 1, 4, 6, 8, 9, 10, 11, 12 and 13
• 4.1 Implementing the process of critical self-reflection in a practice setting	• 5 participants in total, including participants 1, 4, 6, 12 and 13
• 4.2 Challenges when applying critical self-reflection	• 5 participants in total, including participants 1, 8, 9, 10 and 11