Improving mental health service access for women survivors of child sexual abuse in BC, Canada. A system thinking perspective.

By

Mackenzie Hoff-Bell

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We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

Supervisory Committee

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MacKenzie Hoff-Bell

B.Arts., Simon Fraser University

Supervisor: Dr. Walter Lepore, Assistant Professor
School of Public Administration, University of Victoria

Second reader: Dr. Sarah Marie Wiebe, Associate Professor
School of Public Administration, University of Victoria

Abstract

This study explores the systemic barriers that women child sexual abuse survivors (WCSAS) face when accessing mental health services in British Columbia (BC), Canada. Using an interpretive, qualitative, and system thinking approach, this study integrates the perspectives of survivors and service providers to uncover economic, social, cultural, and structural barriers to care. Semi-structured interviews with WCSAS and a mental health service provider (MHSP) informed a thematic analysis and the creation of actor and causal system maps.

The study identifies key intervention points to enhance accessibility and recommends trauma-informed, culturally responsive, and publicly funded psychotherapy services. It fills a critical gap in Canadian literature by centring survivor voices and offers actionable pathways for policy, programming, and system reform. This research advocates for equitable, long-term support for WCSAS across BC's fragmented mental health system.

Keywords: child sexual abuse; women survivors; system thinking; mental health access; British Columbia; psychotherapy barriers

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List of Abbreviations

- MHSP – Mental Health Service Provider
- WCSAS – Women Child Sexual Abuse Survivors
- BC – British Columbia
- CSA – Child Sexual Abuse
- PE – Prolonged Exposure Therapy
- ImRs – Imagery Rescripting Therapy
- EMDR – Eye Movement Desensitization and Reprocessing
- CBT – Cognitive Behavioural Therapy
- DBT – Dialectal Behaviour Therapy

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Dedication

I dedicate this work to every soul, past and present, who has carried the weight of childhood abuse. To those who have known the ache of powerlessness, the silence of invisibility, the fracture of disconnection.

This is for you.

Chapter 1. Introduction

The sexual abuse of children is one of the most significantly unaddressed, unacknowledged, and unresearched social problem in our country. Despite extraordinarily high rates of abuse, the topic remains hidden at social, political, and personal levels. The World Health Organization describes childhood sexual abuse as a "silent health emergency" (Pinheiro, 2006, p. 117), however it remains a taboo subject worldwide. This study seeks to identify and define the barriers that women child sexual abuse survivors (WCSAS) in British Columbia, Canada face when accessing mental health services. This study also investigates how these barriers impact WCSAS experiences, and offers solutions to improve WCSAS access to adequate mental health care. To achieve this, it primarily explores survivors' perspectives while incorporating insights from a mental health service provider (MHSP) with over 30 years of experience working with CSA survivors. The inaccessibility of psychotherapeutic services in BC for women who have experienced childhood sexual abuse (CSA) represents an inherently complex systemic problem (Westley et al., 2007), which includes economic, political, social, and public health interrelated aspects within the mental health care system.

Prior research on this topic outside Canada has indicated that CSA survivors often encounter barriers such as time constraints, lack of access, counsellor qualifications, and financial obstacles (Schoon & Briken, 2021). To my knowledge, this is the first study evaluating mental health service barriers from the perspective of adult CSA survivors in Canada. The primary objectives of this study are to empower WCSAS, address the identified research gap regarding the lived experiences of WCSAS in their efforts to access and utilize individual mental health services in BC, and identify solutions to this complex issue.

Utilizing system thinking methodology, a causal and an actors systems map (Gopal & Clarke, 2015) are developed to reveal the relationships between WCSAS and relevant actors in the mental health care system, including government, social service, community, and private sectors. These visual tools emphasize the causal connections between important factors of the mental health care system for WCSAS, while also highlighting the voices of study participants throughout the process (Powell et al., 2023). The information used to create the actors and causal maps includes primary data from study participants, supplemented by background research on mental health service accessibility, policy, and CSA. Central to the study's goal is the fundamental objective of advocating for CSA survivors and providing them an opportunity to use this study to effect change within their community and identify potential pathways for systemic change.

Problem Definition

Since 1986, a wave of public programs and policies have been developed and enacted to protect and serve children who have experienced sexual abuse. However, the same has not been done for adults. Typically, the mental health system in Canada responds to and treats individuals when they are in crisis and qualify to be recognized under the Mental Health Act (Fraser Health Authority, 2022). Despite numerous recommendations from organizations and sector professionals to increase funding for mental health services, access remains limited for those who cannot afford private services, while free counselling sessions are predominately available for a short-term basis. For individuals seeking psychotherapy services, accessing mental health services is significantly easier for those who can afford to pay privately or have extended health insurance, as counselling is not covered under universal healthcare. Mental health services, such as counselling, are primarily provided by non-profit organizations and private practitioners. Public mental health services are strained under BC's overwhelmed healthcare system, as physician shortages, long wait times, and overcrowding commonly affect service users' mental health. The availability of mental health services in rural BC is even more sparse (Maddess, 2006).

The province of BC offers two primary resources through which WCSAS can access therapy: the Crime Victim Assistance Program (CVAP) and the Stopping the Violence program. WCSAS can also obtain subsidized therapy services through Community-Based Victim Services (CBVS) and sexual assault centres (Endingviolence.org, 2023). Among these four options, the only program that provides long-term access to individualized counselling is the CVAP, which offers partial financial compensation for up to 48 sessions of individualized psychotherapy to survivors of historical crimes (Government of British Columbia, 2024). The CVAP program enables CSA survivors to have greater choice in their service providers; however, the estimated wait time to receive benefits typically exceeds one year.

WCSAS's challenges in accessing mental health resources is a complex public health issue that directly impacts survivors and indirectly affects their interpersonal relationships, the public health care system, and the social service sector through increased utilization and cost (Bonomi et al., 2008). The impact of historical abuse on CSA survivor's family and friends, "as well as other children and staff in the institution in which the abuse occurred, the community and wider society [can create] ripple effects [that can be] can be long-lasting, even affecting future generations" (Commonwealth of Australia, 2017, p. 12). If access is not improved for WCSAS, the negative long-term effects of CSA will continue to put strain on our public health system.

As mentioned, there are multiple layers to this *complex problem*, including economic, political, social, and health-related aspects, which require utilizing system thinking tools to navigate the evolving, multi-layered, and intricate nature of this issue. Complex problems have several key characteristics, such as ambiguity, root causes, symptoms, and interdependency. These characteristics are found within this research topic. Complex problems are ambiguous in nature, often lacking clear information regarding the issue and encompassing symptoms and root causes (Stroh, 2015). Symptoms are often displayed as events, trends, or patterns, while root causes lie within the system's structure (Stroh, 2015). Inadequate access to mental health services for WCSAS is a symptom of several root causes that this study intends to investigate. Lastly, complex problems consist of multiple systems that depend on each other to operate (Kauffman, 1980). In this case, the political, social, economic, and healthcare systems interact with and depend upon each other. The nature of this issue requires utilizing system thinking tools to navigate its evolving and multi-layered complexity.

Background

There is no universal definition of child sexual abuse, and in North America alone, the issue received minimal attention until the late 1970s. In Canada, child sexual abuse was not recognized as a serious issue until the late 1970s, when Nova Scotia redefined child abuse to include sexual abuse. In BC, sexual abuse was not officially recognized as child abuse until 1981 (The Cornwall Public Inquiry, 2008; Verdun-Jones et al., 2008). It was not until 1993 that Canada reported its first study on child abuse and neglect incidence in Ontario, followed by another in British Columbia in 2008 (Canadian Child Welfare Research Portal, n.d.). It is worth noting that some efforts have been made by the BC government to mitigate the inherent barriers associated with the current social and economic infrastructure. In 2020, the BC government announced a 10-million-dollar grant program to support culturally informed emergency sexual assault response in BC (CBC, 2020).

CSA survivors experience internal and external stigmatization through media representations, stereotypes, and dominant narratives that the victim is blameworthy and reinforces shame and secrecy (Kennedy & Prock, 2018). The exact number of child sexual abuse assaults in Canada remain unknown due to the challenges survivors face in disclosing their experiences. Although the rate of recorded cases has alarmingly increased in recent years, the true number is likely higher than anticipated (McGregor et al., 2010). A recent study by Afifi et al. (2025) estimates that BC holds the highest child sexual abuse rates at 13%. In 2022, a report from Statistics Canada indicated that sexual abuse cases had risen by 18% compared to the previous year. Between 2020 and 2022, recorded cases of child pornography possession increased by 22% as well (Statistics Canada, 2022). Furthermore, women are three times more likely than men to experience sexual abuse by an adult during childhood (Heidinger, 2018).

Government reporting suggests a steep decline in CSA; however, independent reporting indicates higher rates. Early estimates show that as many as 54% of girls in Canada experienced child sexual abuse in 1986, with a report rate of 22% (Stalker et al., 2007). Moving forward to 2018, Statistics Canada reports that 7.8% of Canadians experienced CSA before the age of 15 (Heidinger, 2018). However, a recent study conducted by the Association of Alberta Sexual Assault Services found that 34% of Albertans were sexually abused before the age of 18.[1] The fluctuation of statistics and underreporting of CSA leads to the belief that the correct number is much higher. In a Canadian study, for instance, researchers found that over 95% of CSA cases are not reported to the authorities (Martin & Silverstone, 2013). Prior research also states that it takes survivors between 17.2 and 21.4 years on average before they disclose to somebody their abuse experiences as “the longer the delay before disclosure, the more serious the symptoms are” (Halvorsen et al., 2020, p.2).

In addition, WCSAS have unique needs when it comes to selecting optimal treatment options. The characteristics and context of the child sexual abuse (CSA) that an individual has experienced can influence which psychotherapy treatment option best suits them (Drauker et al., 2011). Studies have demonstrated a correlation between CSA and an increased risk of depression, anxiety, alcohol and substance use, suicide attempts, PTSD, high-risk sexual behaviour, attachment insecurity, and economic, marital, and family problems (Dube et al., 2005;

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[1] Association of Alberta Sexual Assault Services, 2020, p. 6.

Currie & Widom, 2010). Furthermore, research on CSA survivors have concluded that they encounter challenges in adult functioning related to substance use, education, relationships, parenting, and sexuality (MacIntosh & Ménard, 2021). WCSAS are inherently vulnerable as they are more likely to be revictimized later in life (Cannon et al., 2010). CSA survivors also face disproportionately high rates of suicide attempts, and their suicidal ideation is primarily motivated by the desire to end post-CSA suffering (Cortes et al., 2020; Tsur et al., 2022). In a study evaluating the results of the 2012 Canadian Community Health Survey, 80% of participants who attempted suicide had a history of child abuse (Martin et al., 2016). A similar recent study in Spain found that 20% and 22% of suicides and suicide attempts among women can be attributed to CSA exposure (Cortes et al., 2020). Individuals such as WCSAS, who require high-quality mental health services, generally struggle to access these services on a global scale (Wainberg et al., 2017). A recent survey found that 78% of Canadians report that the cost of psychological services is a very or somewhat significant obstacle, while 68% of Canadians say that wait times to see a psychologist are too long (Canadian Psychological Association, 2021). Reducing these barriers is crucial for WCSAS, as it can be a turning point in their lives (Sigurdardottir & Halldorsdottir, 2018). Studies outside Canada have highlighted barriers WCSAS faces in accessing and receiving individualized psychotherapy (Schoon & Briken, 2021; Chernomas & Mordoch, 2013; McGregor et al., 2010; Wainberg et al., 2017). The inaccessibility of this resource supports long-term negative impacts on WCSAS, such as emotional distress, mental illness, post-traumatic stress disorder, abuse, substance use, and economic disenfranchisement (Lahav, 2021; Harland et al., 2012; Burczycka, 2017).

Just as a universal approach cannot be applied to WCSAS in the context of counselling services, the same principle must apply to policy, programming, education, and evaluation. The WCSAS community is diverse and includes a high proportion of women from various minority groups. For many women who have experienced this type of abuse, there are additional compounding traumas related to racial, cultural, religious, disability, sexuality, and/or gender discrimination that can create complex barriers to access and worsen mental illness for the individual. Girls under 15 years of age who live with disabilities face higher rates of sexual abuse (DAWN Canada, 2022). Women with disabilities experience disproportionate rates of poverty, violence, incarceration, and discrimination. Upwards of 35% of Black and Indigenous women live with a disability, and the health of these women is heavily impacted by racism (DAWN Canada, 2022).

Black and Indigenous women are among the most racialized groups in BC. In addition, BC has the highest rates of discrimination and stigma in Canada, in addition to a disproportionate need for mental health and substance use services (CMHA British Columbia, 2024). Taylor and Richards (2019) describe racialized women as experiencing "double stigma" stemming from the burden of mental illness, combined with prejudice and discrimination due to their group affiliation (p. 3). Similarly, Patricia Hill Collins describes the social organization of intersecting oppressions against women of colour as a matrix of domination, which takes into account race, gender, class, sexual orientation, and age (p. 228). I argue that WCSAS, who are members of a minority group, face additional stigmatization that changes the way oppression from race, gender, class, sexual orientation, age, ability, mental health, occupation, and class is experienced, especially when they have endured sexual abuse during childhood. CSA impacts the relationship survivors have with each facet of their existence. For example, for women who experienced CSA, aging might be seen as less valuable due to societal norms, and childhood or youth, which are linked to deep trauma and pain, are also devalued. Black women make an average of six attempts to seek help before accessing health care, often doing so through adverse pathways (Taylor & Richards, 2019).

Indigenous girls are significantly overrepresented in cases of sexual exploitation, trafficking, and other forms of sexual abuse. They account for 50 to 90% of these cases in Western Canadian cities despite making up only 2 to 5% of the population in those regions (Louie, 2018). The marginalization of sexually exploited Indigenous girls has been intensified by inadequate institutional responses and a widespread victim-blaming mentality in the national consciousness (Sethi, 2007). To challenge this perspective, the Native Women's Association of Canada (2014) emphasized the importance of reframing the discussion of sex trafficking in Canada to include knowledge of Indigenous overrepresentation.

Additionally, a recent study found that 50% of Indigenous women and 57% of transgender and non-conforming individuals experienced sexual abuse as children (Sharma, 2023). The extraordinarily high levels of sexual abuse that occurred in Canadian Residential Schools have resulted in a significant number of adult survivors while also contributing to the lasting impacts of colonialism that promote poverty, trauma, mental illness, disability, and substance use disorders within Indigenous communities.

Women who are members of the LGBTQI2+ community also face significantly higher rates of sexual abuse. LGBTQI2+ youth are particularly susceptible to CSA due to societal discrimination, stigmatization, and biases stemming from socio-cultural, religious, and family contexts. Notably, transgender children and youth are vulnerable to high rates of stigma, violence, and transphobia (Capaldi et al., 2024). Certain narratives surrounding queerness reinforce self-blame, underreporting, and a lack of recognition of abuse. These narratives include stigma against homosexuality, internal guilt related to sexuality and identity, and myths that suggest CSA leads to queerness (Capaldi et al., 2024).

Significance of Study

Meade et al. (2016) describe community development as "a process through which ordinary people collectively attempt to influence their life chances" (p. 3). This study contributes to community development by allowing WCSAS to enhance a growing body of research and provide valuable insights aimed at improving community well-being and advocating for women's empowerment. It is designed to impact academic, communal, societal, and individual levels.

Researchers often emphasize the need for more information on CSA survivor perspectives (e.g., Chouliara et al., 2011). From an international viewpoint, the inclusion of CSA survivor perspectives in studies is rare; however, it is even less common in Canadian academia. When analyzing a system, gathering insights from various key actors within that system is crucial to understanding potential areas for intervention. Background research on this topic was unable to locate an original study in Canada that gathers data from both CSA survivors and/or MHSP regarding any Canadian mental health care system. Thus, this study aims to address this knowledge gap by incorporating the perspectives of survivors and a mental health service provider on this topic.

As previously mentioned, CSA survivors have limited opportunities to safely express their experiences on public and academic platforms. For the participants in this study, both WCSAS and MHSP may provide empowerment, learning, value, and relief. Research indicates that most sexual trauma survivors feel gratitude when given the chance to share their experiences with researchers who are "unlikely to judge or condemn them," finding the process valuable, relieving, and therapeutic (Seedat et al., 2004, p. 262). Similarly, Campbell and Adams (2009) found that among 92 participants who were female rape survivors, most described their experience in the study as positive, using terms such as "helpful, healing, therapeutic, supportive, useful, insightful, and comforting" (p. 403). While participating in research can pose risks for trauma survivors, researchers who have worked with female sexual trauma survivors often find that participants feel empowered and valued when provided the opportunity to share their voices.

The impact of this study on the WCSAS community and society overall is expected to be positive, as it will provide policymakers and MHSPs with concrete data to improve WCSAS access to psychotherapeutic resources. Findings from this study can inform the development of future WCSAS-centered mental health programs and reconfigure funding streams, thereby supporting the health of women in our communities. In addition, this study challenges pre-existing norms of silencing, policing, and stigmatizing the topic of child sexual abuse by providing survivors with a platform to collectively work toward solutions for the betterment of the broader survivor community. The message communicated to the public through this study is one of strength and perseverance, as it is conducted by WCSAS, with WCSAS, for WCSAS.

Thesis Goals & Scope

This study aims to contribute to a modest body of knowledge on this topic and provide essential data needed to improve both access to psychotherapy and the quality of care for WCSAS in BC. These objectives will be accomplished through a system thinking approach that helps analyze how different parts of a system interact and influence each other within that system (Teague, n.d.). The main goal of this study is to explore this systemic phenomenon from the perspectives of WCSAS and MHSP, illuminating their experiences in navigating the mental health care system in BC. This research project is exploratory in its design as it aims to gain further insights into this topic where few to no resources are available in BC, Canada (Texas State, 2023).

By gathering the perspectives of WCSAS and MHSP in BC, participants of the study assisted with the production of a causal systems map and an actor systems map designed to influence change and increase service availability by acting as a guide to improving programs, policies, legislation, and oversight. The scope of the actor's map is limited to actors that directly and indirectly influence WCSAS mental health service access. The causal systems map includes a historical and present-day scope of temporal, informational, geographical, financial, psychological, and cultural accessibility within BC. This study will not investigate the perspectives or experiences of minors and will prioritize the experiences of women and femmes.

Research Questions

System thinking theory requires developing a challenge statement as a starting point for systems mapping within a study (Ryan, n.d.). A challenge statement provides clarity and direction to the study by going beyond symptoms and adopting a long-term viewpoint. This study's challenge statement is as follows: *How can we improve access to adequate psychotherapy treatment for WCSAS in BC?*

This study aims to address the challenge statement by answering the following research questions:

1. What types of barriers do WCSAS experience in BC when trying to access psychotherapy treatment?
2. According to MHSP in BC, what recommendations do they have for increasing access to WCSAS mental health treatment and what kind of treatment model is currently recommended?
3. From the perspective of WCSAS, what do they recommend to improve their access to mental health care?

Positionality Statement

Before presenting the findings of this study, it is essential to discuss the primary researchers' (myself) positionality concerning this topic to promote transparency and self-reflexivity. I see myself as an insider regarding the topic I am researching, as I am a member of the WCSAS community. Like many other CSA survivors, I have faced challenges in my life related to mental illness, addiction, revictimization, and suicidal ideation. Additionally, I am a queer, university-educated, white woman from a middle-class socio-economic background who grew up in BC, Canada.

My interest in pursuing this research project stemmed from an innate desire to help CSA survivors and other vulnerable communities' access mental health resources. After navigating the BC mental health system firsthand, I noticed significant barriers I encountered and wondered whether other members of my community faced similar challenges. This curiosity, along with my professional background in working with marginalized groups, shaped the development of this study.

My race and socio-economic status, while maintaining the researcher's perspective, grant me inherent privilege and power over some participants in my study who do not share the same racial or socio-economic background. My lived experience navigating the mental health care system in BC as a white person differs from that of many Black, Indigenous, and people of colour (BIPOC) due to the systemic racism that remains embedded in the Canadian mental health care system (Gajaria et al., 2021).

My personal background regarding CSA could negatively influence my research process if I allowed my intrinsic bias toward supporting survivor perspectives and promoting the survivor voice to affect my data collection methods and research results. I recognize that my privilege and access to resources shape my position, and I have been cautious not to make assumptions based on my experiences and opinions. To ensure the quality and validity of my study results , I employ strategies such as data triangulation and peer review.

Structure of Thesis

Following this first chapter, this research study comprises other five chapters. **Chapter two** presents a review of relevant literature and the conceptual framework guiding the study. **Chapter three** outlines the methodology, methods, and data analysis. This chapter will also touch on the ethical considerations and recruitment and interview procedures used. **Chapter four** presents findings obtained from interview data, divided into five key themes: barriers, experience, intersectionality, key actors, and recommendations. In this chapter, direct quotes from study participants will be presented within these categories to grant a deeper understanding of their perspectives on the study topic. **Chapter five** utilizes primary data and themes established in the previous chapter to create an actor’s map and a causal systems map, and identify intervention points to change the mental health care system for WCSAs. **Chapter six** is dedicated to the discussion of results. **Chapter seven** contains conclusions, including recommendations for policymakers, practitioners, and researchers. The final chapter will close with a personal statement.

Chapter 2. Literature Review & Conceptual Framework

The thematic literature review presented in this chapter consists of two parts. Part One discusses literature related to actor perspectives and treatment options, including the impacts of CSA on survivors, treatment outcomes, potential solutions, as well as the perspectives of MHSP and CSA survivors. Part Two focuses on access to mental health services, particularly outlining the various demographics of service users and the barriers they face, along with policy and advancement opportunities. Following the literature review, the conceptual framework is presented, outlining key concepts and constructs to steer the study. Part one of the review will review five articles, while part two will review eleven.

The University of Victoria Library search engine and Google Scholar were utilized to locate resources using Boolean operators and critical terms in both parts of the literature review. The quality of the chosen sources were assessed by reading through the abstract, filtering keywords while prioritizing primary research and evaluating the methodologies and results of the resources. The chosen search terms in Part One include child sexual abuse*, psychotherapy*, survivor*, experience*, women*, adult* AND/OR mental health services*. In Part Two, the chosen search terms include mental health*, care*, access*, Canada*, women*, adult* AND/OR women*, British Columbia*, system*, and policy*. These articles were further filtered by subject, language, topic, article type, and discipline. To categorize the findings, a separate Literature Review Matrix was utilized for both Part One and Part Two (McGregor, 2018) (see Appendix A).[2]

Part One – Actors' Perspectives & Treatment Options

Five key themes have emerged from the research: Effects of Child Sexual Abuse (CSA) on Survivors, Survivor Perspectives, Service Provider Perspectives, Treatment Outcomes, and System Solutions.

Effects of CSA on Survivors

While the scope of this study mainly concentrates on access, it is important to also consider the effects of CSA on adult survivors. These are mentioned by Gibbons (1996), Talbot et al. (2011) and Chouliara et al. (2011). This includes descriptions of the social, psychological, social, and physiological consequences that survivors of CSA face due to the abuse they endured as children. All three sources agree that adult survivors of child sexual abuse experience disproportionate rates of mental illness. While mental illness is the foundational CSA result for survivors, each article elaborates further on different trends and behaviours. While Gibbons (1996) shares the high rates of substance and alcohol use among adult CSA survivors in Australia, Talbot et al. (2011) share an increased likelihood of relational problems and assault risk among female CSA survivors. Only Chouliara et al. (2011) cast a broader scope of the recorded effects that CSA survivors face when stating that "adult survivors of CSA are likely to

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[2] An example of a search entry is child sexual abuse* AND survivor* AND *mental health services AND *experience AND *psychotherapy OR *women AND *adult.

present with psychological/emotional, social/relational, and physical/sexual difficulties ranging in severity” (p. 129).

Survivor Perspectives

A common theme that emerged from the reviewed articles was survivors' perspectives regarding their experience with respective mental health services and/or systems. Gibbons (1996), Schoon and Briken (2021), Boterhoven de Haan et al. (2021), and Chouliara et al. (2011) all shared confirmed statements by survivors of negative experiences regarding mental health services or system navigation in their local regions. On a micro level, Gibbons (2011) and Schoon and Briken (2021) mention survivors' challenges in receiving adequate care from their mental health service provider. This includes deficient qualifications, expertise, support, and empowerment from individual counsellors and therapists (Gibbons, 2011; Schoon & Briken, 2021). On a macro level, Chouliara et al. (2011), Gibbons (2011), and Schoon & Briken (2021) illuminate the shared perspective of survivors who voice their concerns in navigating the mental health care system to access individualized psychotherapy by citing obstacles regarding information, support from institutions, access, funding, and duration and consistency. In contrast, Boterhoven de Haan et al. (2021) shift the focus to a more differentiated category of perspectives, emphasizing individual experiences and outcomes of therapy. In their study, adult CSA survivor (ACSAS) patients expressed that they were willing to process the thoughts, feelings, and experiences of their pasts to move on and acknowledged the difficulties of this process; however, overall, most participants were open to confronting their memories (Boterhoven de Haan et al., 2021). These sources differ from the present study because they were not developed or conducted in Canada.

Mental Health Service Provider Perspectives

Boterhoven de Haan et al. (2021) and Chouliara et al. (2011) introduce another essential theme: the contrasting perspectives of MHSP. In their study, Chouliara et al. (2011) reveal that all but one professional in their research highlighted a need for increasing resources for adult CSA survivors systematically. On a treatment-based level, service providers claim that treatment avoidance is common for those who do not feel confident in handling distress in patients in trauma therapy (Boterhoven de Haan et al., 2021). When looking at both the survivor and service provider perspectives, there is an overlap in the desire for change and improvement within the mental health care system in which they operate.

Treatment Outcomes

Schoon and Briken (2021), Talbot et al. (2011), and Boterhoven de Haan et al. (2021) discuss in detail the outcomes of specific treatment models for CSA survivors. While the topic is mentioned concurrently, each source carries a different conclusion regarding effective treatment models. Across the board, there is no ‘one size fits all’ approach to working with ACSAS; however, some models are more effective in facilitating healing than others. Many models see “the integration of an incomprehensible experience into one’s understanding of self and the world as the most meaningful part in dealing with CSA” (Schoon & Briken, 2021, p. 2). This idea of CSA survivors understanding their identity is mentioned again by Boterhoven de Haan et al. (2021) as they conclude in their study that imagery rescripting (ImRs) and eye movement desensitization and reprocessing (EMDR) therapy allowed survivors to “change their view on themselves and their future” (p. 9). Both EDMR and ImRs therapy is conducted on an individual level, which is emphasized by Talbot et al. (2011) as being favourable in "improving psychiatric symptoms and reducing shame among sexually abused women" (p. 374).

Solutions

As a final key theme, two of the articles emphasized solutions to the systemic issues that adult CSA survivors face. Both Gibbons (1996) and Chouliara et al. (2011) advocate for increasing service accessibility for survivors. In addition, both authors highlight the importance of specified training for therapists who work with CSA survivors. Skills in loss and grief work, post-traumatic stress, groupwork, transference issues, and dissociative states are essential for therapists working with survivors (Gibbons, 1996). Chouliara et al. (2011) similarly suggest increasing training in "managing disclosures, trauma-focused work, child protection issues, and supervision/consultative support" (p. 151). Gibbons (1996) delves deeper into sustainable options for systematic change by suggesting that reallocating resources could save money by targeting the needs of survivors. Chouliara et al. (2011) make no mention of reallocating resources within the system but instead suggest promoting self-help interventions, increasing consistency of sessions, and flexibility of time limits.

Conclusion

A prominent outcome of this stage in the literature review is the reported similarities in the perspectives of CSA survivors and MHSP. Both groups seek change and improvement within the mental health care system and express their dissatisfaction. Regarding treatment outcomes and models, multiple authors mention EMDR therapy as an effective intervention. Various authors also recommend enhancing accessibility and training for MHSP.

While abundant literature focused on individual psychotherapeutic treatment options and CSAS symptoms and effects, a gap has been identified related to this study's topic in Canadian literature. Challenges arose in locating sources in Canada and BC that highlight the CSA survivor perspective in navigating the mental health care system. After several search strings and terms revisions, four sources were identified that shared this perspective. However, difficulties remain in locating studies centered around WCSAS perspective on mental health service experience exclusively, even though girls face higher rates of CSA (Heidinger, 2018).

Despite these challenges, there is an opportunity for growth and further development of this topic in academia. Chouliara et al. (2011) share that "there is a distinctive lack of published research obtaining the views and experiences of survivors and professionals working with survivors" (p. 129). Researching this topic in Canada will illuminate different barriers, obstacles, and perspectives than what has already been studied, considering geographical differences. Despite this, these sources have been foundational for understanding WCSAS challenges from their perspectives, in addition to that of MHSP. As indicated by the reviewed literature, disparities in the perspectives of MHSP and WCSAS present an opportunity for a comprehensive analysis. Examining their points of agreement and disagreement from a systemic standpoint provides a pathway to identify a holistic solution.

Part Two – Access to Mental Health Services

Following part one of the literature review, eleven more sources were chosen and analyzed, whose focus does not require the inclusion of WCSAS and instead includes the topic of access. This literature review aims to explore how the term *access* can be understood and examined in the context of current mental health system in BC, Canada. Four key themes have been identified: Service User Demographics & Barriers to Access, Policy & Funding, Programming Alternatives, and Advancement Opportunities. Of the eleven articles, all but one were published in Canada. Only one article was published in BC. Four of the selected articles are original studies.

Service User Demographics & Barriers to Access

Stigma. The most common theme identified across all the articles chosen for this review was Service User Demographics & Barriers to Access. The most common barriers that were mentioned were related to stigma, gender, race, and financial status. The concept of stigma as a primary barrier preventing individuals from seeking and continuing mental health services is mentioned by Thompson et al. (2015), Corrigan (2004), and Lamoureaux & Joseph (2014). Corrigan (2004) highlights that stigma diminishes self-esteem and robs people of social opportunities, thus impeding treatment. Often, folks will opt out of pursuing treatment due to the harm that comes along with being labelled as mentally ill. Stigma towards mental illness operates differently in diverse communities. Thompson et al. (2015) share the impacts of stigma on immigrant women. Racialized immigrants may not seek help or even acknowledge mental health problems due to stigmatization stemming from cultural barriers. Alternatively, stigma has resulted in newcomers expressing mental health symptoms as somatic and approaching general practitioners instead of mental health specialists.

Similarly, for individuals of diverse gender identities, gender expressions, and sexual orientations, their experience with stigmatization is more complex as it can occur as "a result of both a mental health diagnosis and a minority sexual identity [when interacting] within psychiatric and mental health service settings" (Lamoureaux & Joseph, 2014, p. 217). In a study conducted by Wang (2006), it was found that one of the top reasons that mentally ill individuals do not seek help is because they are "afraid to ask for help or of what others would think" (p. 193). Stigmatization is different for various groups requiring mental health services. Thus, there cannot be a one-size-fits-all approach to address and eradicate stigma in our present society. The authors, while agreeing that stigma is a primary barrier to access, present different types of stigma, including public stigma, self-stigma, perceived stigma, and health practitioner stigma.

Financial status. While stigma stands out as a critical barrier to accessing mental health services, the chosen articles frequently mention others, such as rural location, long waitlists, lack of information, cultural language barriers, poverty, and the deficiency of community care integration. In a study conducted by Amanda Slaunwhite (2015) and Faber et al. (2023), it was found that women from low-income households are more likely to report barriers to care. In addition, women experience financial barriers to accessing care more often than men (Faber et al., 2023). Furthermore, according to Moroz et al. (2020), 2.3 million Canadians reported unmet or partially met mental healthcare needs; 78.2% of participants claimed that they do not know where to get help, are too busy, or cannot afford to pay for services. It is made clear through the chosen literature that financial disenfranchisement plays a crucial role in preventing access to mental health services in Canada. The price of mental health treatment, such as counselling, is relatively high for both individuals with and without private insurance plans, as coverage typically covers only 2-8 therapy sessions a year (Moroz et al., 2020). Bartram (2018) expands on this statement as they mention that an estimated 12 million Canadians are without access to employment-based psychotherapy benefits.

Knowledge. A deficiency in public information and resources regarding mental health services acts as a critical barrier for service user demographics and those who have a mental illness. This is mentioned and considered an essential barrier by Moroz et al. (2020), Wang (2006), Faber et al. (2023), Thompson et al. (2015), Corrigan (2004), and Lamoureaux & Joseph (2014). By not providing enough information about resources and incorrect information, stigma is promoted, which fuels the development of stereotypes (Corrigan, 2004). Furthermore, Wang (2006) claims that doubts about the effectiveness of services are a primary barrier preventing non-service users from seeking out resources. Moroz et al. (2020) support this claim in a different sense as they argue that many Canadians do not know where to go for help. Similarly, Faber et al. (2023) claim that a general lack of knowledge regarding mental health prohibits individuals in their recovery. There are dual components to this barrier. The first is an overall lack of information available to folks who require mental health services, and the other is the emergence of incorrect information, which in turn fuels stigma and stereotypes regarding mental illness.

Gender and race. The intersectionality of race and gender impacts the severity and type of barriers to access that folks experience. Individuals of minority racial groups and/or who are lesbian, gay, bisexual, transgender and/or gender expansive, queer and/or questioning, intersex, asexual, and two-spirit (LGBTQIA2S+) experience unique barriers and interact with the suggested barriers above in different forms.

In their case study, Lamoureux & Joseph (2014), claim that LGBTQIA2S+ individuals require “affirming and appropriate services that do not participate in the reproduction of Othering through labelling and stigmatization” (p. 213). These requirements are like those of racial minority groups who have expressed an inadequacy of cultural safety and awareness within the Western healthcare system (Auger, 2019). In a study conducted by Monique Auger (2019), participants who are Metis spoke on a need for “access to culturally responsive health care spanning both Western and traditional systems” (p. 92). In Canada, Indigenous community members experience among the highest rates of depression, anxiety, suicide, and substance abuse (Auger et al., 2019). Thompson et al. (2015) found in their research that racialized immigrants also experience an inadequacy of culturally appropriate services and linguistic discrimination. While many racial minorities and queer communities can find common ground in the requirement for needs-specific programs, there cannot be a one size fits all approach. Each community of individuals experience unique needs based on their background. However, there is overlap and intersection. For instance, Lamoureaux & Joseph (2014) found in one study that 49% of black transgender respondents have attempted suicide. While the available statistics paint a clear picture of disenfranchisement, it has also identified a clear gap in the available literature. Faber et al. (2023) claim that “the intensity of the mental health crisis for people of colour is not receiving the attention it deserves, in part because of the lack of racial data” (p. 314). Black, Indigenous, and people of colour (BIPOC) seek mental health care more often than white

Canadians and have more difficulty accessing care (Faber et al., 2023; Auger, 2019; Thompson et al., 2015; Lamoureaux & Joseph, 2014). High levels of distrust towards the mental health system, along with negative experiences that stem from colonialism, further enforce the inaccessibility of care for racial minority groups.

Policy and funding. The Canadian mental health care system prohibits accessibility for citizens in need of mental health services through several inadequacies related to policy and funding (Bartram, 2018; Faber et al., 2023; Moroz et al., 2020; Auger, 2019; Gloomberg & Gratzer, 2023; Goldbloom & Gratzer, 2016). Bartram (2018) describes the Canadian mental health care system as having long-standing gaps and inequities resulting in psychotherapy inaccessibility. The negation of mental health policy that focuses on racial minorities is described as the "weaponization of policy" (Faber et al., 2023, p. 314).

The long-standing gaps and policy weaponization are reinforced by Canada's Medicare model, where public funding covers psychotherapy when provided by "physicians, in hospitals, or limited community-based services [but the] broader range of psychotherapy services that are provided by psychologists, social workers, and other mental health professionals is not covered" (Bartram, 2018, p. 65). Similarly, Goldbloom & Gratzer (2023) call hospitals the last refuge of fully publicly funded and multidisciplinary mental healthcare. Considering this now, Moroz et al. (2020) and Goldbloom & Gratzer (2023) have revealed promising steps made by organizations and policymakers to improve access through policy change. In 2007, the Mental Health Commission of Canada was created to assess need, and ten years later, the Common Statement of Principles on Shared Health Priorities was created, later followed up with a commitment of five billion dollars over ten years to support mental health (Moroz et al., 2020). Similarly, the Mental Health Commission of Canada published *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, a document designed to improve and increase mental health services in Canadian communities (Goldbloom & Gratzer, 2016). In 2019, BC committed 74 million dollars over three years to enhancing access to mental health services (Moroz et al., 2020). When it comes to funding mental health initiatives and policies, the current mental health system is severely underfunded, comprising only 7% of the total spending on health in Canada (Bartram, 2018; Goldbloom & Gratzer, 2023). Out of the 11 chosen articles for this review, only Moroz et al. (2020) mentioned provincial funding decisions in BC. The chosen literature mainly discussed funding decisions on a federal level. While this is very important, provincial and territorial governments provide substantial funding. They should be examined closely as current mental health programs differ from province to province.

International Programming

Bartram (2018), Moroz et al. (2020), and Goldbloom and Gratzer (2023) specifically refer to two mental health programs operating in England and Australia as sound alternatives and potential options for programming and policy in Canada. Australia and England have introduced programs that have successfully increased access to mental health services. While both countries have introduced significant policy reforms to increase access, their approaches differ (Bartram, 2018).

United Kingdom. In 2008, the United Kingdom introduced the Improving Access to Psychological Therapies (IAPT) program. This was done after the National Institute for

Health and Care Excellence (NICE) found that evidence-based psychotherapy treatments such as CBT can outperform antidepressants and that the "costs of expanded psychotherapy services would be fully recouped within two years, as a result of improved productivity and reduce disability benefits payments" (Bartram, 2018, p. 64). The program follows a stepped care model, meaning individuals requiring care more urgently are prioritized first. In addition, IAPT is publicly funded and is free for the public to access – individuals can also refer themselves to the program, thus reducing access barriers (Goldbloom & Gratzer, 2023). Data on pre- and post-measures of symptoms are collected every session and reported monthly to ensure quality and efficiency (Bartram, 2018; Moroz et al., 2020). The IAPT program's thorough evaluation techniques allow program operators and policymakers to understand the cost-effectiveness and benefits of the program to the public and to know precisely how effective the treatment options are for participants (Moroz et al., 2020).

Australia. In 2006, the Australian Commonwealth introduced the Better Access program in response to a population health survey in 1997 that revealed "only one of every three Australians with common mental disorders was utilizing mental health services" (Bartram, 2018, p. 63). Unlike the IAPT program, Better Access takes an insurance-based approach; this approach expanded universal public insurance through Medicare to cover psychotherapy and increased the treatment rate over two years by 9% (Bartram, 2018). Goldbloom & Gratzer (2023) mention recent efforts in Australia to deliver CBT psychotherapy services through the internet (iCBT). This is done through several programs, which include Moodgym, Shade Treatment, THIS WAY UP Clinic, and My Compass (Goldbloom & Gratzer, 2016). iCBT programs offer CBT courses that individuals can do themselves and also access to therapists who can work with them; however, much like the IAPT program, iCBT does not offer counselling sessions past a short term (Goldbloom & Grazter, 2023; Moroz et al., 2020; Bartram, 2018). Despite this, virtual services have seen some success, with therapist-guided programs displaying strong positive results from users, while self-guided programs retain high drop-out rates. (Goldbloom & Gratzer, 2016).

Advancement Opportunities

Funding. All selected articles advocated for increased access to mental health services in Canada. Several authors had, however, different approaches and suggestions for how this should be achieved. Still, the most common request identified by multiple sources is an increase in funding, research, culturally informed care, and public education. Multiple sources referred to Canada's current mental health system spending, which currently sits at 7% of the total budget, despite frequent and consistent recommendations to increase mental health spending to 9% (Mental Health Commission of Canada, 2015). Faber et al. (2023) state, "increased funding for mental health care is essential to remove financial barriers to wellness" (p. 330)—an investment in programming, training, production of providers, research, and public education campaigns. Similarly to Faber et al., Moroz et al. (2020) suggest specifically increasing funding for cost-effective service delivery interventions such as internet services, management and evaluation of programs and initiatives, and a "centralized national body to evaluate the mental health programs being implemented across Canada" (p. 285). While there have been calls to increase funding to the mental health sector, the chosen articles failed to diversify this command. From an equitable standpoint, different marginalized groups will require different types and levels of care, which will operate at different price points. A clearer picture is needed from a financial standpoint of how much money should be going to different initiatives based on current barriers and access points.

Patient-Oriented Research. Slaunwhite (2015), Auger (2019), Thompson et al. (2015), Lamoureaux and Joseph (2014), and Corrigan (2004) mentioned expanding on current research on improving access; the focus of suggested research differs from each source; however, Auger (2019) and Lamoureaux & Joseph (2014) both push for a participatory approach. For instance, Auger (2019) advocates for developing research into how we can improve Metis people's access to mental health services. They highlight the importance of including Metis folks in the research design, policy change, and social change. Similarly, Lamoureaux and Joseph (2014) shares the importance of policymakers and mental health service providers working with queer groups and organizations when conducting research and developing new programs. Consulting, involving, and considering the needs and perspectives of marginalized and underserved groups leads to more equitable and barrier-free mental health access (Lamoureaux & Joseph, 2014). While the authors mentioned above refer to research pre-service delivery, Moroz et al. (2020) highlight the need to collect data mid and post-service delivery to evaluate the impact of a program proactively.

Culturally informed care. For people who are BIPOC, additional barriers are met when trying to access mental health services in Canada due to a lack of culturally informed care. Faber et al. (2023), Auger (2019), and Thompson et al. (2015) agree with this recommendation. In their study, Thompson et al. (2015) suggest broader training in cultural and language competency, partnerships between service providers and immigrant groups and social and settlement agencies, incorporating trauma-informed practice tailored to refugees, and altering standardized assessment tools. Furthermore, they claim that culturally sensitive assessment methods are required as "contemporary assessment tests have limitations of cultural equivalency in language, concepts, norms and scaling methods" (p. 1899). Culturally informed training is critical in providing adequate access to BIPOC folks, especially newcomers and refugees. Faber et al. (2023) reinforce this claim by advocating for increasing racially and linguistically diverse service providers and more culturally informed training of existing providers. Auger's study mentions the value of connecting service users with providers from the same culture. Metis study participants expressed their thoughts on the lack of culturally informed care in the BC mental health care system and described the kind of care they would like access to. Some of the Metis women in the study described individual care as impersonal and intimidating; in addition, participants described a "lack of culturally safe mental health practitioners and historical trauma rooted within healthcare experiences" (Auger, 2019, p. 95). One of the participants in the study referenced the medicine wheel and its inherent differences to Western culture; they stated, "I'm drawing the medicine wheel right now, and I'm writing the four quadrants: body, mind, heart, and spirit. And I actually think they're all one, but in Western culture, we have a focus on the body and mind" (Auger, 2019, p. 94). Understanding core differences between Westernized health practice and traditional Indigenous health practice is fundamental to providing adequate care for WCSAS.

Public education. Corrigan (2004), Lamoureaux & Joseph (2014), and Thompson et al. (2015) collectively mention the need for developments in educating the public on destigmatizing mental illness and providing information on available mental health services. Lamoureaux & Joseph

(2014) reflects on the need for organizations to create "inviting relationships with lesbian/queer women that facilitate self-disclosure opportunities and foster recognition, acceptance, and affirmation of women's sexual identities" (p. 217). In contrast, Thompson et al. (2015) promote the development of public education initiatives to assist in eradicating stigma specific to immigrant populations and newcomers. While Corrigan (2004) and Thompson et al. (2015) both focus on different communities in their research, their underlying suggestions regarding education align with destigmatization for both groups. There are three ways to eradicate stigma effectively: protest, education, and contact (Corrigan, 2004). The articles fail to delve deeper into the ideal approaches for educating the public on various and concurrent mental illnesses, however. Some mental illnesses, such as psychosis, are stigmatized far more than more common illnesses, such as anxiety or depression. This is also true for personality disorders.

Conclusion

Sources in this review emphasize the significant role stigma plays in obstructing access to mental health services for WCSAS. Researchers note that racialized and LGBTQ2I+ women encounter both overlapping and unique forms of stigma that exacerbate barriers to receiving care. Similarly, a weaponization of policy occurs against racialized women, reinforcing levels of stigma and socio-economic barriers such as financial status. Multiple authors in this review advocate for culturally informed care and culturally informed policy. They collectively call for increased funding, which would positively impact minority survivor groups. Additionally, mental health programs developed in the UK and Australia routinely gather data at a standard rate, underscoring the importance of evaluation and data collection within the mental healthcare system.

While data was collected in Canada primarily by the chosen sources, there was a distinct gap in information and data about the BC mental health system. All but Auger (2019) referred to barriers, demographics, policy, funding, and opportunities on a community and federal level without recognizing the condition of the BC mental health system. Similarly, apart from Thompson et al. (2015), the available literature needed to define access and the different types of access. However, we know from this review what inhibits access and what elements are required to provide adequate access, including some of the efforts made. About the topic of this research study, the information gathered in this section has laid the framework for past, present, and future analysis of the Canadian mental health system access. The information provided will act as an umbrella as we narrow down the themes and experiences most relevant in the province of BC.

Conceptual Framework

Based on the reviewed materials, the conceptual framework presented in this section seeks to understand and define access to psychotherapeutic services, in order to inform data collection, and analysis, and the discussion of results presented in Chapter 6. These goals will be achieved through an intersectional policy lens. Intersectionality "aims to explain the discriminations, disenfranchisements and disadvantages […] experienced by some social groups […] with the intersectional effects of multiple factors and power systems" (Yang, 2024, p. 6). An intersectional lens shifts from a mono-categorical perspective to, in the context of this study, one that seeks to understand the connectedness between race, gender, ethnicity, ability, financial status, mental health, and addiction (Collins, 2019). Rather than treating individuals as homogenous groups (e.g., "women," "BIPOC"), this framework acknowledges the diverse and interlocking identities of WCSAS and the unique barriers they may face.

Thompson et al. (2015) define access to services as “not only getting to service but also getting to the right service at the right time to promote improved health outcomes” and barriers to services as “real and perceived obstacles that prevent or interfere with access to services” (p. 1897). For the purpose of this study, access is operationalized in terms of the ability of WCSAS to utilize psychotherapeutic services without experiencing barriers or obstacles due to the interplay of their social locations.

This framework views access as part of a complex, dynamic, and adaptive system in which six interrelated types of accessibility interact. For each WCSAS, these categories function and overlap in ways that are contingent upon intersecting factors such as race, gender identity, income level, disability status, Indigeneity, and geography. These types of access permeate various levels of policy, service delivery, and social life. Thus, access is not only situational but structurally embedded and unequally distributed.

Drawing on the reviewed literature, this study identifies six types of accessibility, which are examined through an intersectional lens (see also Table 1):

- **Geographic Accessibility** – Geographic accessibility is defined as the availability of services in proximity to service users. WCSAS in rural and remote areas of BC may face geographically compounded barriers due to underinvestment in rural infrastructure, systemic racism, and colonial displacement, which force individuals to travel long distances to meet with a MHSP (Maddess, 2006). These challenges intersect with other barriers such as low income, caregiving responsibilities, and limited access to transportation.
- **Informational Accessibility** – Informal accessibility is measured by the availability and awareness of information regarding services. A frequently documented barrier to accessing mental health services in Canada is not knowing where to go for help (Moroz et al., 2020). Structural inequities in education, language access, and digital literacy mean that marginalized populations—such as newcomers, disabled individuals, and those with low formal education—often lack access to culturally and linguistically appropriate information.
- **Financial Accessibility** – Financial accessibility is defined as the affordability of services. Individuals who generate lower incomes face increased difficulties in accessing services. Individuals earning under $50,000 per year are more likely to report financial barriers and negative experiences with a MHSP (Faber et al., 2023). Financial barriers must be understood not only in economic terms but as reflective of structural discrimination in labor markets and social policy, reinforcing WCSAS exclusion from the health system.
- **Psychological Accessibility** – Psychological accessibility refers to the willingness and ability of WCSAS to seek out services and feel connected to service providers. *Therapeutic alliance* is a term used to describe the collaborative and engaging relationship between the provider and client (Stubbe, 2018). The development of the

therapeutic alliance can be hindered by barriers associated with race, gender, ethnicity, disability, and politics. The therapeutic alliance can also be undermined by intersecting stigmas (e.g., the compounded effects of racism, gendered stereotypes, anti-Indigenous bias, transphobia, and psychiatric ableism). These dynamics affect both service-seeking behavior and provider responsiveness. For many WCSAS, past experiences of institutional betrayal or discrimination inhibit the psychological safety required for healing relationships.

- **Temporal Accessibility** – Temporal accessibility is defined as the availability of high-quality services when WCSAS need them. In BC, individuals who require services are often subject to long waitlists to see publicly accessible providers. Temporal accessibility is typically only provided to those who are in crisis (CMHA BC, 2024). Long waitlists and crisis-oriented gatekeeping disproportionately disadvantage those facing cumulative social disadvantages, such as BIPOC women in precarious housing or youth who experience intersecting barriers related to age, income, and identity. Crisis thresholds for access often fail to recognize chronic and intersectional stressors as legitimate needs for support.
- **Cultural Accessibility** – Cultural accessibility is defined as services tailored to diverse cultural backgrounds. As opposed to white service users, BIPOC service users disproportionately experience lower access to services, premature termination rates, and unfavourable treatment outcomes due to a shortage of culturally appropriate services, discrimination and cultural mistrust (Bathje et al., 2022). Intersectionality, in this regard, highlights how Indigenous, racialized, and immigrant WCSAS may experience cultural mismatch with Eurocentric models of mental health, compounded by institutional racism, microaggressions, and lack of trust.

Table 1. *Conceptual Framework*

Concept	**Definition**	**Construct**	**Indicators**
Geographic Accessibility	Availability of services in proximity to service users.	1. **Geographic location** 2. **Travel cost** 3. **Availability of transportation**	1. Where does the WCSAS and MHSP live 2. Price of travelling to service 3. What type of transportation is available, if any
Informational Accessibility	Availability and awareness of information regarding services.	1. **Source of information** 2. **Type of resource** 3. **Comprehensiveness of resource**	1. Public, private, personal, government, educational 2. Print, online, poster, brochure, email, meeting, PSA 3. How detailed is the resource
Financial Accessibility	Affordability of services.	1. **Cost of service** 2. **Income of service user** 3. **Cost of living**	1. Price of each session to the user 2. How much the service user makes
Psychological Accessibility	Willingness and ability of WCSAS to seek out services and	1. **Therapeutic alliance** 2. **Treatment model** 3. **Role of stigma**	1. Trust and collaboration between MHSP and WCSAS 2. Type of therapy

	feel connected to service providers		3. How the negative connotations surrounding CSA impact accessibility to services
Temporal Accessibility	Availability of high-quality services when WCSAS need them.	**1. Wait times** **2. Flexibility** **3. Frequency/Consistency**	1. (time it takes to receive services) 2. (ability for WCSAS to access services when they need them) 3. (ability to access services routinely)
Cultural Accessibility	Services tailored to diverse cultural backgrounds.	**1. Language barriers** **2. Culturally informed care**	1. (appropriate treatment models, awareness and knowledge of WCSAS culture, self awareness of MHSP)

By integrating an intersectional lens, this conceptual framework emphasizes that access to psychotherapeutic services cannot be understood through single-axis categories. The interplay between different forms of social advantage and disadvantage must be accounted for in both research and policy responses. Informed by principles of Intersectionality-Based Policy Analysis (Hankivsky & Cormier, 2011; Hankivsky et al., 2014), this framework allows for a more nuanced, equity-driven, and justice-oriented understanding of access for WCSAS. It ultimately supports the goals of addressing structural and systemic inequalities, uncovering and challenging power relations within the mental health system, seeking transformative change, and encouraging inclusive, responsive, equity-focused, and context-sensitive policymaking/mental health systems.

The conceptual framework will guide the data collection and analysis of this study by providing an established list of concepts, constructs and indicators rooted in the existing literature, which reflect multiple dimensions of access to psychotherapeutic services and will serve as a foundation for identifying structural and experiential barriers. In line with an intersectional perspective, data collection during interviews will explore how these constructs and indicators are shaped by the interplay of participants’ social locations (e.g., race, gender, class, ability, Indigeneity) and broader systems of power.

Thus, the study takes into consideration how overlapping identities and contexts influence access, and acknowledges that access is not experienced uniformly, but rather through complex, intersecting dynamics that require context-sensitive analysis. To reflect this, linkages between the core concepts will be established through a causal systems map that incorporates the structural, relational, and identity-based dimensions of access. This will enable a more nuanced understanding of the interconnections and inequities embedded within the psychotherapeutic service system.

Chapter 3. Methodology, Methods and Data Analysis

This chapter outlines and describes the selected methodology, methods, and data analysis for this study, as well as the reliability and validity of the study. It will delve into the reasoning behind choosing an interpretive, qualitative approach and a system thinking strategy. This chapter will also outline the ethical considerations taken throughout the study.

Methodology

This research study employed an interpretive qualitative research approach. Interpretive researchers do not "[bring] their own scientific definitions with them to field settings to test the accuracy of those understandings, [instead] they seek to understand how those concepts, roles, and so forth are utilized in the field" (Schwartz-Shea & Yanow, 2018, p. 18). Interpretive qualitative research is a paradigm that aims to comprehend a social phenomenon from the perspective of those involved, viewing reality as subjective and interpreted differently by each individual (Weber, 2004). This approach is particularly well-suited to address the chosen research questions, as some of its key features include understanding phenomena from an insider perspective and incorporating exploratory research questions.

The chosen research strategy for this study is system thinking, which can be defined as both as a mindset to problem-solving and decision-making, and a methodology to produce knowledge on complex societal issues (Diedre, 2025). As a methodology, system thinking approaches have increasingly been employed to examine complex public health issues in adaptive systems (Kiekens et al., 2022). It conceptualizes poor health and health inequalities as "outcomes of a multitude of interdependent elements within a connected whole" and enables researchers to identify how to reshape a system in favourable ways (Rutter et al., 2017, p. 2603). A system thinking methodology has been selected to explore this complexity in greater depth and to uncover the dynamics of relationships between actors and variables within the system.

System thinking is particularly relevant to this study as it strives to understand the perspectives of various actors from different sectors of society. It has been characterized as facilitating better patient-centred care and enhancing problem-solving (Henry, 2023). Utilizing a system thinking approach commonly requires "defining system scope, mapping interconnections, diagnosing patterns, and identifying leverage points for change" (SixSigma, 2024).

What follows is a brief explanation of the key components of this approach; namely, feedback loops, leverage points, visualization tools, and interconnectedness (EvalCommunity, n.d.) *Feedback loops* illustrate the reinforcing and balancing dynamics that shape a system's behaviour. Feedback loops can be labelled as either balancing, positive reinforcing, or negative reinforcing. A balancing feedback loop counters change in one direction with change in the other, while reinforcing loops compound change in either a positive or negative direction (Lannon, n.d.). Complex problems arise from the combination of two or more balancing or reinforcing feedback loops (Stroh, 2015). Feedback loops highlight areas of a system where behaviour either increases, decreases, or remains stabilized (Simon Fraser University, n.d.). Once the loops are identified within the system, *intervention points*, otherwise known as *leverage points*, can be located. Intervention points are areas within a system where small changes can lead to large-scale outcomes on the rest of the system. The most effective places to intervene in a system are paradigms, goals, and the distribution of power over the system's rules (Meadows, 1999).

System thinking requires the incorporation of visualization tools and techniques, such as maps, diagrams, and simulation models. In this study, an actors map and a causal loop diagram will be used (EvalCommunity, n.d.). On the one hand, *actor maps* visually depict key organizations, actors, and individuals that comprise and influence a system (Gopal & Clarke, 2015). Actor maps not only identify who the actors are but also their level of impact and influence on the system (Gopal & Clarke, 2015). This visual tool serves as a crucial element and step in a system thinking approach, as it addresses the 'who' before answering 'how' and 'why' a particular phenomenon occurs. Actor maps are foundational to identifying who holds the power to control a complex system and where there are gaps or blockages within that system (FSG, n.d.). Having a clear understanding of who is involved and at what level provides additional information on where the root causes lie. On the other hand, *causal system maps* utilize feedback loop diagrams to analyze and tell a story or narrative about a specific issue by visually connecting key systemic variables (Lannon, 2016). These diagrams illustrate both the positive and negative relationships between variables within a system (Lannon, 2016). Within the causal systems map, several important feedback loops are highlighted for deeper discussion. By understanding the types of reactions that occur within the system, it is possible to identify where to intervene in the most efficient manner.

Overall, this study adopts a qualitative, exploratory and interpretive approach, due to the current gap in academic literature that it seeks to fill. Similar topics focusing on CSA survivor perspectives are not often explored in Canada, making this study exploratory in nature. Key goals of an exploratory approach include establishing research priorities, gaining background information, and developing research problems (Texas State, 2023). Exploratory designs create "an alternative way to make sense of the world, offering new approaches and angles, and counter-hegemonic alternatives to the act of explaining the world" (Rieter, 2017, p. 139). For this reason, this research study does not offer a hypothesis.

Study Design

The methodological steps taken to answer the research questions were carried out in five phases. Maani and Cavana (2023) describe a five-phase process for system thinking and modeling that includes causal loop modeling, dynamic modeling, scenario planning and modeling, implementation, and organizational learning. After conducting participant interviews, a causal system map and actor map were developed to identify key actors, connections, and leverage points, illustrating their relationships (Maani & Cavana, 2023). Dynamic modeling was not included; instead, intervention points were pinpointed within the causal systems map by utilizing both secondary and primary data (University of Waterloo, 2023).

The actor map was developed by first outlining the boundaries of the map and the core variable (WCSAS) before creating a frame for the system. During this time and throughout the study, a comprehensive list of actors who both directly and indirectly influence WCSAS was formed and refined. This list was then carefully placed into one of four quadrants of the frame titled

Government, Social Services, Private Sector, and Community Members. The actors were further organized by their influence on WCSAS and the type of impact they have on WCSAS. This map was altered throughout the study to include data collected from the interviews.

Following the development of an actor map and the collection of primary data, a causal system map was created. Following data collection, key variables were selected from the data and plotted on the map near the core concept to which they aligned. Once all of the variables were selected, the loops that emerged were labelled either negative, positive, or balancing.

The initial four phases of the research plan include:

1. Conduct virtual semi-structured interviews with MHSP and WCSAS to gather their perspectives on the research topic.
2. Develop a causal systems and actors map based on background information and primary data.
3. Conduct a comparative and thematic analysis and synthesis to check for points of agreement and disagreement between participants to produce feedback loops and points of intervention.
4. Corroborate findings with study participants.

Methods

Trustworthiness, Reliability and Validity: Ensuring Data Quality

In qualitative research, reliability seeks to uncover consistencies across studies (Leung, 2015). This study employed internal consistency reliability to validate the interview results. Internal consistency evaluates the correlation among multiple test items designed to measure the same construct (Trochim, 2023). Additionally, internal consistency enables reliability estimation without the need to split or repeat items, as only a single test is necessary (Carmines & Zeller, 1979).

A triangulation method was employed throughout the study. “The logic of triangulation is based on the premise that no single method ever adequately solves the problem of rival explanations” (Patton, 1999, p. 1192). Rival explanations were minimized by incorporating the perspectives of MHSP and WCSAS in the study. By using data source triangulation, this study effectively addresses the research questions through multiple perspectives (Flick, 2019). The validity of this study is strengthened by employing convergent validity, which compares interview results with pre-existing studies from countries outside of Canada (Trochim, 2023).

Recruitment Procedure and Sample

Data collection and analysis for this study occurred over a span of six months, from September 2024 to February 2025. Study participants were recruited from throughout BC and were interviewed virtually. After obtaining ethical approval for the study, two recruitment posters were distributed via email and social media (Appendix C). Recruitment materials were sent to organizations across the province that are part of British Columbia’s Stopping the Violence

Program, which funds free counselling services for women who are survivors of sexual violence. Those interested in participating reached out to the primary researcher directly via email, who then provided additional information, including an informed consent form. Subsequently, a date and time for the participants to attend a virtual interview was arranged with the researcher.

This recruitment procedure resulted in eight WCSAS participants, one of which who works as a MHSP. All participants were adult women. Most participants were recruited through social media and the snowball sampling technique. The WCSAS participant sample was selected based on the following inclusion criteria: currently lives in British Columbia; 19 years old or older; identifies as a woman or femme; and experienced sexual abuse under the age of 16 years old.[3] The MHSP participant sample was selected based on the following inclusion criteria: currently lives in BC; 19 years old or older; and provides mental health services to WCSAS in BC as a social worker, counsellor, therapist, psychologist, or psychiatrist.

Interview Procedures

All participants took part in one virtual semi-structured interview lasting up to one hour from their own homes. One interview was conducted over the phone due to unforeseen computer connection issues. The researcher guided all participants through the same interview procedure and checked in verbally to ensure they felt ready to proceed. None of the participants chose to skip any questions, pause, or end the interview. Upon completing the interview, the researcher verbally reminded the participants of the next steps in their optional involvement in the study, including approving interview transcripts and systems mapping results. Most of the participants expressed interest in being involved in this process. After their interview, participants were sent a document outlining available resources for WCSAS in BC—this includes funding programs, crisis lines, databases, informational sites, etc. (Appendix E).

Two distinct sets of interview questions were created for each participant group (Appendix B). These questions were crafted to address the core concepts from the conceptual framework with a trauma-informed approach. The questions were composed to cover foundational elements of the conceptual framework while deliberately avoiding historical CSA and related emotional experiences by focusing exclusively on access to services.

Interviews were conducted using Zoom video conferencing technology on mobile phones or computers. Each interview was recorded using Zoom software provided by the University of Victoria, and the video file was then saved to a password-protected and encrypted Microsoft OneDrive account with the University of Victoria. The researcher transcribed the interviews, and the transcriptions were saved to the Microsoft OneDrive account under the participant's pseudonym. Following transcription, the video files were deleted.

Data Analysis

Reflexive thematic analysis was employed to examine the results of the virtual interviews by identifying key themes discussed by the study participants. Crosley (2021) describes thematic

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[3] This age was chosen as the age of consent in Canada is 16 years old and trauma experienced in early adolescence can have different long-term effects than that experienced in older adolescence.

analysis as the ideal method for obtaining subjective information, including participants' experiences, views, and opinions. The interviews provided additional insight into participant perspectives and allowed for a thematic analysis approach to categorize and identify patterns among the differing perspectives. Unlike other forms of thematic analysis, the reflexive thematic analysis does not predefine themes; rather, "themes are produced by organizing codes around a relative core commonality, or 'central organizing concept,' that the researcher interprets from the data" (Byrne, 2022, p. 1393). This core concept is *access*, along with its various types, as outlined in the conceptual framework. This approach aligns with the exploratory nature of the study, where results are not anticipated but instead emerge. The steps taken to analyze the data included:

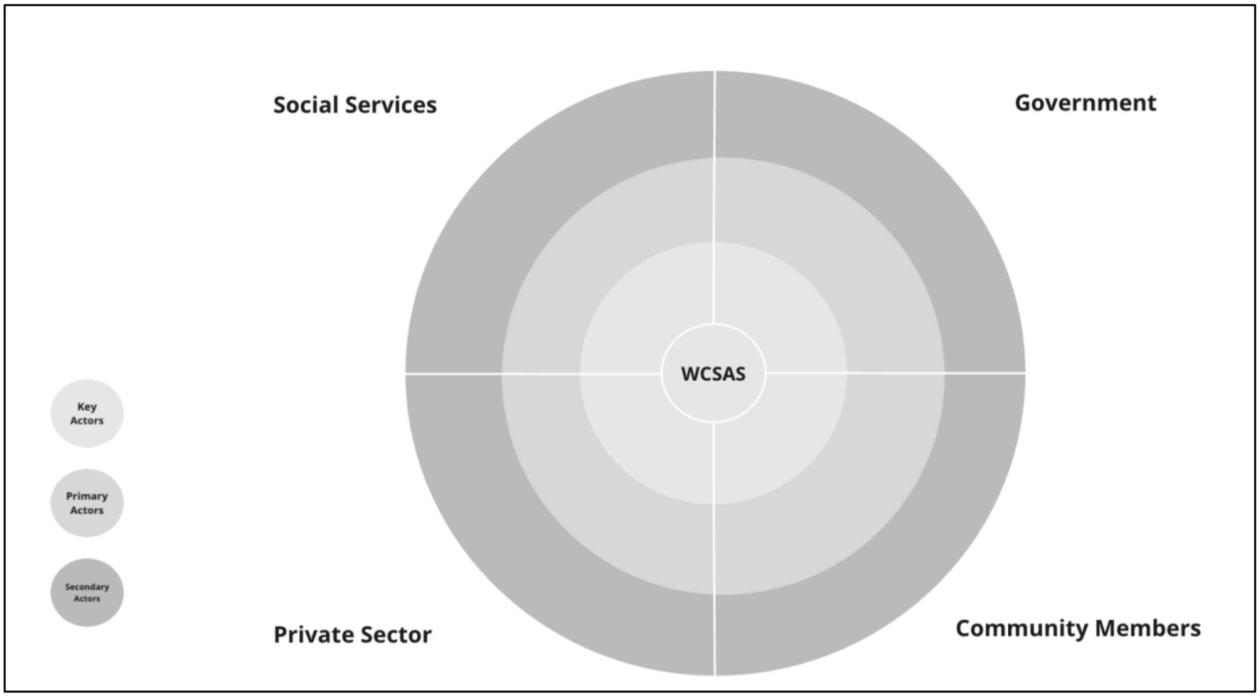
1. Familiarization with data
2. Generation of initial codes
3. Search for themes
4. Review potential themes
5. Define and name themes
6. Produce final report (MAXQDA, 2022**)**

Data collected from the interviews was first transcribed and analyzed. Upon completion, the transcriptions were uploaded to the software program NVivo for coding and analysis. NVivo supports qualitative research and allows researchers to gather and import both qualitative and quantitative data into the platform, including quantifiable demographic information as well as qualitative data ranging from open-ended survey questions to in-depth interviews, along with pictures and videos (Cresswell, 2014, p 175).

The online application *Miro* (https://miro.com/) was used to create the system maps, as it enables individuals to build visual tools such as maps. The codes that were generated from the interviews were then used to identify variables for the causal system map and actors for the actor map.

The actor map required listing relevant actors with direct and indirect influence on WCSAS. During the thematic analysis of the interviews, several core themes and sub-themes were identified. Information from these themes, along with background research, was used to create a comprehensive list of actors, which were plotted onto a circular frame (see Fig. 1). The frame of the map consists of a circle divided into four quadrants, titled Government, Social Services, Private Sector, and Community Members. Inside the circular frame are three rings, each a different colour. These rings indicate the level of influence or connection that an actor has to WCSAS. These levels are titled Key Actors, Primary Actors, and Secondary Actors. The actors were plotted onto the frame according to their categorization. Following this placement, the actors mentioned by study participants were further categorized and highlighted on the map. These actors were labelled as either Facilitating, Hindering, or Reciprocal to describe their effect on access to services for WCSAS.

Figure 1. *Actor Map Frame*



Understanding the positioning and relation of key actors within the complex system is essential before seeking causal linkages, as it ensures that the causal map is grounded in realistic and accurate perspectives in addition to theoretical ones. The main components, sub-themes, and main themes found during the interviews were used as variables for the causal system map. By identifying the positive and negative connections between these variables, the causal system map illustrates the common narratives and experiences shared by study participants. Once the positive and negative connections between variables on the map were made, feedback loops were identified.

Ethical Considerations

This study required UVic's Human Research Ethics Board (HREB) approval because it involved working with human participants, including those within a high-risk demographic (Government of Canada, 2022, Article 6.12). Prior to recruitment and data collection, the HREB fully approved the study (approved ethics protocol 23-0632). The key ethical considerations for this study include informed consent, participant well-being, confidentiality, and risk disclosure. Prior to this, the TCPS 2: Core 2022 Course on Research Ethics was completed (Appendix D).

The well-being of participants was fundamentally the highest priority during the operation of this study. Interview questions were designed with a trauma-informed approach. While the questions themselves did not ask participants to reflect upon the abuse they endured in childhood, the focus of the study could potentially bring up distressing memories. Due to this, a protocol was developed to ensure that participants were provided with space and resources, and their body language was constantly monitored for signs of distress. Additional procedures were included to protect participant well-being:

1. At multiple points throughout the study, participants were reminded that they could take a break, reschedule or withdraw at any time without consequence.
2. Post-interview, participants were provided with a document outlining current mental health services and resources for WCSAS in BC. Individuals who initially showed interest in participating were also provided with this information.
3. During participant interviews, if participants began to share details regarding the abuse they endured, they were listened to but gently guided back to the original question asked.

The informed consent form outlined the potential risks to participants and the limits of confidentiality within the study. Within the informed consent form, the positionality of the primary researcher was disclosed to participants to build trust, as previous studies have shown that many trauma survivors are grateful for the opportunity "to share their experiences with a researcher who is unlikely to judge or condemn them" (Seedat et al., 2004, p. 262).

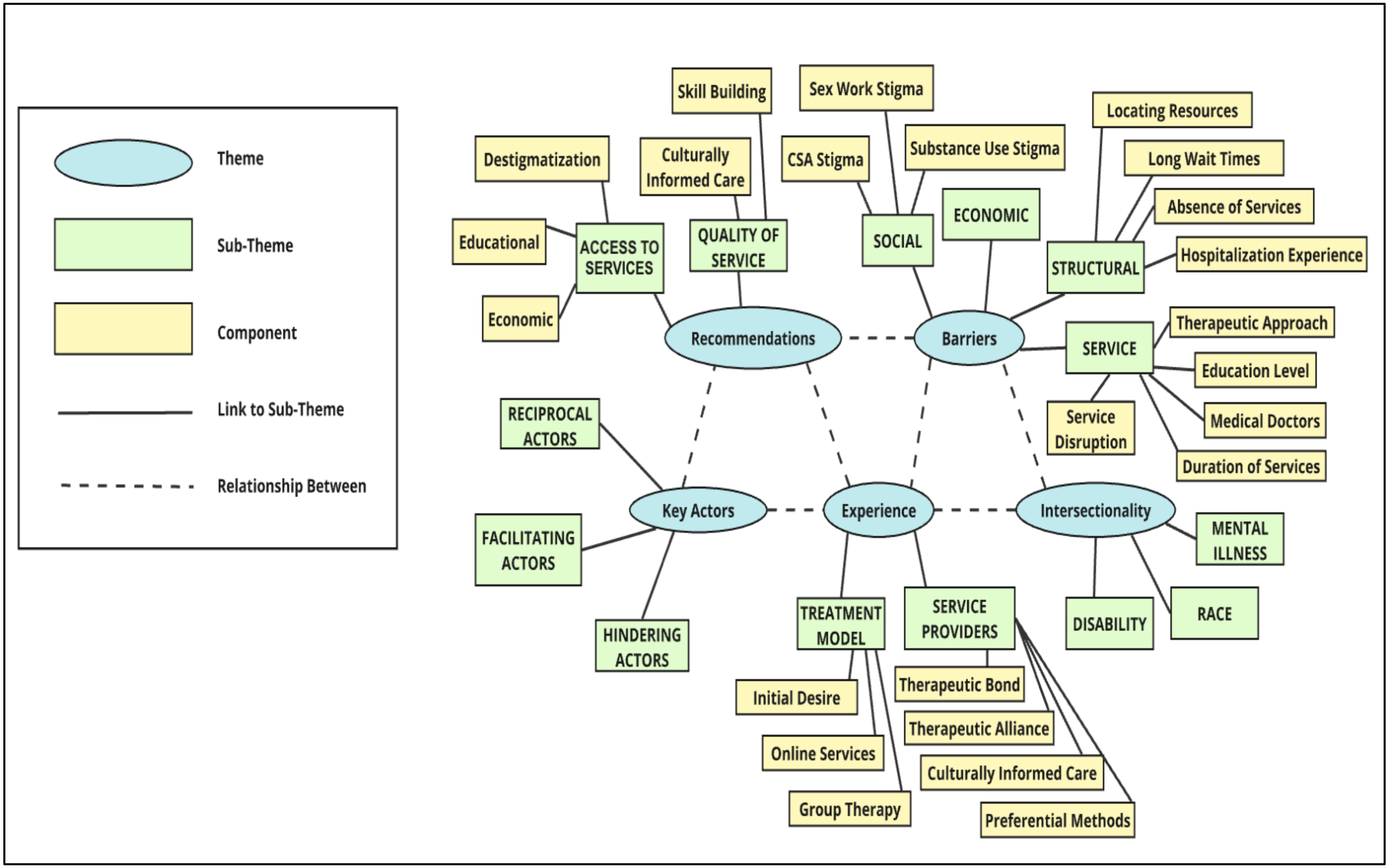
Chapter 4. Thematic Results

This chapter contains the results of the interviews conducted. It organizes the data collected from the interviews into themes and recognizes how the themes relate to the question of how we can improve WCSAS access to mental health services in BC. The purpose of collecting this data is to gather variables and identify actors to aid the development of the actor and causal systems map. These maps contributes to the overarching goal of this study; that is, to improve access by deepening our understanding of this complex system. One of the key goals of this study is to honour the voices of the participants. To achieve this, this chapter intentionally includes a significant number of direct quotes, allowing the reader to interpret the data through the words of the participants rather than the researcher. Quotes from the WCSAS participants are highlighted in blue, while quotes from the MHSP participant are highlighted in green. To preserve the study participants' anonymity, all names have been altered (i.e., Participant A, B, C and so on), and any organizational entities have been substituted with a placeholder description in brackets. The MHSP participant in this study is a registered clinical counsellor who has specialized in working with CSA survivors for over 30 years and is also a survivor of CSA. This participant's responses and views on several topics were often similar to the responses of WCSAS; this includes subjects such as financial barriers, stigma, substance use, absence of services, specialty treatments, and duration of services. All names mentioned by participants have been exchanged with pseudonyms.

Five superordinate themes emerged from the data collected from the interviews (Figure 2). Within these themes, fourteen sub-themes emerged. Each sub-theme was divided into components. The main themes include:

- Barriers
- Experience
- Intersectionality
- Key Actors
- Recommendations

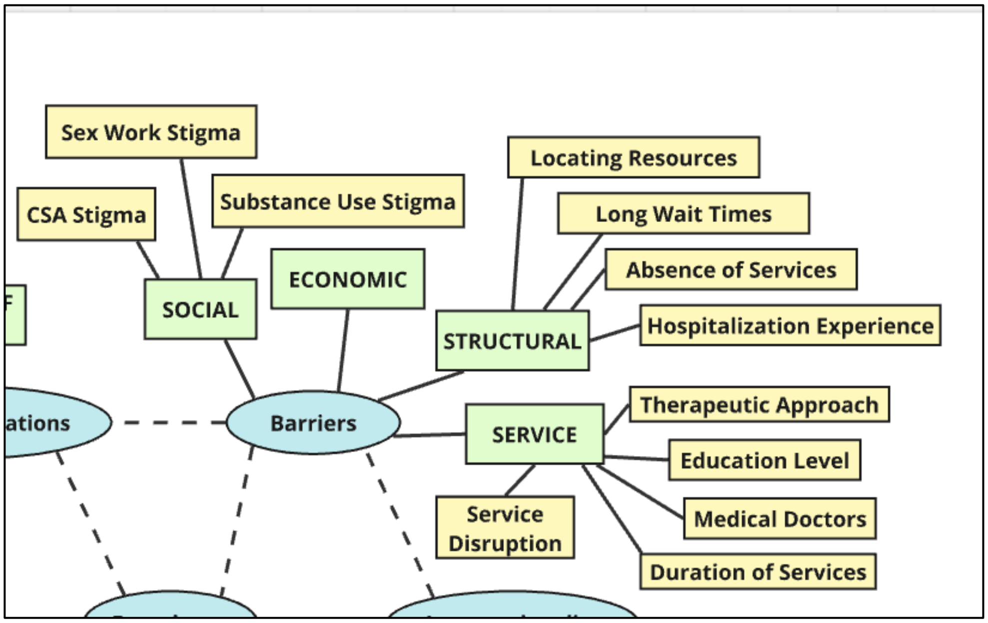
Figure 2. *Thematic map*



Theme 1: Barriers

Theme 1 describes the barriers that WCSAS participants experienced when trying to access psychotherapy services in BC. These barriers were categorized into four subthemes: Economic, Social, Structural, and Service (Figure 3).

Figure 3. *Barriers, sub-themes and components*



Sub Theme: Economic

All WCSAS participants referenced finances as a significant barrier to accessing adequate therapy options. This included the price of psychotherapy services and a lack of funding by the government to support free or low-cost options. Participants criticized the quality of government-funded services and the availability of funds for counselling services.

"Like therapies that are provided for free under MSP are kind of trash and they're also not well funded." (Participant C)

"We have funding for children, but there's no funding for adults." (Participant F)

The only mental health service provider who participated in the study (from now on, Participant MHSP) expressed agreement with the other participants and elaborated on the systemic challenges of funding mental health services for WCSAS from their perspective.

"The first one that's sort of really obvious to me is money. It's money related to the fact that the provincial health does not fund services or they're very minimal." (Participant MHSP)

Participants consistently mentioned the cost of private counselling services as a barrier in addition to a shortage of low-cost options when trying to access services. Multiple participants referenced the cost of living and current job salary, in addition to intersecting factors associated with mental health, addiction and trauma, as contributing to preventing WCSAS from being able to afford private therapy services that are high in cost.

"With the cost of living and especially like anyone who's gone through any kind of abuse, you probably have some trauma, some mental health stuff, addiction, like all those things. No one has spare money like to be paying $300 for that." (Participant H)

"I know that the cost is a barrier. I have like combed the internet far and wide to find all the available low-cost options. I was doing my therapy with [non-profit organization] before, but since I've moved to [city] I haven't really found another low-cost option." (Participant D)

Participant MHSP referenced the challenges that WCSAS face financially, even with the assistance of programs such as the Crime Victim Assistance Program (CVAP). The Crime Victim Assistance Program is operated by the BC Government and provides victims of crimes with funding that can used to subsidize the cost of resources and supports such as private counselling (BC Government, 2024).

"So the Crime Victim Assistance Program, they've been underfunded for years. I think they set their fees in the eighties or the nineties. I'm not kidding. They were paying $80 an hour, which was what I was paying my counsellor when I was seeing her in the nineties. […] they didn't update the fees until this year. Just this year they finally updated it to $135 an hour." (Participant MHSP)

While the CVAP program offers up to 48 individual payments of up to 135$ per session for counselling to child sexual abuse survivors, until recently they only offered 80$ per session, leaving program participants to pay the rest. In addition, lower rates offered by the program reduce the number of service providers registered to accept clients who are a part of CVAP.

"What does that actually mean for survivors? It means that what that really meant in a practical sense is that a lot of counsellors just wouldn't work for CVAP because they couldn't make a living off of that […] so clients had great difficulties even finding a counsellor that would work with them and or they would find a counsellor and the counsellor's like, 'you gotta top up 20, 30, 40 bucks each time, because CVAP's only paying me this. I need more to make a living.' So that is a real problem for survivors as well." (Participant MHSP)

The economic barriers experienced by the WCSAS participants are supported by Participant MHSP. While WCSAS participants have identified a general lack of funding for public mental health services, Participant MHSP's response differs slightly in that it specifically addresses the ways in which this lack of funding affects programs such as CVAP. The WCSAS participants in this study did not mention CVAP during their interviews, suggesting contrasting levels of awareness of the program and its benefits between WCSAS and MHSP.

Sub Theme: Social

Within this sub-theme, three components are revealed: Child Sexual Abuse (CSA) Stigma, Sex Work Stigma, and Substance Use Stigma.

CSA Stigma. Participants referenced stigma surrounding child sexual abuse and emotions of shame as an important barrier to accessing services. Shame and 'self-blame' are commonly used by participants to describe what prevents WCSAS from seeking out services in the first place. Shame is also mentioned as preventing participants from seeking help in adolescence, which is then carried into adulthood. In addition, participants described the stigma surrounding sex work and substance use as a barrier.

"Especially with childhood sexual trauma, there is a lot of shame and a lot of stuff that's not talked about because I know the statistic is it mostly happens within families and that needs to be talked about, that needs to be discussed." (Participant E)

Participant MHSP, also a CSA survivor, builds upon the notion of secrecy and lack of communication surrounding CSA, referencing a level of denial within the government of the severity of this issue.

"Why can't they serve folks who have been abused as children? I think the problem is that there's too many of us. There's been kind of a whole big denial around this, there's so many of us, and I think the policymakers really know that. And they're like, 'man, if we said, okay, we're setting up shop. Here's a mental health clinic for survivors of childhood abuse. Everyone, anyone can go', they'd be overrun." (Participant MHSP)

Participant MHSP also emphasized how WCSAS experience stigma from organizational bodies and health providers through misdiagnosis and being led through routes by the system that are unnecessary and unlikely to be trauma-informed.

"Because they've got no options, being forced to go through mental health channels to get their needs met. So they're like, 'ah, I need some help and so I guess I'll have to go to The Access and Assessment Center and get diagnosed with depression or anxiety and then that might be a pathway for me to kind of get some counselling somehow.' […] And that's not fair because survivors may not actually need a mental health diagnosis or medicine at all […] They may not need any of that. And that's sort of unfairly stigmatizing them or forcing them to go through a channel that they don't actually have to go through, but that they're desperate to get services so they'll go through that channel." (Participant MHSP)

Participants also described a key barrier as finding people that believed them when they disclosed their abuse history in adolescence as well as adulthood. Struggling to feel seen and believed supports CSA stigma.

"I think number, like for me personally, number one, I think whoever you express to that you need help. I think their ability, like when you're a child, their ability to believe you and help you. Also, just dealing with doctors in general for any issue, is almost impossible it feels like

most of the time. Just trying to get them, to get anybody, to believe you and see you and try to get you the help that you need, I guess." (Participant C)

Sex Work Stigma. Two participants in the study reference experiences where they could not connect with a service provider due to the provider's reactions to their experience with sex work. The stigmatized depictions of sex work impacted the level of connectedness participants felt with their counsellors. One participant shared that having lived experience of sex work was an essential trait they looked for in a counsellor before working with them.

"A challenge definitely for me with sex work stuff has been finding someone who, I don't know, I think honestly it's probably hard to have a therapist that doesn't have lived experience of that for myself. Just because I think people just don't understand. It's so highly stigmatized. And then a lot of the time also people will just like go to the other end of the spectrum and be like "empowerment, like, yeah!". And it's like just like relax and listen." (Participant B)

"A lot of it is based off just stigma despite it [sex work] being something that is providing me with a lot and not causing harm, but it's stereotyped as like a harmful thing. So they're like automatically just rushed to trying to convince you to not do it." (Participant D)

Substance Use Stigma. Participants also noted additional barriers that substance users face when trying to seek out mental health services. Participants referenced the connection between mental illness and addiction. When sharing their experience of navigating provincial health services for mental health, Participant B shared an example of how people who use substances face even more barriers than those who do not when it comes to accessing services.

"I would call that a hindrance for a lot of people and a lot of people who need it [access the psychiatric services] because often they're like, "oh you have meth-induced psychosis, so it's not a mental health problem, it's a drug problem." (Participant B)

Participant MHSP touched on the importance of recognizing the relationship between childhood trauma and substance use and similarly shared concerns over the treatment of WCSAS substance users within the mental health system.

"This is my experience when I worked in Child Protection Services, and many of those people had, you know, addictions problems. So the addiction was the child protection concern, but what was really actually going on, every single client I saw in that work had been abused as a child themselves. Every single one. […] And so they're just muddling along, trying the best they can. They've got kids of their own, but now they've got this addiction problem. Now they're in trouble with MCFD […] If they, if they'd been able to heal or recover from their trauma initially, they would never have been in this position to begin with, I think. So it's complicated. I think this piece, recognizing the connection between addictions and trauma." (Participant MHSP)

Within this sub-theme, participants shared examples of how stigma can create unnecessary barriers to accessing mental health services for WCSAS. While CSA stigma was described by participants as internal shame and external denial, Sex Work Stigma and Substance Use Stigma are described as contributing factors to inadequate treatment by service providers. Results implicate the importance of providing mental health services that are free of sex work stigmatization and incrimination as they can prevent trust between clients and providers.

While the WCSAS participants elaborated on the unique barriers substance users face presently when attempting to access resources, the MHSP provided an example of how these barriers can have a lasting effect spanning over generations. Both WCSAS and MHSP agree on the connection between trauma and addiction.

Sub-Theme: Structural

Within this sub-theme, the following components were found: Locating resources, long wait times, absence of services, and hospitalization experience.

Locating Resources. The most common structural barrier named amongst participants was difficulty in finding information and resources regarding services. Five participants mentioned that they currently or formerly did not know where to go to get help and had to extensively research their options for finding available counsellors. When trying to locate resources, one participant mentioned experiencing challenges with locating and understanding resources when using the internet.

"I'm not very like good at like navigating the internet so sometimes, sometimes when I try to try to do a search, it's just really difficult to comb through and understand what's out there." (Participant D)

Two participants also described this barrier occurring in adolescence as well as adulthood. One participant did not know where to turn to within the school system and struggled to understand that what they were experiencing was sexual abuse in the first place.

"It has always been me finding stuff on my own. And like when you're a child or like a youth going through something like that, you don't know where to go […] So, yeah. Yeah. I think also the school system, when I was going through relationship abuse in school or even mental health stuff. There's nothing in schools." (Participant H)

Long Wait Times. Another commonly mentioned barrier was long wait times to connect to a MHSP. This includes psychiatrists and psychologists, where three participants were told to wait between six months to two years before being connected with a service provider. One participant provided details on their experience being hospitalized for mental health concerns in which they were told to wait between two to three weeks before seeing a psychologist.

"And when you've gotten to the point where you're like in an emergency and you still have to wait two to three weeks, like that's like, feels like months, years." (Participant H)

For one participant, waiting to see a psychologist ultimately lengthened the time she had to wait before finding a counsellor to see on a regular basis.

“Seeing a psychologist […] took a very long time, unless you are willing to pay for it out of pocket. I was on a waiting list for six months before I even got officially diagnosed. And that was hard as well, 'cause I didn't know what type of therapist to see 'cause I wasn't diagnosed.” (Participant E)

Absence of Services. Participants also referred to an absence of available services that paired them with a counsellor they felt comfortable with. This resulted in participants either waiting to access an initial session or meeting with a wide variety of counsellors in the hopes of connecting with one.

“Trying to find the right one also is hard because you have to go through so many counsellors to try to find the right one. It took me probably eight years to find the one that I actually feel comfortable talking to.” (Participant F)

Participant MHSP shared their perspective on how funding cuts have impacted service providers such as non-profits, thus impacting the availability of services.

“There are no services for abuse survivors. Like provincial health services, [where you] walk into your local mental health clinic and get services. They aren't there. They don't exist. The only services there are out are through nonprofit organizations. And they get government funding. But it has been very limited, very cut back. My career has spanned 30 years. So that can be a helpful perspective. And I think there used to be services like through regular mental health services walk into your local clinic and if you were having depression or anxiety or if you were a survivor of abuse, you could get some support and help and counselling there for sure. 30 years ago maybe.” (Participant MHSP)

“And bit by bit over, over years governments have cut and slashed funding to mental health services. It seems like you can only get service there if you have a severe mental illness […] Schizophrenia, bipolar, you know, this kind of thing. And even then you can't really get one-to-one therapy. You can get maybe a CBT group or something, which is really tokeny. Like really pathetic, in my opinion. The government has completely gotten out of the business of helping people heal and recover from various things in life. And also they're in charge of funding nonprofit organizations and nonprofits have experienced a lot of cutting back and clawing back on their funding. And another actor is that there really aren't very many nonprofit organizations that serve this population.” (Participant MHSP)

Hospitalization Experience. Three participants mentioned multiple barriers associated with their experience of hospitalization for mental health reasons. During their stays at a hospital, three women reflected upon a negative experience they had. Their reports include long wait times, feeling dismissed by hospital staff, and being separated from community support in addition to being unable to access adequate mental health care or resources for counselling.

“It was hard like to get into the psych unit because they have so many [patients], it's a hard time to try to get people in because they're so full. But even the doctors at the hospital will always be like, oh, ‘you're fine. You don't need to go to the hospital’. Well, you don't know how I feel deep down inside.” (Participant F)

This sub-theme illustrates how participants have experienced structural barriers at differing stages in their journey to receiving services. Participant MHSP's perspective on public service shortage supports and reaffirms the components within this sub-theme. Long wait times and difficulty locating resources support the absence of services and negative hospital experiences.

Sub Theme: Service

Within this sub-theme, five components exist: Therapeutic approach, education level, medical doctors, service disruption and duration of services.

Therapeutic Approach. All WCSAS participants referenced incompatibilities with a service provider as a barrier to them accessing adequate care. One of the more common experiences participants had specifically worked with counsellors who would push them to discuss topics they wished not to speak of.

"She wanted to very much dive into one certain event […] And she only wanted to focus on that one event. […] I have CPTSD,[4] so I have a very wide range and what I'm learning in my journey is all these little events that have happened, that creates a big whirlwind in your brain." (Participant E)

Professional Training. Another common barrier that participants faced was the impact of their MHSP's education level when it came to treatment. Multiple participants mentioned having experiences with counsellors who they felt lacked the necessary skills and education to work with them.

"There's no solution, there's no action. I think it was nice to be validated that, but like […] I already know that. I shouldn't have been abused when I was 15. I know that. No one really helped me to like figure anything out or build any tools or anything. It was all just like, "yeah, I'm sorry you went through that. That's valid, um, how does that make you feel?" (Participant H)

"I understand from a professional side of things, she told me that, I don't wanna say I was too much for her, but my amount of trauma, was just 'out of her scope.'" (Participant E)

"So my barriers to accessing psychotherapy services included […] not being able to find a provider who was trained and comfortable in the areas I needed." (Participant G)

"That was difficult to find. It did take time to find someone that did specialized in trauma therapy specifically, and childhood trauma as well." (Participant E)

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[4] Complex post-traumatic stress disorder (CPTSD, C-PTSD or cPTSD) is a mental health condition that can develop if you experience chronic (long-term) trauma. It involves stress responses, such as anxiety, having flashbacks or nightmares, avoiding situations, places and other things related to the traumatic event (https://icd.who.int/browse/2025-01/mms/en#2070699808)

Similarly, Participant MHSP shared their thoughts on the potential effects that can occur from service providers working with WCSAS without adequate training.

"There's all these different sort of specialty treatments that are geared towards helping people process trauma in a contained and controlled way. That's important. We can't just sort of open somebody up and go, 'oh, just talk about your trauma and get all hyperactivated.' It activates in the central nervous system. It can really re-traumatize the person. This is the harm that could be done. That they could re-experience their trauma, go into re-experiencing it. It could sort of reinforce that trauma. It could put them into a tailspin." (Participant MHSP)

Participant MHSP's professional opinion on the impact of training inadequacies on WCSAS highlights the importance of specialty training among service providers and validates the WCSAS participant's concerns that this is a key barrier.

Medical Doctors. Another barrier mentioned by participants was the personal and political views of their counsellors. Participants reported bias in areas of faith and politics that prevented them from being able to connect with and feel comfortable with their counsellor.

"Maybe it's biased, but I would prefer a liberal therapist because I'm a liberal person." (Participant C)

Four participants also mentioned medical doctors as a barrier to accessing services. Participants consistently mentioned not feeling heard or prioritized by medical doctors, in addition to feeling that they were not provided with adequate resources.

"I think that once you're older you can advocate more for yourself, but I think doctors still like, it really depends who you're talking to. They definitely can be a barrier themselves because they just don't, for whatever reason, want to help a lot of the time, or just don't believe you or just don't care enough to really move you in the right direction." (Participant C)

"It took me a year [to access services]. My GP didn't even know who to refer me to half the time. I want counselling, a mental health, an assessment service of any kind, I have to find my own. I have never in my life had a GP refer me to someone and had it work out […] I know for a fact my GP takes on way too many clients. I've never once felt heard by my GP." (Participant H)

Service Disruption. Two participants mentioned that they had been cut off from receiving services by the organization or individual they were working with, and multiple participants found it difficult to find a service provider.

"It was an organization that offered very cheap therapy on the phone. But if you were disorganized or having a problem, you forgot like one time, they just like cut you off. It was specifically for people with disabilities. So I was like, 'I feel like this is like really not helpful.' I was just kind of 'oh I'm being like disciplined for like missing one session', which I'm like in a bad place and I forget things all the time. So that was just like really unfortunate." (Participant B)

Duration of Services. One participant noted that the low amounts of sessions offered was a barrier and expressed that building the comfortability to open up to a new service providers takes time.

"Generally for me, speaking from my experience, it's a complex thing and so having more sessions or the ability to have more sessions, I think is really important because if you just open up some stuff in three sessions and then there isn't any care after, then you're feeling like very abandoned by the system." (Participant B)

Participant MHSP shared their opinion on how many sessions they suggest WCSAS be able to access. They recommend allowing weekly sessions for between 6 months to a year.

"It does take time. It does. Especially, it really depends, right? Some of my clients have multiple layered traumas and that is so much more complicated than somebody who's sort of had a single experience. […] Like EMDR[5] sort of has a whole structure and a framework. It just takes time for that to unfold. I'd love six months […] Or a year. Like the CVAP session, interestingly, CVAP grants initially 24 sessions, and then up to a max of 48, which looks like weekly sessions for a year. That's actually really generous and really good. That would be ideal. That would be amazing. If I could have weekly sessions for a year, oh my gosh. I could heal and transform that person. I can put her in a whole new life. So yeah, that would be great. Six months would be nice. A year would be amazing." (Participant MHSP)

Participant B shared an important insight that being limited to the constraints of the short service duration results in feelings of abandonment. This indicates the need for evaluation of current service models when it comes to connecting vulnerable clients with experienced providers. Women may experience these feelings from the process of navigating the system itself, not just from their interactions with service providers. Participant MHSP advocates for an optional six months of weekly sessions available to WCSAS, referencing how complex trauma can take a longer amount of time to unfold.

When MHSP and health providers such as medical doctors are provided with inadequate levels of education surrounding CSA and the treatment of CSA survivors, it directly impacts the therapeutic approach of MHSP and the experiences of survivors with practitioners. The disruption and short duration of services also directly influences the therapeutic approach of MHSP.

Theme 2: Experience

The women who participated in the study reflected on their overall experience receiving mental health services and working with various counsellors throughout their lives during their interviews. Sub-themes that were identified within this theme are Treatment Model and Service Provider (Figure 4). While a multitude of barriers were previously noted, this theme investigates the positive experiences that the women have had and finds commonalities among their accounts.

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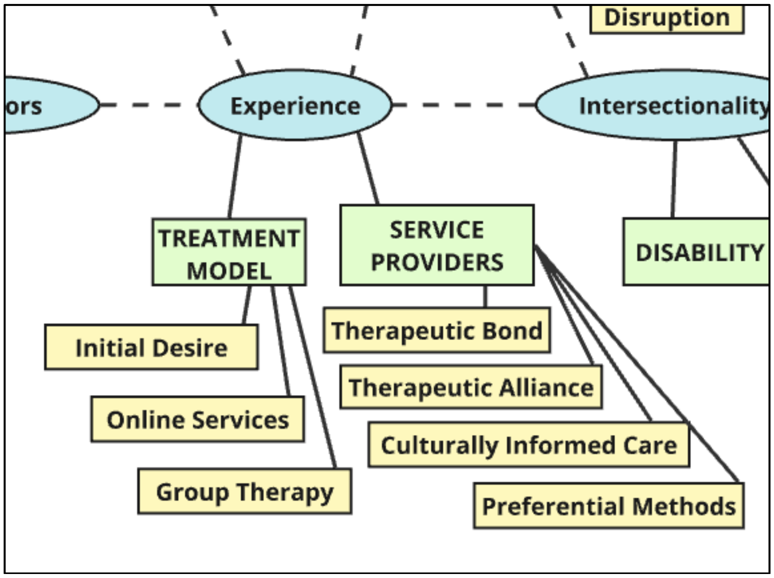
[5] EMDR is a treatment model that stands for Eye Movement Desensitization and Reprocessing.

Figure 4. *Experience, sub-themes, and components*



Sub Theme: Treatment Model

Within this sub-theme, three main components emerged: Initial desire for services, online services, and group therapy.

Initial Desire for Services. All of the women shared reasons as to why they chose to seek psychotherapy services at different points in their lives. Their reasoning included wanting to heal from childhood trauma, seeking help navigating a mental illness, navigating the loss of a loved one, and seeking assistance with neurodivergence.

"There's a lot of people that they don't realize mental health is a thing until they're affected by it. It's really hard for people to relate. Just what I've seen in my own personal circle, but before I was diagnosed, I have a mother with mental health issues. I was more aware of it. So when I started to see the pattern within myself, it made it a priority to figure it out." (Participant E)

"Not having access to that would've been really shitty because I think it's like just a pretty major like intense thing that I don't personally wanna like unpack on my own. 'cause I think it is just such a big thing." (Participant B)

"I came to him because of the autism diagnosis […] And in my intake they kind of ask you what you are wanting to work with. And for me it was the neurodivergence and I got paired with him because his focus was on Neurodivergence because he was also neurodivergent." (Participant H)

"At the time, willing to support when I was suicidal, and experience with grief, and finding someone who was open to in-person services." (Participant G)

Online Services. Of the seven WCSAS participants, three women preferred accessing services online, while two preferred meeting with service providers in person. The remaining two were indifferent to the type of session they had. When discussing their experiences with online platforms such as Zoom and Better Help, participants who preferred meeting their counsellors online cited reasons such as increased flexibility, increased comfort due to being in one's own home, and increased access to a racially and geographically diverse range of service providers.

"I liked online therapy actually. I've done online therapy through Betterhelp. I personally really liked it. I like that they can match you to so many different therapists in the world. And I think that it's, it's a lot easier. It was a lot easier for me to find a therapist that had similar life circumstances. Like someone that I found like a black therapist, which is like hard to find in BC and stuff like that. So I was happy with it." (Participant D)

"I have severe social anxiety. I don't drive. So, instead of just being able to focus on my online therapy session, I have to worry about the cost of transit. I have to worry about allowing the amount of time I need beforehand to get there. And then the amount of time I need after an exhausting mental health session where I'm left emotional, I have to get home. I just find, for me, being in the safety of my home, having my things around, having my dog with me, having those things makes it so much easier. Being able to, like, just for my sensory stuff, like drawing the blinds, having my correct lighting, having my specific comfy blanket. Like being able to control my environment instead of sitting on a cold leather chair with fluorescent lights in an office or somewhere." (Participant H)

"I recommend online to anyone I talk to, there's just something about being in the comfort of your own home, which is really nice. I have my comfort items, especially going into deep trauma. It's nice to have. And also the accessibility. My therapist has moved, he moved to the island and I'm here on the mainland and we're still able to do our sessions because of being online." (Participant E)

As for the two participants who preferred in-person services, women shared reasons such as an increased feeling of connectedness to the service provider, increased comfortability, and reduced distraction.

"Right now, I do Zoom with my counsellor. Because she lives up in Prince George. But to tell you, between Zoom and seeing her when she was down here, I would rather see her face-to-face. In Zoom you get distracted by things all around you. But when you're face-to-face, you can sit down, you can make yourself feel comfortable and you can talk and you continue talking." (Participant F)

While the two remaining participants were indifferent to their method of service delivery, most participants, including those indifferent, cited that their preferred counsellor lived outside of their geographical area. They noted that online services allowed them to see their providers as they lived in different municipalities and were inaccessible in person.

“She does offer in person, she's just far away from me, but I've only ever done like a few sessions of in-person therapy when I was like a teenager. And I don't really see like a huge difference. I feel like, just because I'm just like comfortable online or like in person. I don't know, it doesn't really matter to me, I guess. I don't feel a huge difference.” (Participant C)

An unexpected result from the study was the amount of preferability women had for online counselling services. The responses from the women reveal the implications of how straying from a traditional model of in-person therapy can produce unexpected positive benefits such as increased feelings of comfort and control.

Group Therapy. Two participants mentioned the topic of group therapy. One participant discussed their experience joining group therapy as having a positive outcome. The other participant shared that they have not tried group therapy as it does not interest them.

“It was a really awesome group. I never had done group therapy before and it was like a small room and like kind of dimly lit. […] And there was five of us and there was three facilitators and it was just really, really good. We weren't rehashing our experiences but kind of just talking about coping and I dunno, it just felt really good. […] It was like a really nice space. It was one of the first times that I really had just a experience of talking to other people. Like not the same experiences but who kind of you could just feel through stuff. It was really beautiful, honestly. It's one of my favorite groups, I think it's the only group therapy I've ever done. But I really liked it.” (Participant B)

“A lot of my trauma work has been around the shame. […] And I think it really stems down to that and not being comfortable enough to talk about in a group is hard, especially with sexual trauma, there’s an openness and a rawness to it.” (Participant E)

Participant MHSP shared during their interview their personal involvement in facilitating group therapy for CSA survivors and how therapy groups can bypass service providers in some cases.

“And we, at [private practice], we used to run a group where me and Betty would kind of lead the group. So sometimes these groups are kind of facilitated by counsellors, but they're also self-help. So there's a group that's facilitating for sure, healing and it's very empowering to the survivors. It's like, “here's a program that you can work with other survivors.” You don't need a professional, right? And it's a very good program. I endorse this as a professional in psychology. I endorse it.” (Participant MHSP)

Both online therapy and group therapy are used as alternatives to traditional individual in-person therapy models. There were mixed reviews of both types among participants. Participants initial desire for psychotherapy services directly supports online and group therapy services. Additionally, online formats directly support the development group therapy meetings that host service users who are located in different geographic areas.

Sub-Theme: Service Provider

Within this sub-theme, the following components emerged: Preferential methods, culturally informed care, therapeutic alliance, and therapeutic bond.

Preferential Methods. During their interviews, all the women participating in the study were asked what qualities they look for in a service provider. They not only provided a comprehensive list of qualities and traits that they sought but also described aspects of the positive connections they currently or formerly have with chosen service providers.

The most common qualities that half of the study participants sought in their service providers were sliding-scale financial flexibility (or free services), a non-judgmental attitude, and a level of training adequate to meet their specific needs related to grief, disability, race, trauma, and/or suicidal ideation. Participants appreciated service users who provided a diverse range of skills and tools aside from standard psychotherapy. Two participants shared that they are currently receiving EMDR therapy.

"I think more research also obviously into different types of therapies and how well they work. 'cause like talk therapy never was like a great option for me and until I started EMDR, I've been doing it for almost a year and my life has completely changed. I'm a completely different person and I was in multiple different types of therapy, like talk therapies with multiple different people over my life and it never helped me." (Participant C)

"I do special EMDR therapy so I see like a specialist that specializes in trauma therapy." (Participant E)

In their interview, Participant MHSP frequently noted EMDR as an effective treatment method when working with CSA survivors.

"The trauma experience just gets frozen in time. Time does not heal that wound at all. It just gets frozen. And it gets frozen kind of in your body. Your body remembers these things. It's like your mind has moved on, but your body remembers the trauma and it's all in your senses. So when we do an approach like EMDR, that helps you figure out what your senses are experiencing or what your senses perceived in the midst of the trauma. It's amazing what comes out. You're like, 'I just got a sound. I heard this sound.' You get back the memories, the trauma, it's like fragments of the trauma experience in sensory memories, like sounds and smells and sense of touch. All these things. So that's important too, to include the body and the sensory stuff for trauma healing." (Participant MHSP)

Culturally Informed Care. Two participants expressed feeling more comfortable working with a service provider who was BIPOC, while in total four participants mentioned the need for BIPOC providers to be more accessible.

"For me personally, because I am POC, finding a non-white therapist was really important to me. Just to understand like the dynamics of an immigrant, like a family of a mother who was an immigrant kind of situation and how somebody that's not white because they can understand how like colonialism has affected, it's hard to explain, but yeah, somebody who

understands like that dynamic of having like an immigrant mother or immigrant family, someone who is a woman, someone who is accepting of LBGTQ people, somebody who's not racist." (Participant C)

Therapeutic Alliance. Three participants desired to work with a counsellor whose fundamental values aligned with their own; this includes progressive political views, queer-friendly and those that were not based on religion. A majority of the women shared overlapping fondness regarding the demeanour and personality traits of service providers. Participants used words such as nurturing, kindness, present, understanding, empathetic, trusting, gentle, patient, and funny to describe what they are looking for in a counsellor. Furthermore, two participants shared that they seek a service provider who can hold them accountable, while another two participants shared that they enjoy when service providers share resources with them. One woman preferred to work with a service provider who could maintain a relationship that felt professional rather than friendly.

"We don't have that friendship. And that's what I need. Not a friendship. I need a counsellor-patient relationship." (Participant F)

Therapeutic Bond. A key part of participants' experience with mental health services is the connection and relationship that the women have previously or currently held with a service provider. Most of the women expressed close connections to their current or former service providers and elaborated on the strength and importance of their relationships.

"It took me a lot to try to find the counsellor that I have now and her name's Daphne, and she's excellent. You know, I haven't opened up to anyone but her, like I haven't felt more comfortable with her than anything else." (Participant F)

"He is like someone who is patient, gentle, kind. He just felt safe, just like a bear. He never made me feel judged. He always made me feel heard. He held me accountable softly. If I didn't do something one week, he never made me feel bad about it. He always just gently offered solutions instead of just listening and saying, 'how does that make you feel?'" (Participant H)

"I miss him." (Participant H)

"Through [non-profit organization] I have had access to my most wonderful dream counsellor Velma […] And so she's very just like smart and yeah, just that's my favourite counselling of all time. So I feel very fortunate to have access". (Participant B)

"She makes me feel very understood. Like every time she comes up on my iPad, she's like, 'wow, like you look awesome today, like, I love your shirt,' And as somebody who was never complimented by people who were looking after me, as a kid especially, it's like nice to have that kind of like love and guidance that I didn't get as a child while I'm going through this childhood trauma therapy kind of era. She's just all around like such a great, awesome, funny, kind, empathetic person. And even though we only do our sessions through a screen, I can just feel how much she cares and how important my healing journey is to her also." (Participant C)

The depth of the relationships between the participants and their service providers exceeds standard descriptions of a therapeutic alliance and reveals a level of adoration and admiration from client to provider while also fostering a sense of safety. The closeness of these bonds has improved the outcome of service delivery for these women, which is an important observation. For some, the service provider has provided a level of guidance and love that had been absent in childhood. One participant shared that the only space where she does not feel stigma, shame, or judgement upon herself is in sessions with her counsellor.

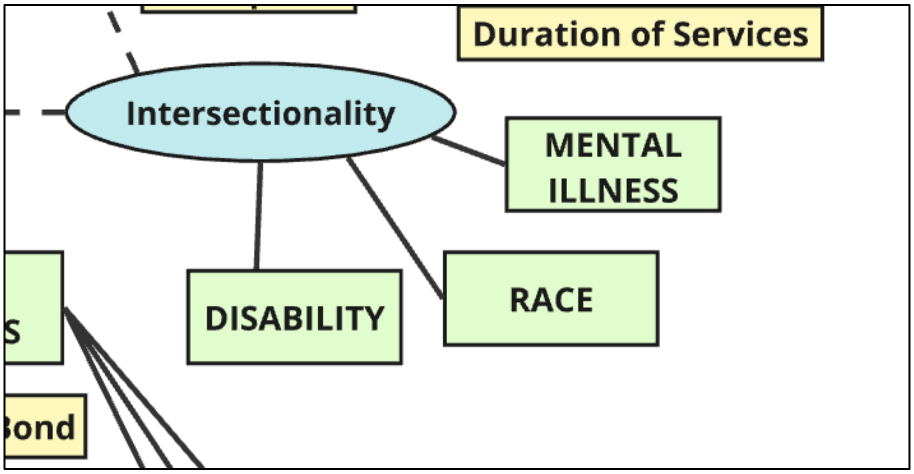
"Just in therapy really […] That's very much my safe place. I've talked about my trauma with some people and it's not very safe." (Participant E)

The use of preferential methods and culturally informed care directly promotes a healthy therapeutic alliance and strong therapeutic bond for WCSAS participants. For participants, feeling safe was often mentioned in conjunction with their appreciation for their service provider. Having a strong therapeutic alliance directly supports a close bond that, for many of the participants, they shared as being a core element to their healing journey.

Theme 3: Intersectionality

Many of the women in the study shared their experiences with overlapping systems of oppression associated with being a racial minority, having a disability, and/or having concurrent mental illness. The theme of Intersectionality emerged through these exchanges, with three identified sub-themes: Disability, Race, and Mental Illness (Figure 5). Intersectionality is a term introduced to mainstream academia by black feminist scholars that states "individual identities such as gender, race, sexuality, and others, overlap and intersect and reflect macro-level forms of oppression and privilege, such as sexism, racism, and heteronormativity" (Kelly et al., 2021, p.1).

Figure 5. *Intersectionality and sub-themes*



Sub-Theme: Disability

Three participants shared experiences of how their disabilities impacted their ability to access mental health services. Two of the women described their experiences with seeking out mental health services from non-profit organizations whose mandate is to assist individuals with disabilities specifically. While Participant F was successfully connected to a service provider, Participant B was forcibly discontinued from accessing services through the organization.

"So [non-profit organization] in [city] that serves for people with disabilities. We went and tried to find different counsellors and we found one through a friend. And I went and met her one day with Archie, my friend, like the boss at [non-profit organization] and we sat down and talked to her and I've been seeing her ever since. And I feel so comfortable. She's so awesome." (Participant F)

Two participants also shared differentiating perspectives regarding access to financial assistance for counselling services. While Participant F could access coverage for mental health services, Participant H expressed difficulty in accessing knowledge of what compensation she was eligible for.

"When you're on disability they will cover it, but going to different counselling places and trying to find the right counselling and the resources, you have to do a lot of research." (Participant F)

"Not that this has anything to do with childhood sexual abuse or anything like that. But like even if you think about my autism assessment, it's almost $4,000. […] If I want a counselling, a mental health, an assessment service of any kind. I have to find my own." (Participant H)

"When I got on disability, I remember asking [the government], 'what benefits do I have?' And they were like, 'oh well you have to if you want, like help with something. Like ask them.' So if I'm like, 'do I have dental coverage?' They'd be like, 'oh, I don't know. You have to talk to your dentist about that.'" (Participant H)

The participants who are disabled face both new and intersecting challenges apart from the challenges they face with a history of CSA. Financial struggles were common amongst all the participants; however, for disabled participants, financial limitations are often long-term due to work restrictions that limit income. Another key difference is the general knowledge of benefits associated with long-term disability status. Participant H had not received information on her benefits, while Participant F was aware of what services her insurance covered.

One of the women experienced challenges associated with the approach of counsellors they have worked with in the past, referencing a lack of comfortability with their fixation on empowerment and positivity.

"I do appreciate the in-person at [university] because I've seen two people there and one of the people I didn't overly connect with, but that was just mainly just like a hyper-focus on empowerment and positivity. I think it's hard 'cause I get it and people wanna be like pausey

and like disability justice and all these things. But if I'm sad about my disability or I'm having a bad time at work, let me do that." (Participant B)

Participant H, however, found a very strong connection with a counsellor who had lived experience of neurodivergence following her autism diagnosis. Participant B similarly sought out a service provider with lived experience of sex work.

"He has ADHD. He helped me to navigate being neurodivergent and around medication and stuff like that too. I think a big part of that was because he has lived experience, which is why I think you're gonna get a better connection with someone who has lived experience." (Participant H)

"I think honestly it's probably hard to have a therapist that doesn't have lived experience of that for myself. Just because people just don't understand. It's so highly stigmatized." (Participant B)

Within this sub-theme, participants who identified having a disability shared, in some cases, contrasting experiences. Non-profit organizations and service providers were described as facilitating and hindering access for the participants mentioned. Experiencing financial difficulties was common among participants who were disabled. Financial limitations negatively impacted the period it took to be matched to a service provider within their budget.

Sub-Theme: Race

Four participants in the study shared their thoughts on how race and ethnicity impact access to mental health services for either themselves or others. They all similarly spoke to the importance of the lived experience of service providers and being able to understand their clients. Two women shared their thoughts on why they prefer to work with a service provider who is black and/or a person of colour. At the same time, the other two expressed their thoughts on the importance of ensuring that mental health service providers who are BIPOC are accessible to people who share similar racial, cultural, or ethnic backgrounds to ensure comfortability and connection between service providers and service users.

Participants C and D both shared that having a counsellor who was a person of colour is important to them as their shared lived experiences allow them to connect and foster a stronger therapeutic relationship. Participants B and H spoke about the importance of service providers educating themselves on topics such as colonialism, racism and social consciousness in addition to ensuring that BIPOC service users have access to providers who are not white.

"You never totally understand someone's experience but like putting some actual work into like [social consciousness], same with looking into like being a white settler or the effects of colonization and, or racism. If you're not doing some actual work to understand that as a therapist that's pretty fucked." (Participant B)

“For the marginalized groups, when I think of Black, Indigenous, People of Colour, to have someone with lived experience, instead, if there's like a kid going experiencing racism in school and they go to their white counsellor, maybe there should be a counsellor who has firsthand experience that they can provide them with. Do you know what I'm saying?” (Participant H)

The participants mentioned in both Disability and Race sub-themes all similarly mention a preference for working with providers who share lived experiences relative to their own. This extends past dimensions of race and disability and leans into occupation as well for some, as one participant shared that having a counsellor with lived experience of sex work was required for them to be comfortable. Participants also mentioned the importance of social consciousness and education regarding service providers working with BIPOC clients. Similar to the Treatment Model sub-theme discussed above, participants noted that adequate training is required; in this instance, in particular, the training should extend past therapeutic skills and move into culturally informed care.

Sub-theme: Mental Illness

Most participants shared that they had concurrent mental illnesses. This includes complex post-traumatic stress disorder, bipolar, anxiety, depression, suicidal ideation and eating disorders. Alongside seeking mental health services for trauma, a priority for the women who experience concurrent mental illnesses was finding a provider who specialized and can address their specific needs. Multiple women expressed that they found finding a service provider more challenging due to this.

“I was looking for someone after I was diagnosed. I'm diagnosed with CPTSD and Bipolar II. So I really looked at someone that dealt with those issues.” (Participant E)

Three of the participants revealed that they had been hospitalized due to mental health reasons and that they did not receive the help they needed when hospitalized, thus causing them further harm.

“The hospital is not really where you wanna get your psych treatment. So yeah, I would say that like a hindrance would be that I did go there and I did stay there for like three weeks, not by choice. And it just sucked because you're away from your community. Obviously people come and visit you but you're not locked in but kinda. And then so you’re forcibly medicated and like I wasn't and yeah, like you can't leave and stuff if you're formed so I would call that a hindrance. And then they actually don't recommend that you even access psychotherapy while you're hospitalized.” (Participant B)

Two participants also spoke about addiction as an extra barrier women face in receiving services. Participant B shared how, in her experience, people experiencing substance abuse issues have a more difficult time accessing hospitalized psychiatric services, while Participant H spoke on how addiction affects an individual’s financial capacity to afford private mental health services. Both participants draw a connection between substance use and mental illness.

"Also friends who use substances and then they're not allowed to even access the psychiatric services […] Unless they're sober for like any period of time. And that's just unbelievable." (Participant B)

"Just with the cost of living and especially like anyone who's gone through any kind of abuse, you probably have some trauma, some mental health stuff, you know, addiction, like all those things. No one has spare money like to be paying $300 for that." (Participant H)

The MHSP participant shared their thoughts on addiction amongst CSA survivors.

"So many people turn to addiction to cope with the pain of trauma that is so common. I almost expect all of my clients to have some sort of substance use concern because of this. Because all trauma does something really severe to our central nervous system. It activates our central nervous system. The fight, fight and freeze reaction in us is all haywire and gone wonky, and it's firing every five minutes. And so people are just seeking what will actually calm or soothe their central nervous system and alcohol and drugs work great. I mean, they just do. So this is why people turn to them because they're actually effective. And so then now you've got a trouble where somebody's like an addict say, and they're struggling, maybe struggling with homelessness and whatever. What's at the root of it all is actually childhood abuse and trauma. And they never get to deal with that. […] Because they can never get money or they can never get into those services, the services that don't really exist are minimal. […] And so I don't know how to change that, but I certainly think that part of this pathway, I think it's about recognizing the addictions and the trauma piece together." (Participant MHSP)

Participants illustrated varying ways in which mental illness plays a role in preventing access to services. This includes concurrent addiction and other mental health diagnoses that add extra steps between the initial desire for services and being matched to a provider. These extra steps include hospital stays, extensive searches, and stigma. The components of this sub-theme have overlapped for some of the study participants.

Both Participant MHSP and Participant H described a correlation between substance use and childhood sexual abuse and how this relationship can jeopardize the economic status of survivors who are seeking access to mental health services.

Theme 4: Key Actors

The fourth main theme to emerge from the data was that of Key Actors. The study participants shared their experiences and opinions of who facilitates and hinders access to mental health services such as counselling for WCSAS. Three sub-themes were determined: Facilitating Actors, Hindering Actors, and Reciprocal Actors. *Facilitating actors* improve and foster access to services while *Hindering actors* work to limit and prevent access. *Reciprocal actors* are those who participants have described as doing both. This theme will be used to form the actor and causal systems maps displayed in Chapter 6 by identifying key actors.

In the interviews with seven WCSAS participants, they collectively identified six Reciprocal Actors (those that facilitate and hinder), thirteen Facilitating Actors, and four Hindering Actors.

All the actors mentioned by the study participants will be listed; however, only the most commonly shared ones will be discussed.

Sub-Theme: Reciprocal Actors

Six key actors were named by participants. These actors both facilitated and hindered access to mental health services for the participants.

This included:

1. Counsellors
2. Non Profit Organizations
3. Schools
4. Family
5. Websites
6. Post Secondary Institutions
7. Virtual Software Companies

The most common actors mentioned were counsellors, non-profit organizations, and schools. Most participants felt that counsellors facilitated access by providing excellent services and a high-quality level of care. However, some participants found that counsellors hindered their access by terminating services, providing short duration of services, and lacking the experience and education to work with their unique needs. Services were terminated either by administrative removal from programs due to missed sessions or by completing allotted sessions and/or the end of a patient and provider relationship.

Most participants mentioned non-profit organizations as facilitating access by providing affordable mental health services and connecting participants to service providers; however, a few participants shared that they had negative experiences receiving services from non-profit organizations.

"They've always been really good at giving me physical pamphlets of numbers to call and people to reach out to. Sometimes I get overwhelmed trying to access the internet. So having it just laid out all in a really easily digestible format has been beneficial for me." (Participant D)

"I actually had like a bad experience." (Participant B)

Three participants mentioned schools as both facilitating and hindering access to services. While two participants shared that their schools provided them access by connecting them to programs and services in both high school and post-secondary, one participant shared that they did not receive any education on consent or support for the abuse she endured while in high school.

"I didn't feel safe to go to my parents. I didn't have the education to even understand that I needed help. Like within schools, I didn't find any support in schools." (Participant H)

"I first did a set of counselling sessions in high school that was like specifically for survivors of sexual violence. I think the group was called [program]." (Participant D)

Two participants mentioned family as being a key actor that facilitates and hinders access. Both participants noted that family can act as a support. However, Participant E noted that abuse often occurs within families, and Participant H shared that she did not feel safe going to her family for help. Both participants, however, felt that there needs to be more education on the topic of childhood abuse within families to foster a safe environment for disclosure.

"It mostly happens within families and like that needs to be talked about, that needs to be discussed." (Participant E)

The most common reciprocal actors were counsellors, non-profit organizations and schools. The negative experiences shared by participants for these actors fall under service and structural barriers. These actors, therefore, retain a high level of power in addressing these barriers. Non-profit organizations and schools directly support counsellors through employment and referrals. Family can either connect or disconnect WCSAS from counsellors based on their reaction to abuse disclosure.

Sub-Theme: Facilitating Actors

Eleven actors were mentioned by participants who connected them to services. They include:

1. Friends
2. Public Spaces
3. Call lines
4. Employers
5. Survivor Community
6. Insurance Companies
7. Outreach Nurses
8. Businesses
9. Social Workers
10. Group Therapy
11. Women

The most common facilitating actors mentioned by participants were their friends. Participants often mentioned how friends were crucial in connecting them to services either by referral or by providing emotional support.

"I would say honestly, like in my personal experience, the people who have connected me to the sources that I need have been friends, other women, who have done their own research and like gone through the same things and like pushed and push and push to find what worked for them." (Participant C)

Two women also mentioned public spaces such as libraries or leisure centers as access spaces as they provided resources for them.

"I went to the Vancouver library downtown this week and I was really impressed with the amount of leaflets they had had out there just at being someplace that's like a free third space that a lot of people that struggle with finances go to. So definitely putting it in areas that people would normally gravitate to, especially in times of life where they're struggling." (Participant D)

Both friends and public spaces press against social barriers, such as the stigma that WCSAS experience when trying to navigate and access services. Public spaces were also found to be effective ways for participants to overcome structural barriers associated with resource-seeking and awareness of available services.

Sub-Theme: Hindering Actors

Three actors were mentioned by participants as hindering their access to services. From their perspectives, this includes:

1. Provincial and Federal Government
2. Medical Doctors
3. Hospitals

Most of the women felt that the Canadian government hindered access by not providing sufficient funds for public mental health programs and services, education about services, and training of mental health providers, and feeling disconnected and unseen by policymakers.

"Obviously our government because the mental health, you know, like therapies that are provided for free under MSP are kind of trash and they're also not well funded." (Participant C)

"The government is the primary actor controlling access to mental health services in British Columbia, both provincial and federal. I have not had a single experience where the government has helped me access mental health services. The government has hindered my access by not covering mental health services under our health care system and not training enough providers. This lack of prioritization communicates to me that as a resident of British Columbia, preventative mental health (not acute services) is not a priority to my government, and therefore, neither is my long-term, sustainable bodily sanctity. This means they have failed at their role as an authority of care for their citizens." (Participant G)

The majority of participants shared that they had negative experiences working with medical doctors. They describe feeling disregarded and ignored by doctors, in addition to not being provided with resources or connected to mental health services.

"I mean, just dealing with doctors in general in any, you know, for any issue, is like almost impossible" (Participant C)

“The doctors at the hospital will always be like, ‘oh, you're fine. You don't need to go to the hospital.’ Well, you don't know how I feel deep down inside.” (Participant F)

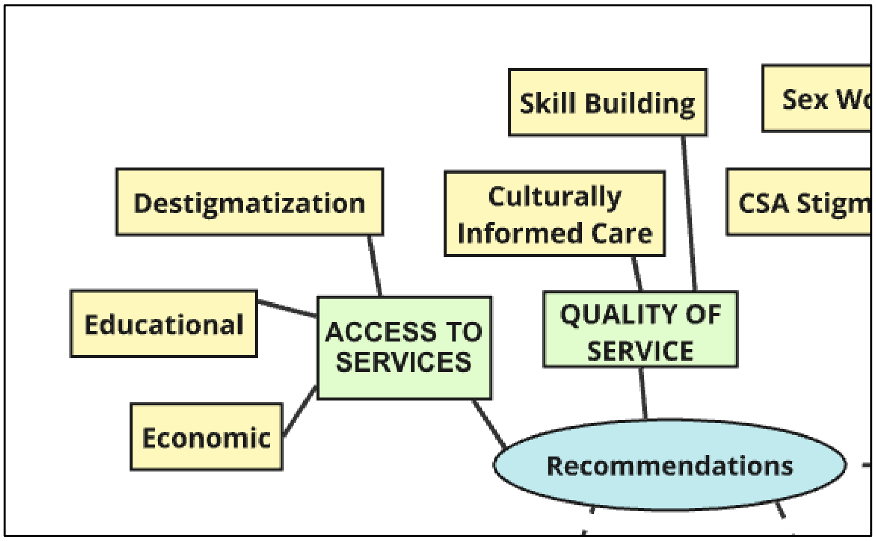
Lastly, hospitals are mentioned as an exclusively hindering actor by three of the women. The three noted that when attempting to seek help for a mental health emergency, they were not provided with adequate treatment. Participants were turned away from services or told to wait extended periods of time to talk to a service provider during an emergency. All three women did not feel satisfied with the services provided to them at the hospital.

Participants’ relationships between these three actors display distrust and a lack of support. Some participants claim that during these experiences, they feel unseen – an emotion familiar to many participants from their descriptions of adolescence. The provincial and federal governments provide funding and directly support hospitals and medical doctors.

Theme 5: Recommendations

The seven survivors who were interviewed were asked what recommendations they would make to improve access to mental health services for women in their survivor community. These recommendations were categorized into two sub-themes: Access to Services and Quality of Service. Access to Service represents recommendations that overlook the time period before an individual has gained access to a service, while Quality of Service represents the time period during and after an individual has received services.

Figure 6. Recommendation, sub-themes, and components



Sub-Theme: Access to Services

Within this sub-theme, the following components emerged: Economic, educational, and destigmatization (Figure 6).

Economic. Most of the participants recommended efforts to make mental health services for women more financially affordable. Two participants recommended making counselling services free to access, while others suggested specifically including counselling as a service covered under universal healthcare.

"Make it free. Make it as free as humanly fucking possible. […] Obviously it starts when you're a kid, right? If you get abused when you're a kid and nobody believes you, if you kind of have to wait till you're an adult. You kind of have to rely on the adults to do something when you're a kid. So, yeah, make it free. And also one in three women have been sexually abused in their lives, whether it was like in childhood or adulthood or both. So why shouldn't a woman just get comprehensive fucking therapy any way? Like either way, we should be able to access it. You know, once you turn 18, maybe, I guess, once you're not under your parents' control, you should be able to access those things for free until you're done needing it." (Participant C)

Participants also consistently mentioned increasing access to funding for mental health services and programs. One participant shared their thoughts on the risks associated with clients missing subsidized appointments.

"We can include that in our policy that people get paid anyway because I don't want providers to be harmed by people missing, but I don't think they are." (Participant B)

Participant MHSP noted a desire for increased funding and expansion in programming that focuses solely on CSA survivors.

"I'd love to see more funding for government mental health services. Or creating a new program for childhood abuse survivors instead of CVAP, sort of a whole new program that says, 'you deserve to heal from your abuse experiences. You were a child, you had no power over this bad, these crimes actually happening to you, you deserve some help with that.'" (Participant MHSP)

Educational. Another common suggestion by the women was to increase public and professional education on both available services and recognizing sexual abuse. Participants recommended increasing service providers' education on topics such as childhood sexual abuse, sex work, substance use, and other criminalized behaviours. Participants also recommended improving the standardized training of service providers to include alternative therapy models such as EMDR that are highly effective for healing trauma.

"More research into how and why these types, different types of therapies, whether it's EMDR or CBT[6] or whatever should be accessible to everyone who has experienced childhood sexual abuse, especially now." (Participant C)

Participant MHSP corresponded with WCSAS participants on the need for diversification of available public services to WCSAS.

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[6] CBT is a treatment model that stands for Cognitive Behavioural Therapy.

“There needs to be a lot of different options 'cause healing looks different for everyone. So different kinds of therapy methods and approaches are important. And for example, here at [private practice]. We've got a diverse team for that reason. I think it's important to include non-verbal approaches, right. Art, we've got expressive arts and art therapy. That's really important. EMDR, a really different and interesting approach. In some ways it's considered sort of nonverbal. It's partly nonverbal. It's partly verbal.” (Participant MHSP)

“I also think they should have some advanced training in a methodology to work with trauma. It's not because just regular talk therapy is insufficient. It's necessary, but not sufficient for healing. A person needs a different method like EMDR, […] like internal family systems doing art therapy or expressive arts therapy.” (Participant MHSP)

As for improving public awareness and education on the topic of CSA and related resources, multiple participants suggested utilizing public spaces such as libraries, schools and leisure centers as ready points of access to resources.

“I feel like nowadays there's more ‘call this number’ like an 811 type vibe or ‘if you're struggling go to this website’. I don't know about that, but I feel like those things should exist at a more speakerphone standpoint. Like those numbers and websites should be available in schools. They should be available in even like leisure centers. Like they should just be everywhere.” (Participant H)

Participant MHSP recommended specifically increasing policymakers and public awareness of the relationship between trauma and physical illness, referencing the research of Canadian physician Dr. Gabor Maté.

“[Dr. Gabor Maté] has worked with people with addictions and trauma for years and years and years. And it's amazing his insights into things. Also his insights into trauma as unresolved trauma, if you've never resolved or healed your trauma, how it leads to negative health outcomes later […] And interestingly, he's made traces between autoimmune disorders and neurological things like MS, all the autoimmune disorders […] If people don't get a chance to work through their trauma or heal, they will get these illnesses later […] I think he's really onto something and there's a lot of people who are followers of him and his ideas are amazing. And we need general public to be more aware […] And the policymakers to be aware of this connection.” (Participant MHSP)

One participant shared her recommendation of improving awareness and standard procedure within educational institutions to both educate students on consent, abuse, and resources as well as train faculty and staff to protect students and recognize signs of abuse as well as operate as a space for parents to learn.

“To me it should just be a part of curriculum. If you can have a class that is like ceramics or criminology, you should have a class on relationship consent.” (Participant H)

"I think that there is a safe and healthy and appropriate way for as young as kindergarten to educate. Like, 'this is my no touch zone.' Like this is a big thing, you know, quotes like, 'don't tell anyone.' Or 'this is our secret', why those are bad. So I think as young as possible to all the way to grade 12 and having access to stuff like that. Even in colleges or universities. To just have that conversation be constant in school." (Participant H)

Destigmatization. Another recommendation some of the women shared was improving efforts to decrease the stigma associated with childhood sexual abuse.

"I think if it was more socially accepted and talked about, people would be more willing to get the help they need […] End the stigma, end the stigma, end the shame around it. Especially with childhood sexual trauma, there is a lot of shame and a lot of stuff that's not talked about because I know the statistic is it mostly happens within families and like that needs to be talked about, that needs to be discussed." (Participant E)

Participant MHSP similarly spoke to the obscure and secretive nature of CSA. They raised concerns about the low availability of services despite recorded knowledge of the estimated prevalence of childhood sexual abuse. Participant MHSP, similarly to Participant E, alludes to the importance of public recognition and noted how, traditionally, CSA is reticent.

"Like, come on, you just have to look at the stats. And the stats are not even reflective of how many people are really abused because this stuff takes place behind closed doors quietly. […] So it's shocking to me that there's just not the services." (Participant MHSP)

Two women recommended that service providers not turn survivors away from services.

"You know what? I would honestly say, don't turn the person away." (Participant F)

One participant recommended that doctors alter their approach to focus on promoting counselling instead of relying solely on prescribing medications to survivors.

"Doctors need to stop, at least in my experience, push medication instead of therapy. Therapy should be pushed. I know it's the more expensive option. […] And people do need medication. That's a hundred percent a thing. But if therapy was more accessible, people won't be on as much medications, and they can find other sources." (Participant E)

In agreement with Participant E, Participant MHSP shared their thoughts on WCSAS navigating public mental health channels that commonly provide a mental health diagnosis and prescription medication as a replacement for trauma-related counselling services.

"And that's not fair because survivors may not actually need a mental health diagnosis or medicine at all." (Participant MHSP)

The recommendations for improving service access address economic, social, structural, and service barriers. Focusing on education was foundational in many of the recommendations. The MHSP participant's recommendations supported those of WCSAS; however, the MHSP introduced new potential methods of increasing access through programming. This includes increasing collaborations between non-profit organizations and private service providers, developing a new federal program for WCSAS, and increasing the number of mental health clinics.

"I have clients at all different levels of pay, you know, depending on if they're a student or whatever. And so I would be willing to give, I've always given that consideration because I've got such a big heart for survivors, and so I wanna make sure they can get in for services some way or another. I see people for pro bono or very discounted services. So if I entered into a partnership I'd be willing to take less pay to just be part of that community initiative and that partnership with a nonprofit. […] That would be part of my way of giving back to the community, right? I take less pay for those clients. So yeah. I love that idea, actually. That would be fantastic." (Participant MHSP)

Participant MHSP recommended fostering more collaborations between private and non-profit services to fill a gap they identified within non-profit organizations as non-profit organizations may not employ enough service providers with specialized training to meet the needs of their service users.

"Some of the people on staff had master's degree and some of them had advanced methodologies, and so they could work with trauma clients with these advanced kind of trainings. But by and large, no, I don't think they offer this kind of thing. You can only get it in private practice. So in other words, people who don't have money can't get this kind of service." (Participant MHSP)

Internally, this sub-theme reveals several causal relationships. Higher funding for programs and services directly improves the level of education that service providers and the public have regarding CSA. This improvement will decrease the stigma surrounding the subject.

Sub-Theme: Quality of Services

Within this sub-theme, two components are mentioned: Skill-building and culturally informed care.

Skill-Building. Participants shared recommendations for improving the quality of services such as counselling. The most common recommendations were increasing and diversifying service providers' skills when working with WCSAS and increasing the number of sessions available to women.

"More sessions for people and maybe understanding that, I mean specifically with WCSAS, that it's not simple and it's not solution space […] Generally for me, speaking from my experience, it's a complex thing and so having more sessions or the ability to have more sessions, I think is really important because if you just like open up some stuff in three sessions and then there isn't any like care after, then you're feeling like very abandoned by the system." (Participant B)

Throughout the interview, the participant MHSP strongly recommended that service providers meet specific requirements before working with a CSA survivor and that they be supervised during the initial stages of learning.

"We must do no harm to our clients. And this is because childhood sexual abuse and this kind of trauma is very delicate. I really think a person needs advanced training. So at the very least, a master's degree in counselling psychology, that's my bias. I just don't think somebody with like a certificate in counselling could do this. Perhaps a certificate in counselling if they've got a bunch of advanced trauma counselling courses, so they take this advanced training, like I also really believe, at a minimum, at a basic, I think the person needs to have a graduate degree in psychology or something like that […] And so it's not okay to work with these folks unless you have adequate training. And to be honest, I think supervision, like work with a mentor or a supervisor at least initially when you're learning how to do this stuff, this kind of work." (Participant MHSP)

Culturally Informed Care. Another common recommendation was to increase and build upon culturally informed care. This includes increasing the opportunity for women of colour to work with a provider who is a person of colour. Similarly, participants recommended that service providers be required to be educated in providing culturally informed care and understand the significance and connection between colonialism, racism, and marginalization.

"If someone's experiencing racism or sexual abuse, you need a counsellor who, you know, specializes in those areas." (Participant H)

Like the previous sub-theme, Access to Services, the recommendations in the sub-theme, Quality of Service, call for increased awareness and learning for service providers. Participants' recommendations are closely linked to their own lived experiences. Ultimately, within this theme, participants advocate for inclusive knowledge systems regarding CSA. Skill building directly increases culturally informed care, and vice versa.

Summary

In sum, the WCSAS who participated in this study face multiple challenges when accessing counselling services, including financial, social, structural, and operational barriers. Financially, women experienced difficulties affording the cost of private therapy services and acknowledge that there is a lack of funding for public mental health programs that provide free or subsidized counselling. Socially, women face high levels of stigma associated with childhood sexual abuse that acts as a barrier for them connecting to services. They also face stigma associated with activities such as sex work and substance use, which prevent them from connecting with service providers and receiving adequate care. Structurally, difficulties seeking out resources, long wait times, a lack of available services, uncomfortable processing, negative experiences at hospitals, and poor education about resources pose as barriers. Within the services themselves, women frequently experience negative treatment by medical doctors, undesired treatment discontinuance, short duration of treatment, technological barriers, and issues with service providers such as bias, treatment model, and experience level.

Women commonly seek out services on their own with minimal influence, and some have even tried group therapy with success. All participants have experienced individual therapy, and both enjoy and dislike online formats. Women feel strongly connected to their chosen service provider and have felt that therapy has been a positive experience, fostering healing. Women face unique challenges associated with race, disability, and concurrent mental illness. According to women, actors that facilitate access to services for women include friends, public spaces, call lines, employers, insurance companies, outreach nurses, social workers, other women, and businesses. Actors that hinder access to services include the government, medical doctors, and hospitals. Actors that do both include counsellors, non-profit organizations, psychiatrists, schools, families, private counsellors, psychologists, video calling software companies, and websites.

Chapter 5. System Mapping

This chapter aims to use the data shared in Chapter 4 to construct an actor map and a causal systems map to better understand and identify further relationships and patterns within the BC mental health system from the perspective of study participants. The chapter is divided into five sections: actors map, causal systems map, feedback loops, systems narrative, and intervention points. The actors map illustrates the influence and nature of the relationships that various actors have with WCSAS. The causal systems map uses the different components identified in the data to understand cause-and-effect relationships between variables within the system. The feedback loops section examines five fundamental relationships between variables that significantly impact the rest of the system. The systems narrative provides an overview of the key relationships within the system and its overarching structure based on the visual tools. After identifying the feedback loops, the discussion will turn to the intervention points. The themes, sub-themes, and components identified in the previous chapter have been used to inform each section of this chapter.

This chapter will help further an understanding of what drives and inhibits the system's outcomes from the participants' perspective. The actor map has been created to enhance our understanding of who holds power and to what extent, from the participants' perspective. While the BC mental health system is broader in scope, we need to grasp which areas WCSAS interacts with and how participants perceive the overall system. In doing so, results from the actor map will inform the development of the causal system map. Five feedback loops within the causal system map have been identified. These loops illustrate how, from the perspective of study participants, patterns are reinforced within the system, resulting in both negative and positive impacts on WCSAS overall. Following the identification of a system narrative, actor map, causal system map, and feedback loops, seven intervention points are identified and discussed.

Actors Map

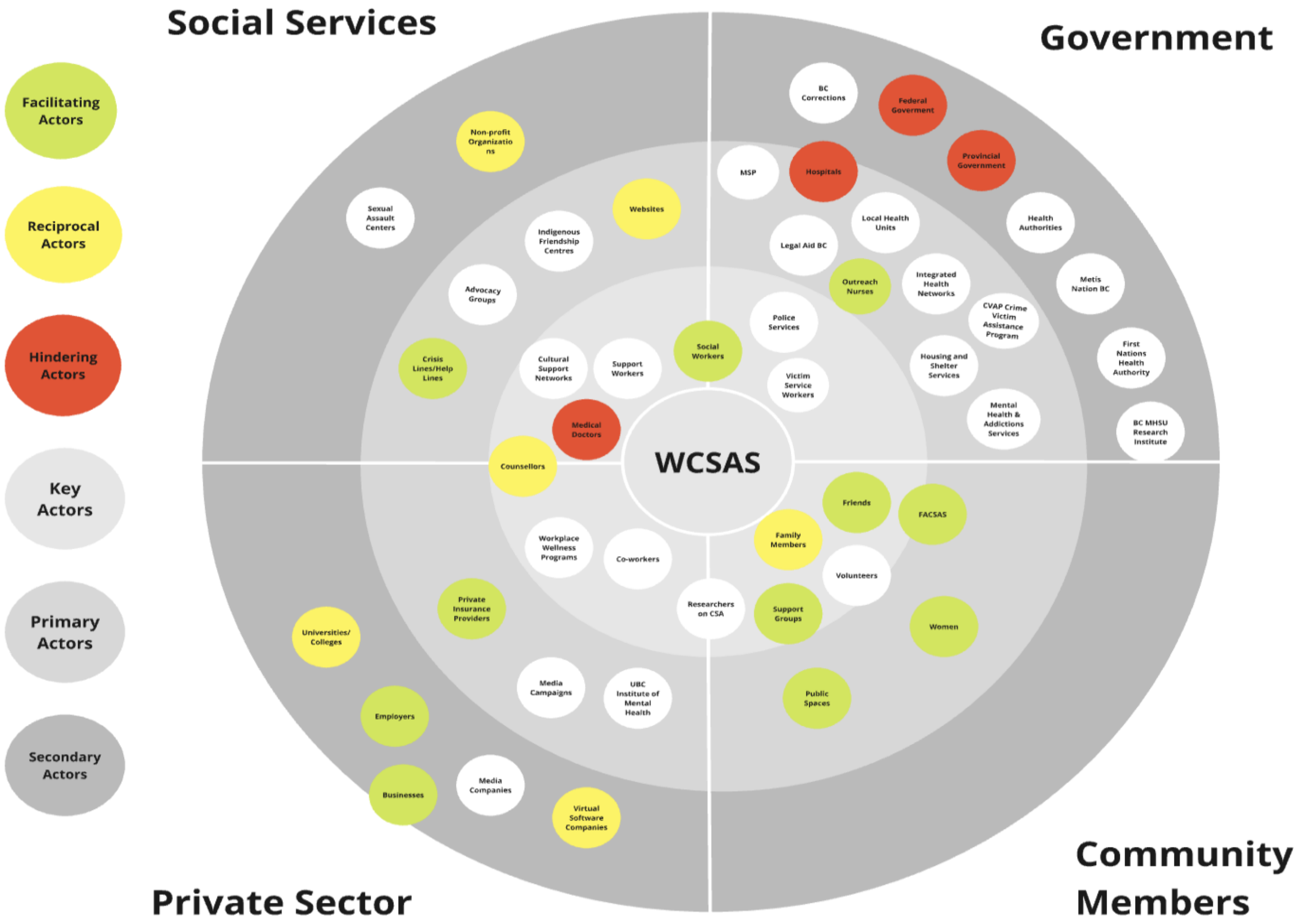
Throughout their interviews, participants of the study mentioned several key actors.
The following actor map highlights the key, primary, and secondary actors connected to WCSAS accessing mental health services. Key actors are those in direct contact with WCSAS; primary actors provide services or resources to WCSAS, and secondary actors provide services to the overall system. Based on the data results, the actors are further categorized by colour into facilitating, reciprocal, and hindering (Figure 7). This actor map allows the reader to understand the general landscape, context, perspectives, and patterns of relative actors within the system (Gopal & Clark, n.d.). On this map, not all the actors are highlighted in colour; these actors also exist within this system but were not mentioned by study participants. Three different sections of this map are coded in grayscale. As they branch out from the center, these circles illustrate the key, primary, and secondary actors connected to WCSAS. For instance, friends are considered key actors due to their significant influence over WCSAS. Hospitals are regarded as primary actors, as they provide services for WCSAS. The Provincial government is listed as a secondary actor, since it provides funding for services.

The map also features four quadrants representing different societal sectors. The Private Sector includes businesses and for-profit organizations, Community Members signify various community groups, Social Services denote non-profit organizations and a range of public programs and services focused on public health and well-being, and Government encompasses municipal, provincial, and federal government entities and groups.

Three key patterns emerge from the actor's map for facilitating, hindering and reciprocal groups. According to study participants, most Facilitating Actors can be seen in the map's Private Sector and Community Members sections. Reciprocal Actors are spread out amongst all sectors apart from the Government, and the Hindering Actors exist primarily within the Government section of the map. Most Key and Primary Actors are identified as facilitating actors, while Reciprocal Actors dominate the secondary actor section of the map. This indicates that, from the participants' perspectives, government-affiliated actors are commonly seen as oppressive and are viewed as central to access barriers.

Another key takeaway from the actors' map is the large number of unmentioned actors within the government sector, for example, health authorities and local health units. This suggests a lack of awareness of the programs and actors WCSAS are connected to in the government sector.

Figure 7. Actors Map



Note. This actor's map depicts primary and background research results.

Causal Systems Map

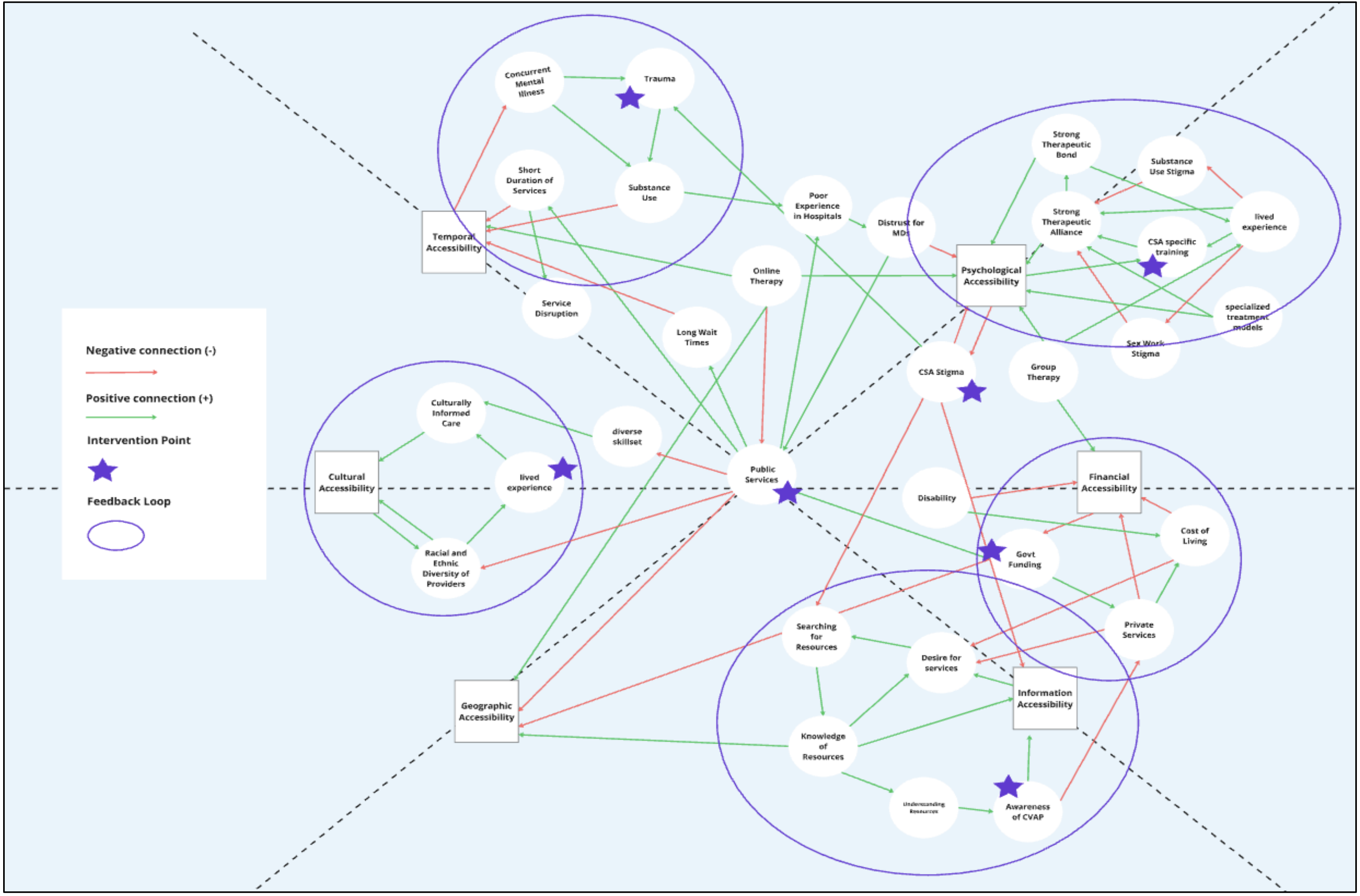
The key themes and components identified in Chapter 5 were used to create and connect variables within a causal systems map representing the system described by study participants (Figure 8). This map visually illustrates the relationship between factors influencing mental health service access for WCSAS in BC.

The causal systems map that has been developed contains six quadrants' that highlight six different types of accessibility, which include:

- Geographic Accessibility - Availability of services in proximity.
- Informational Accessibility – Availability and awareness of information regarding services.
- Financial Accessibility - Affordability of services.
- Psychological Accessibility – Willingness and ability of WCSAS to seek out services and feel connected to service providers.
- Temporal Accessibility – Availability of high-quality services when WCSAS need them.
- Cultural Accessibility – Services tailored to diverse cultural backgrounds.

The map shows both positive and negative connections between key variables. Green arrows represent positive connections or linkages. These are connections where both variables move in the same direction, for instance, as knowledge of resources increases, so does information accessibility. Negative connections are depicted as red arrows. These represent connections where two variables move in opposite directions. For example, an increase in substance use results in a decrease in temporal accessibility. The arrows between variables have created several feedback loops that both stabilize and amplify the current system within the causal systems map. Feedback loops occur when the output of a variable is fed back into the system as an input (Simon Fraser University, n.d.). The key feedback loops discussed in this chapter are highlighted in purple on the map. Intervention points are depicted as purple stars on the map. Intervention points, otherwise known as leverage points, are areas within the same where changes applied can have a significant effect on the rest of the system. They are ideal areas where mitigation measures should be implemented. Intervention points can be identified within feedback loops and also in variables that function as highly interconnected nodes. The most highly connected node is Public Services, which has been found to be one of the chosen intervention points. The intervention points will be presented after the feedback loops.

Figure 8. Causal Systems Map



Note. This Causal Systems Map represents WCSAS accessibility to BC mental health services.

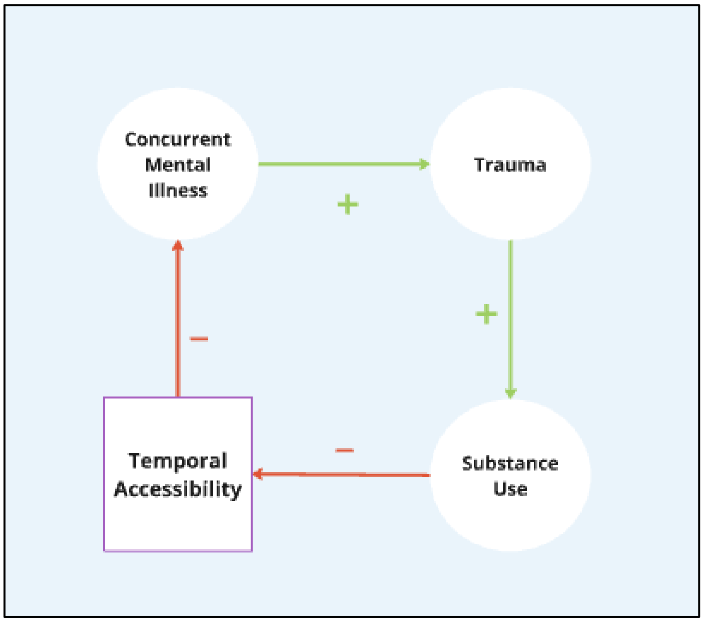
Feedback Loops

From the causal systems map, five feedback loops were pulled for discussion. Two balancing loops and four reinforcing loops were discovered. Balancing feedback loops occur when there is countered change in each direction within the loop; this creates a balancing effect with the system and seeks to "bring things to a desired state and stay there" (Lannon, 2023, p. 4). Alternatively, the reinforcing feedback loops compound change in a positive (increasing) direction, thus creating a growth effect that sustains and amplifies the cycle. Feedback loops can be desirable or undesirable; when increasing access to services for WCSAS, the balancing feedback loops are not desirable, while the reinforcing feedback loops are.

Balancing Feedback Loop – Temporal Accessibility

The balancing loop depicted in Figure 9 represents a stabilizing relationship between concurrent mental illness, trauma, substance use, and temporal accessibility. Concurrent mental illness increases rates of trauma, and trauma increases rates of substance use among WCSAS. However, substance use decreases the level of temporal accessibility. Within this study, participants shared experiences of being prohibited from accessing certain mental health services due to their history and/or current substance use. This feedback loop depicts how the reinforcing relationship between these variables prohibits a change in temporal accessibility. Concepts of mental illness, trauma, and substance use work together within the complex system to limit the availability of temporal accessibility for WCSAS.

Figure 9. Balancing Feedback Loop (Temporal Accessibility)

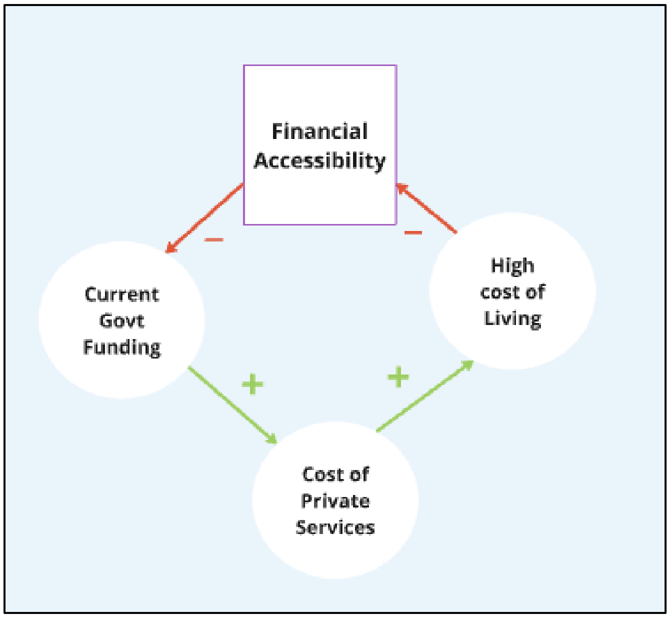


Note. Balancing feedback loop illustrating the relationship between mental illness, substance use, trauma, and temporal accessibility.

Balancing Loop – Financial Accessibility

The balancing feedback loop illustrated in Figure 10 visualizes how current government funding, the cost of private services, and the high cost of living contribute to decreased financial accessibility. The loop illustrates how financial inaccessibility is perpetuated by its connection to current government funding, private service costs, and the high cost of living in BC. As financial accessibility declines, there is an increase in government funding; however, this rise could lead to an inflation of the cost of private counselling services due to heightened demand for services. The increased costs of private services further raise the cost of living for WCSAS as they struggle to cover higher rates for privatized services. This rise in the cost of living further diminishes financial accessibility. This loop illustrates how financial accessibility for WCSAS is sustained. There is resistance to positive change within this loop, as it reinforces funding cycles.

Figure 10. Balancing Feedback Loop (Financial Accessibility)

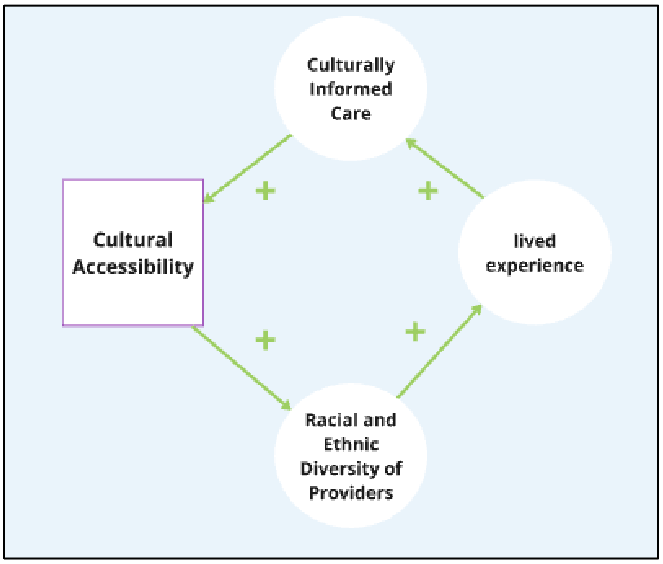


Note. Balancing feedback loop representative of the relationship between current government funding, cost of private services, high cost of living, and financial accessibility.

Positive Reinforcing Loop – Cultural Accessibility

The positive reinforcing feedback loop displayed in Figure 11 represents the relationship between racial and ethnic diversity among providers, lived experience, culturally informed care, and cultural accessibility. The relationships between the variables within this loop support and amplify its effects; in this case, cultural accessibility increases through culturally informed care. Culturally informed care is strengthened by lived experience and racial and ethnic diversity among service providers. Additionally, cultural accessibility boosts and encourages the presence of more racial and ethnically diverse service providers. This loop implicates momentum and growth for cultural accessibility, thereby promoting healing for WCSAS. There is great power for change within this loop, but it is important to recognize its weakened connection to the rest of the system. This loop is not supported by BC's current public services, so while it exists, its strength cannot be fully actualized without integration and support from the remainder of the system.

Figure 11. Positive Feedback Loop (Cultural Accessibility)

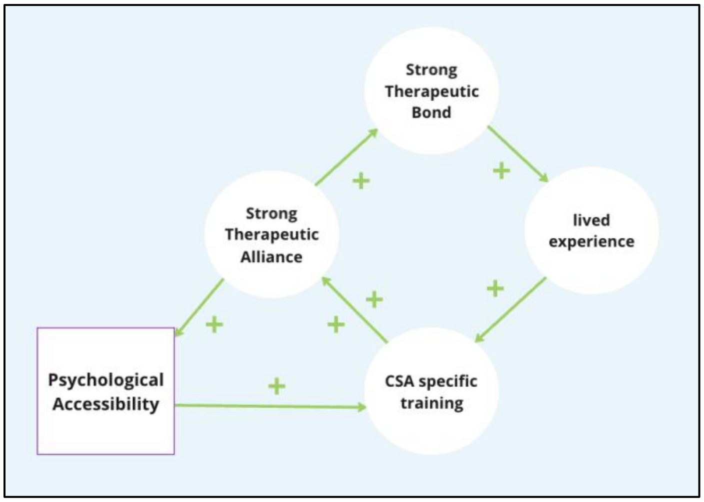


Note. Positive reinforcing feedback loop illustrating the relationship between cultural accessibility, racial and ethnic diversity of providers, lived experience, and culturally informed care.

Coupled Positive Reinforcing Loop – Psychological Accessibility

In Figure 12, two positive reinforcing loops are connected through the variables Strong Therapeutic Alliance and CSA Specific Training. These two loops enhance each other, with growth in one loop fostering growth in the other. Both loops contribute to greater emotional accessibility and illustrate how training and lived experiences, both directly and indirectly, bolster psychological accessibility for WCSAS. Combining these two loops creates accelerated growth and supports increased social change. This leads to long-term emotional accessibility for WCSAS.

Figure 12. Coupled Positive Feedback Loops (Psychological Accessibility)

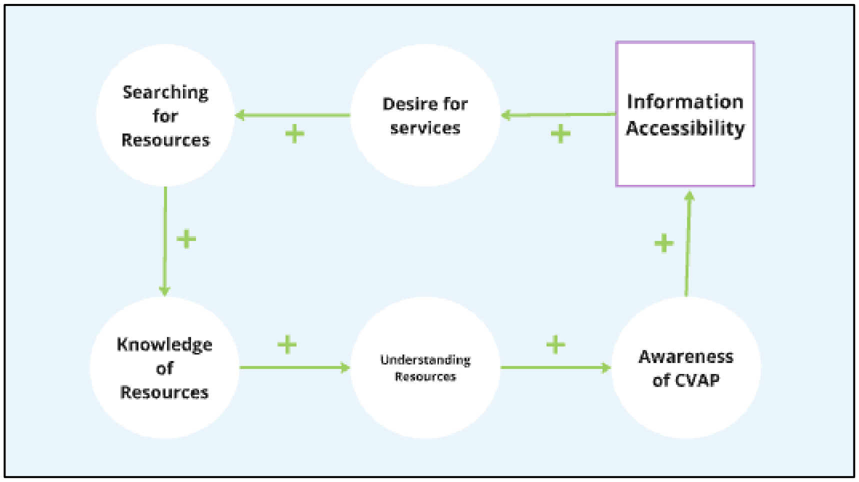


Note. Coupled positive reinforcing feedback loops, connected through variable strong therapeutic alliance and CSA-specific training.

Positive Reinforcing Feedback Loop – Informational Accessibility

The final feedback loop can be found below in Figure 13. This positive reinforcing feedback loop illustrates the relationship and journey for WCSAS when trying to understand and gather information regarding available resources. This loop shows how informational accessibility self-amplifies and leads to increased growth if uninterrupted. As information accessibility increases, CSA stigma decreases, leading to an increase in desire for services. It is important to recognize that this loop faces multiple barriers, including low awareness rates of CVAP and limited resources for WCSAS.

Figure 13. Positive Feedback Loop (Information Accessibility)



Note. A positive reinforcing feedback loop represents the journey from the initial desire for services to increased information accessibility.

System Narrative

The WCSAS participants in this study identified key variables and factors related to six distinct types of access to mental health care: temporal, psychological, cultural, financial, geographic, and informational. The six types of accessibility are deeply interconnected and must be understood within a broader context of structural inequalities and interlocking forms of oppression. While there is a high level of interconnection within this system; however, this narrative will focus on the two root causes that underpin and reinforce a majority of the relationships within the system: financial inaccessibility and stigma. Both are deeply shaped by intersectional dynamics and contribute to enduring feedback loops that reinforce exclusion and trauma.

Financial inaccessibility is typically indicated by income levels that affect access to public programs and the costs of services and living expenses. However, an intersectional analysis recognizes that income disparities are not merely economic, but are the outcomes of gendered, racialized, colonial, and ableist structures.

When public services are adequately funded, individuals with lower incomes can afford to seek help, and with lower living costs or higher incomes, WCSAS can afford to seek and pay for private services. In both scenarios, WCSAS often faces lower income levels and struggles to access sufficient public services due to financial barriers on either side. Insufficient funding for public services constrains the system's capacity to offer services that reflect culturally safe, trauma-informed, and intersectional responsive care, which may weaken the connection between MHSP and WCSAS. With fewer programs available, longer wait times occur, and those receiving services may experience shorter or less frequent sessions. Services that require funding are usually more accessible in or near urban areas. Inadequate funding worsens these issues in rural areas. WCSAS's experiences with publicly available services influence their level of trust in practitioners, government organizations, and other sectors. This systemic inequity not only restricts therapeutic access but also reinforces cycles of trauma and socioeconomic marginalization, especially for women with intersecting vulnerabilities such as racialization, disability, or rural residency.

Stigma functions as both a root cause and a symptom within this complex system. It intersects with structural inequalities to exacerbate financial, cultural, and psychological barriers to care. Survivors often contend with multiple stigmas related to mental illness, sexual abuse, and identity, which hinder their help-seeking behaviors and undermine trust in service providers. The internalization of societal judgment and the fear of disbelief discourage many from accessing already limited services. This stigma is especially severe for racialized, Indigenous, queer, and disabled women, who face institutional discrimination layered over their trauma. Stigma is not only experienced interpersonally but is also embedded in institutional practices that favour short-term crisis responses over long-term healing. These experiences and dynamics reinforce mistrust in service systems and providers, and make services not only less accessible, but also less safe and less relevant to the lived realities of those most in need.

Consequently, stigma and financial inaccessibility form mutually reinforcing feedback loops, sustaining service exclusion and mental health disparities for WCSAS across the province.

Insufficient system funding restricts access to programs and services that aim to combat stigma for WCSAS. While this stigma persists, WCSAS are less likely to seek support, access accurate information, or engage with systems that they perceive as unwelcoming or harmful. This dynamic reinforces system-wide inequities, disproportionately affecting those living at the intersections of multiple oppressions.

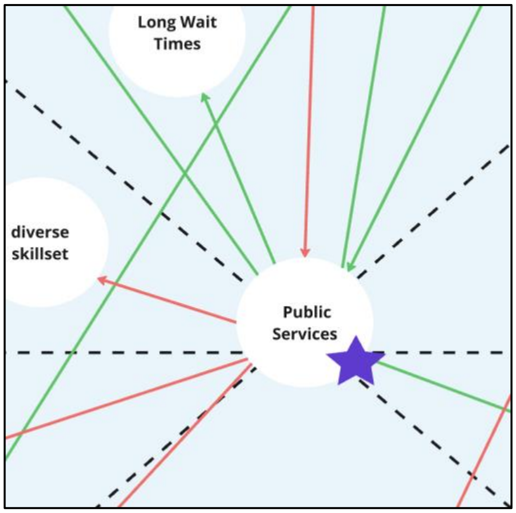
Intervention Points

Five feedback loops within the causal system map have been identified. These loops illustrate how, from the perspective of study participants, patterns are reinforced within the system, resulting in both negative and positive impacts on WCSAS overall. To better understand how to modify this system to create a lasting impact, seven intervention points have been identified. Also known as leverage points, these intervention points are places within a system where action can disrupt its functioning and/or create short-term or long-term change (Reinsborough & Canning, 2022).

Public Services

Meadows (1999) describes system infrastructure as an effective means to instigate change within a system. One of the most interconnected variables within this system is Public Services (Figure 14). Most feedback loops and types of accessibility stem from or feed into this variable. BC’s current public services hinder other areas and positive feedback loops, such as the one focusing on Cultural Accessibility. Study participants have identified a lack of publicly available services, so an effective intervention in this system would involve altering the rate of current public services to increase capacity.

Figure 14. Intervention Point – Public Services (Variable)



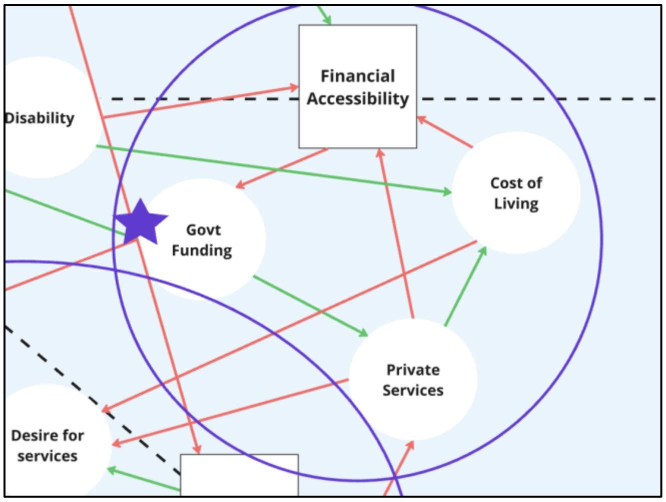
CSA Stigma

The most foundational intervention point within this system is CSA stigma. CSA Stigma is a paradigm intervention point. As it modifies, transcends, or expands a paradigm's beliefs, it is the most influential way to change a system (Meadows, 1999). This is the highest leverage point, as CSA Stigma actively reduces psychological and information accessibility. CSA Stigma also increases the variable Trauma, which supports the balancing feedback loop displayed in Figure 8.

Balancing Loop - Financial Accessibility

Balancing feedback loops are mentioned as effective sites of intervention due to their self-correcting nature (Meadows, 2009). Within this loop lies a key structural intervention point within the system: Government Funding. This variable controls the function of the entire system through its direct linkage to and support for Public Services. If government funding is intervened, it will disrupt the balancing feedback loop, increasing financial accessibility to the system (see Figure 15).

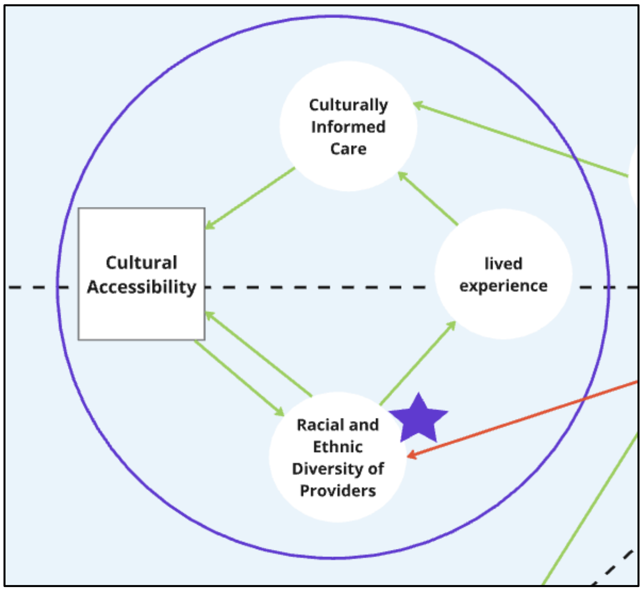
Figure 15. Intervention Point – Government Funding (Balancing Feedback Loop)



Positive Reinforcing Loop – Cultural Accessibility

Within this study, the racial and ethnic diversity of providers has been mentioned by study participants as being central to their cultural accessibility. The positive feedback loop depicted in Figure 16 shows that the racial and ethnic diversity of providers is highly connected and a valuable type of lived experience for WCSAS. Positive feedback loops are self-correcting, however, despite the positive impacts of this loop within the system, it is disconnected from the rest of the structure as public services do not support the racial and ethnic diversity of providers (Meadows, 2009). To experience the benefits of this loop, it must be connected to the system positively by working to increase the number of racial and ethnically diverse providers in the public mental health care system. Racial and ethnic diversity is focused on in this loop due to its prevalence within primary data.

Figure 16. Intervention Point – Racial and Ethnic Diversity of Providers (Positive feedback loop)

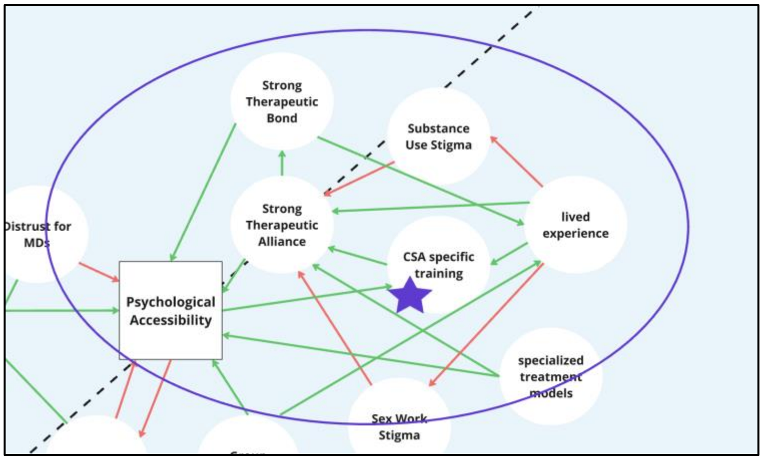


Note. The noted variable from this feedback loop is not supported by the remaining system.

Coupled Positive Reinforcing Loop – Psychological Accessibility

The conjoined positive feedback loops identified in Figure 17 are another key intervention point within this system. CSA-specific training is essential for promoting psychological accessibility for WCSAS. This variable connects both feedback loops and directly supports a strong therapeutic alliance. CSA-specific training is crucial for sustaining these loops; without this variable, both loops cease to function.

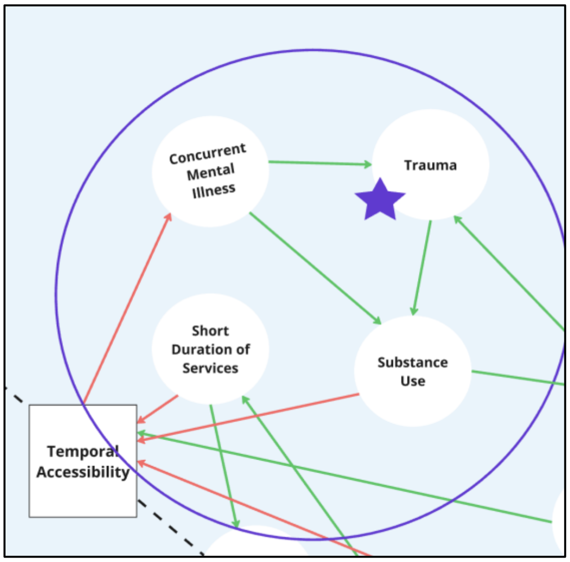
Figure 17. Intervention Point – CSA Specific Training (Conjoined positive feedback loops)



Balancing Feedback Loop – Temporal Accessibility

In this particular case, this feedback loop maintains a negative impact on temporal accessibility for WCSAS (Figure 18). This loop also illustrates how the variable trauma is connected to and central to this inaccessibility. The variable trauma is a key leverage point, as it serves as a highly connected node and is positively linked to the rest of the system.

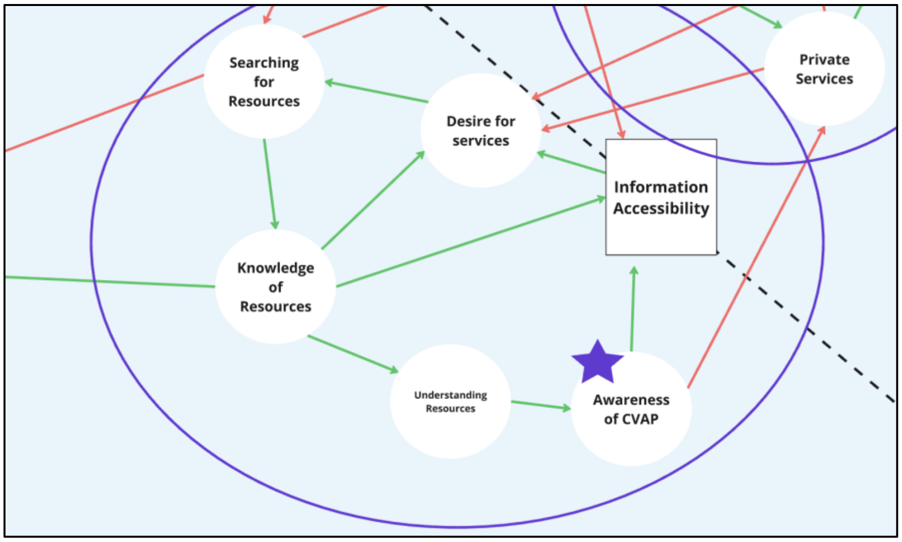
Figure 18. Intervention Point – Trauma (Balancing feedback loop)



Positive Reinforcing Feedback Loop – Informational Accessibility

A key variable within this loop is awareness of the crime victim assistance program (Figure 19). The benefits of this program are significant for WCSAS, who are service users; however, the WCSAS participants in this study did not seem to be aware of the program's existence. This variable, therefore, disconnects this loop from the rest of the system and is an important place to begin an intervention to introduce the benefits of this loop into the broader system.

Figure 19. Intervention Point – Awareness of CVAP (Positive feedback loop)



Summary

The mental health system for WCSAS in British Columbia is sustained by a series of interconnected feedback loops that either reinforce inaccessibility or offer pathways for positive change. One prominent balancing loop involves the interaction between concurrent mental illness, trauma, and substance use. As mental illness increases, so does the prevalence of trauma, which in turn escalates substance use—a coping mechanism that disqualifies many WCSAS from accessing services due to restrictive eligibility criteria. This results in diminished temporal accessibility, particularly when services are limited to those not actively using substances. Participants in this study described being excluded from care solely based on substance use history, reinforcing a cycle where the need for support grows but access shrinks, thus deepening systemic exclusion.

In contrast, positive feedback loops offer a vision for transformation, particularly in areas of cultural, psychological, and informational accessibility, however, these pathways are not fully accessible. Cultural accessibility is strengthened through culturally informed care and a workforce reflective of diverse racial and ethnic backgrounds. This inclusivity fosters greater trust and healing among WCSAS, attracting more diverse practitioners and amplifying momentum for culturally informed care. Similarly, psychological accessibility is enhanced by a strong therapeutic alliance that is grounded in CSA-specific training that empowers mental health service providers (MHSP) to build trust and safety with WCSAS. Informational accessibility functions as a self-reinforcing loop: as awareness grows, stigma diminishes, increasing the desire for services. However, this potential is stifled by low awareness of programs like CVAP and limited outreach resources. Finally, financial inaccessibility emerges as a significant constraint, perpetuated by insufficient public funding, high cost of private services, and an increasingly high cost of living. Even when government funding increases, the resulting demand might drive up private service fees, putting pressure on survivors and limiting access. An example of this is the Better Access initiative in Australia, where private service prices rose after the program was introduced. (Canales, 2024). These interlocking feedback loops demonstrate how systemic barriers and limited interventions maintain the status quo, and highlight where identifying intervention points can promote equitable and suvivor-centered change.

This chapter employs a system thinking perspective to review the data collected during the study. An actor's map and causal systems map were developed to understand the relationships between actors and variables from the participants' point of view. The actor's map highlights that most obstructive actors are found in the government sector, while facilitating and reciprocal actors are present in the private and community sectors. The causal systems map reveals six different types of accessibility linked to variables presented by the participants. Within this map, certain feedback loops and intervention points were identified for discussion. Their significance will be further elaborated on in the following chapter.

To improve access to mental health services in BC for WCSAS, changes are necessary to enhance each type of accessibility while acknowledging the interconnections between these types as a whole. Although the list of intervention methods is extensive, this chapter identifies six crucial points of intervention to start with. A compiled list of intervention strategies will be provided in Chapter 6. Efforts should include increasing public mental health services for WCSAS, boosting government funding without raising the cost of private services, supporting the racial and ethnic diversity of MHSPs, refining and establishing CSA-specific training in all areas of the healthcare sector for professionals, focusing on preventative measures to reduce trauma, and improving public awareness of the Crime Victim Assistance Program.

Chapter 6. Discussion

In this chapter, the theoretical connections between study results and existing literature will be established and critically examined. The primary data in Chapters 4 and 5 connect to preexisting literature and points in this study's literature review. Connections to other bodies of work both reaffirm and challenge the perspectives of the study participants, which demands further discussion. This chapter will also discuss the unanticipated findings of the study and revisit the conceptual framework to make any necessary adjustments.

Theoretical Connections and Analysis

Theme: Barriers

Sub Theme: Economic. Both WCSAS and MHSP participant perspectives on the financial barriers survivors experience when seeking resources align with pre-existing literature and research on the topic outside of BC. The cost of private counselling services coupled with inadequate funding by the provincial government has been touched on by Schoon and Briken (2011) in Germany and Gibbons (2011) in Australia. While researchers outside of Canada have acknowledged these barriers for CSA survivors, within Canada, researchers such as Moroz et al. (2020) and Bartram (2018) have also recognized financial barriers, but without a CSA lens. They recognize that private counselling is generally unaffordable for vulnerable populations in Canada.

The Canadian Mental Health Association (CMHA) suggests that provinces should spend 12 percent of their overall health budgets on mental health care – in reality, Canadian provinces spend an average of 6.3 percent on mental health care. Canada already fails to meet the bar compared to other nations such as France (15%), Germany (11%), UK and Sweden (9%) (CMHA British Columbia, 2024).

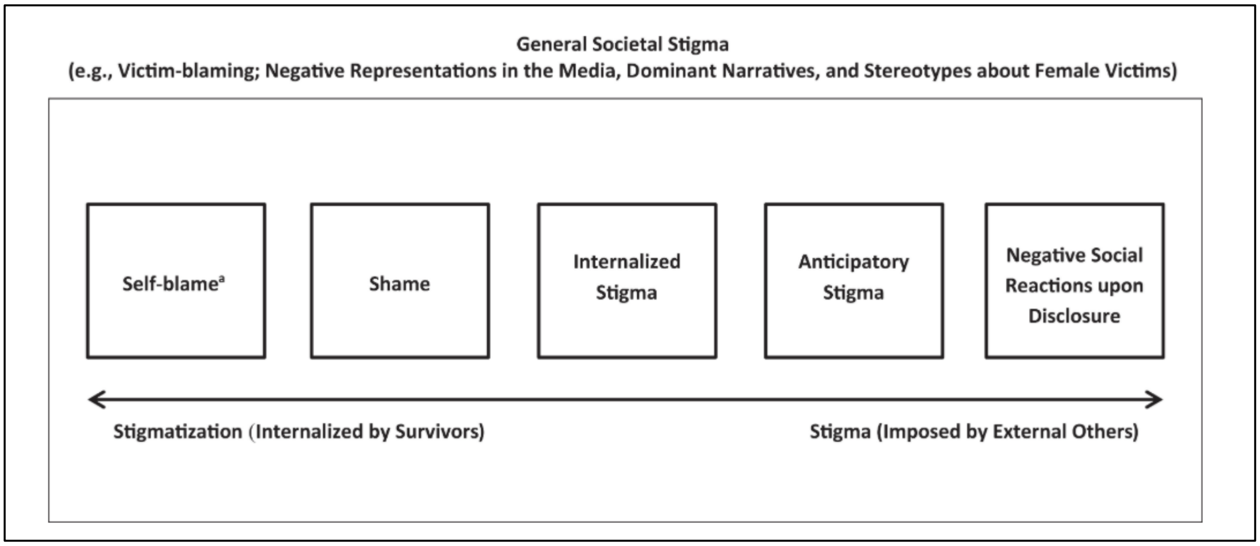
In 2024, the CMHA BC (2024) called for an expenditure of no less than 10% on mental health care in BC in addition to asking for a stepped care system, "universal access to publicly funded and delivered counselling and psychotherapy through a combination of targeted and sustainable grants for those who need it most and a new insurance-based model that works with existing private insurance models" (p.27). A universal stepped-care system would ensure that individuals in critical need of mental health services such as counselling would receive those services in a timely manner and would be able to afford them.

Sub Theme: Social.

CSA Stigma. Finkelhor and Browne (1985) describe stigma and stigmatization as "the negative connotations—*e.g.*, badness, shame, and guilt—that are communicated to the child around the experiences and that then become incorporated into the child's self-image." (p. 532-533). This can occur in many ways, from enforcing secrecy to victim blaming.

Kennedy and Prock (2015) elucidate the various forms of stigmatization. These forms exist on a spectrum that ranges from internalized stigmatization by survivors to stigma imposed externally by others. Participants' experiences similarly spanned the spectrum shown in Figure 19.

Figure 20. *Stigmatization spectrum by Kennedy & Prock (2015)*



Note. Image of stigma and stigmatization forms by Kennedy & Prock (2015).

The impact of an active or passive reaction to the disclosure of abuse has lasting effects on a survivor. Participant C's powerful insight on how the individual a survivor chooses to disclose to can act as a powerful barrier aligns with this notion. Research indicates that negative reactions are associated with stronger PTSD symptoms and reduce the chance that the survivor will seek support (Schoon & Briken, 2021).

Stigma and shame have been recognized in previous studies as common experiences for child sexual abuse survivors. Kennedy & Prock (2015) describe what these participants have shared as being anticipatory stigma where survivors feel as though they will be blamed and demoralized if they disclose their abuse. Stigma is mentioned as a key barrier during the literature review by a multitude of authors, including Thompson et al. (2015), Corrigan (2004), Lamoureaux & Joseph (2014), and Wang (2006). Study participants also shared how stigma operates from a smaller community-based level to a broader societal level through promoting secrecy within families, communities, and government institutions.

Sex Work Stigma. Perspectives from the women in the study regarding sex work stigma strongly implicate the importance of providing mental health services that are free of sex work stigmatization and criminalization as they ensure a breach of trust between clients and providers. Antebi-Gruszka et al. (2019) similarly warn of this result by stating, "sex work stigma among mental health practitioners could be harmful to the therapeutic process in several ways, such as ruptures and premature termination, and could eventually lead to differential, unfair, and even unethical treatment of CSW" (p. 340).

Substance Use Stigma. Participant B's observation of how mental health problems and substance use are connected is becoming more commonplace; however, the understanding that some people who use substances are currently still unable to access mental health services in BC is an important realization. The Public Health Agency of Canada (2020) published *A Primer to Reduce Substance Use Stigma in the Canadian Health System* with the key message: "Substance use stigma is prevalent throughout the health system and contributes to poorer quality of care and negative health outcomes" (p. 5). Despite the recognition of this problem by the federal government four years ago, women still are turned away from care due to substance use, as mentioned by study participants.

Grimminck et al. (2023) claimed that individuals living with mental health substance use (MHSU) disorders disproportionally face structural stigma that fosters "inequitable deprioritization, devaluation, and othering" (p. 225). One of the ways that structural stigma has manifested itself in the BC health care system, according to Grimminck et al. (2023), is through the "artificial separation of services for substance use disorders and mental illnesses, especially since concurrent disorders are the rule rather than the exception" (p. 225).

Sub-Theme: Structural.

Locating resources. Difficulty accessing resources is a barrier often shared by WCSAS on a global scale. In Germany, for instance, Schoon and Briken (2021) noted that childhood sexual abuse survivors struggled to locate resources. Similarly to Participant D's experience, survivors in Germany found that there was "missing information for survivors on official websites, and a lack of support in finding the appropriate information" (p. 7).

While many of the participants of this study were not attending secondary school at the time of their interviews, the absence of adequate education on consent can be traced up to 2022, when the term 'consent' ceased to exist in curriculum vocabulary and, in its stead, offered the term 'healthy relationship'. Participant H's acknowledgement of this gap in the curriculum had become common as four BC school districts saw students protest over the lack of sexual consent education in April of 2022 (Hyslop, 2022). Following this protest, five months later, in November of 2022, the Ministry of Education and Child Care announced that they would update their curriculum to include consent and gender-based violence teachings for students in kindergarten to Grade 12 (Bowman, 2022). Despite recent updates to the public school curriculum, it is important to note the impact that the absence of sexual consent education has had on survivors in BC.

Long wait times. Long wait times are widely recognized as a barrier to accessing mental health services in Canada. Psychiatric and community care that is "not integrated with healthcare services" frequently require long wait times for service users (Moroz et al., 2020, p. 282). Study participants expressed frustration as in times of crisis, they were required to wait weeks, months and even years to see a mental health professional through publicly funded services.

One of the study participants shared that receiving a mental health diagnosis was important to them before they tried to access counselling services as it allowed her to narrow her search and specifications. The shortage of psychologists and psychiatrists in BC delays the temporal accessibility of counselling services for some survivors. Dr. David Dozois, an advocate for provincial and territorial health plan expansion into mental health services, explains that many psychologists and psychiatrists in Canada move into private practice as it is more financially profitable (Becken, 2023). Long wait times to see both medical doctors and public MHSP create a ripple effect through the entire system that exacerbates service provider burnout, service user stress, and temporal and geographic inaccessibility.

Absence of Services. Pre-existing academia on psychotherapy practice for CSA survivors suggests that individual psychotherapy has great benefits for CSA survivors, as it creates a safe therapeutic environment in which to build trust and a strengthened therapeutic relationship with their service providers (Sanderson, 2006). Provided that CSA survivors have experienced severe trauma, they may have difficulties forming a strong therapeutic alliance (Keller et al., 2011). These previous findings correlate with the experiences of participants of the study, who commonly shared that they have, at times, experienced difficulties forging a therapeutic alliance with their provider. WCSAS and MHSP study participants agreed on a shortage of publicly available services. Participant MHSP reflected on the availability of mental health clinics that accept walk-in clients and the exacerbated reliance on non-profit organizations to provide mental health care.

Hospitalization Experience. Study participants commonly held negative experiences within hospitals when trying to access mental health care and support. Participants' experiences ranged from feeling dismissed by hospital staff, isolated from their respective communities, and not provided with adequate resources such as counselling. The most recent provincial survey, accessing the utilization of mental health services at BC hospitals, was in 2011, thus illustrating a need to investigate further by conducting research on the experiences of women accessing psychiatric inpatient care (Provincial Health Services Authority, 2025).

Sub Theme: Service.

Therapeutic Approach & Professional Training. Each WCSAS study participant mentioned disagreeing with one or more approaches by a service provider. These approaches ranged, but participants commonly shared instances where providers who knew of their CSA history would push them to discuss certain topics or memories that they wished not to, thus negatively impacting their therapeutic alliance. Within pre-existing literature, one of the key characteristics named by professionals in the field of treating CSA survivors is providing a safe space where the survivor feels in control. An approach such as the one mentioned above is considered high risk when it comes to working with CSA survivors as it can trigger and re-traumatize the client. In *Counselling Adult Survivors of Child Sexual Abuse*, Sanderson (1990) explains that power dynamics associated with a client's experience of abuse can manifest in the therapeutic process, "whereby the survivor's identification with the abuser is acted out or projected onto the counsellor" (p. 102). By failing to respect boundaries, service providers risk mimicking a power dynamic within the therapeutic relationship that resembles that of the CSA the client experienced. To improve their approach to be inclusive to the needs of CSA survivors, healthcare and mental health service providers can incorporate lessons from the *Handbook on Sensitive Practice for Health Care Providers* and CSA-specific training into their practice. This handbook's second and eighth principles are relevant to this barrier. The second principle emphasizes taking time, while the eighth focuses on understanding non-linear healing, emphasizing the importance of patience, active listening, and boundary setting (Schachter et al., 2008).

Schoon and Briken (2021) found that CSA survivors in Germany similarly perceived that service providers at times lacked the necessary qualifications or experience to assist them, resulting in their needs being unmet during counselling sessions. WCSAS and MHSP participants in this study noted inadequate experience as a barrier to access in BC. Until 2024, the counselling and psychotherapy profession in BC was largely unregulated by the government, increasing risks for service users and providers, promoting provider migration, and instances of misconduct; however, in 2024, the regulation process officially began after extensive advocacy and inquiry (Canadian Counselling and Psychotherapy Association, 2025). The regulation of counselling and psychotherapy as a profession will help maintain educational standards for service providers, particularly those who work with individuals facing high levels of trauma.

Medical Doctors. In their interviews, some WCSAS participants shared their negative experiences when working with physicians in BC. This includes situations where the women did not feel heard, prioritized, or provided with necessary information by their doctors. For some participants, their personal experiences working with medical doctors have developed an outlook on the profession that lacks trust and competency when working with women. The relationship between medical doctors and CSA survivors has been studied outside of Canada, in places such as Israel, where survivors frequently mentioned their healthcare system boasting “a lack of knowledge among health care professionals on CSA, improper diagnoses and an excessive administration of medication” (Tsur et al., 2023, p. 4). Participants from the study shared similar concerns.

Service Disruption. Multiple participants in this study shared that they had been turned away from treatment by an organization or mental health service provider. Rejecting a CSA survivor in any form following the disclosure of their abuse may result in further traumatization. As Salter (1995) states, “the client's ability and willingness to tolerate the process of dragging things out of her anxiety closet is only half the issue. How that tale is received will determine whether the client is revictimized or empowered” (p. 261). This suggests that in the situations described by the women, no procedures considered the impact of the decision on them.

Duration of services. The short duration of counselling services was identified as a barrier by participants in the study and in the literature review. The MHSP study participant also expressed that, based on their experience working with CSA survivors, they recommended a minimum of six months to a year of optional weekly sessions, depending on the severity of the abuse. Chouliara et al. (2011), Gibbons (2011), and Schoon & Briken (2021) also mention the duration and consistency of services as a barrier. Chouliara et al. (2011) found that a group of CSA survivors in Scotland highly valued working with the same service provider throughout their counselling experience, as it allowed them to establish trust and a strong therapeutic alliance.

The recommendation made by the MHSP study participant regarding the preferred number of sessions differs from the guidelines in existing literature. The general recommendation for treatment models addressing severe trauma, such as EMDR, is around 12 sessions (American

Psychological Association, 2017). In contrast, a study conducted by McGregor (2003) found that among 190 CSA survivors in Australia, 60.5% attended between 11 and 100 sessions, 30% attended over 100 sessions, and only 9.5% attended fewer than 10 sessions. McGregor's findings challenge industry standards by showing that most participants required 8 to 12 sessions, a number that is routinely provided to CSA survivors in BC by non-profit organizations (Ending Violence Association of BC, 2023)

Sub Theme: Treatment Model. In this study, most participants sought counselling services of their own accord. Their reasons varied widely, ranging from neurodivergence to grief. McGregor (2009) found that 76% of respondents in their study identified one or more effects of CSA as the reason for seeking therapy. The participants in this study were likewise consciously aware of their mental health status and actively sought help. This is a positive sign; however, it contrasts with many women who live in cultures where help-seeking behaviour is stigmatized. One of the key barriers to accessing services for landed immigrants is the cultural stigma associated with mental health care. Regarding help-seeking, Almeida and Dolan-Delvecchio (1999) argued that "the conflict between values derived from religious/cultural(collectivist) cues and Anglo values (individualistic) inherent in the therapeutic process contributes to the underutilization of mental health services among ethnic minority populations" (p. 656). McGregor (2009) states that "while a history of CSA may have been the fundamental reason for seeking therapy, and participants may have sought therapy for effects resulting from CSA, many may not have connected the effects with their CSA histories at the time they sought therapy" (p. 110).

Online Services. Almost half of the WCSAS participants preferred accessing therapy services virtually, while two other WCSAS participants were indifferent to in-person or virtual therapy experiences. This indifference aligns with a study by Greenwood et al. (2022), which found no difference in effectiveness between in-person and virtual therapy.

Group therapy. Subsidized group therapy sessions have been offered to CSA survivors as an alternative to individual sessions by non-profit organizations such as the National Association of Adult Survivors of Child Abuse (NAASCA, 2025). Group therapy for CSA has been shown to be effective in previous studies and resources. In a study by Westbury and Tutty (1999), most of the women who had experienced CSA reported a positive experience with group therapy. In this study, Participant MHSP shared how group therapy can empower participants and help survivors build connections, an experience similar to that of Participant B.

While group therapy is viewed as a financially viable alternative to individual psychotherapy, it might not be suitable for every survivor. In her interview, Participant E shared her concerns about group therapy stemming from feelings of shame. Both group and individual counselling models present risks for survivors. For some, being alone in a room with just one other person could trigger distress or feel too intense or invasive; for others, expressing their feelings and thoughts in a group setting may be challenging, or they could feel overwhelmed by the contributions of other group members (Sanderson, 1990). Despite these points, both group and individual therapy offer significant benefits to CSA survivors. Nevertheless, group therapy should not be regarded as an adequate substitute for individual treatment models.

Sub-Theme: Service Provider.

Preferential methods. Study participants' familiarity and satisfaction with EMDR as a treatment method supports prior evidence and research asserting that EMDR is an effective and increasingly popular approach for working with trauma survivors. Montoya and Saunt (2024) concluded in their scoping review of EMDR's impact on CSA survivors that the model effectively reduces CSA-related symptoms and PTSD while also enhancing self-esteem. This finding aligns with the literature review published by Boterhoven de Haan et al. (2021), who assert that EMDR improves clients' self-view and outlook on the future (p.11). In her interview, Participant C provided testimony that corroborates this statement through her personal experience. Similarly, Participant MHSP discussed the effectiveness of EMDR, affirming the shared experiences of WCSAS participants.

Culturally Informed Care. Most WCSAS study participants expressed a desire for BIPOC service providers to be more accessible to BIPOC women. Having shared racial and/or ethnic backgrounds between service providers and users has been shown to help establish trust and rapport, and it also improves health outcomes, communication, and perceptions of care – a phenomenon known as Race Concordance (Moore et al., 2022). This contrasts with the findings of similar studies, where the effectiveness of treatment did not significantly differ when service users and providers shared racial or ethnic backgrounds (Meyer & Zane, 2013). Chang and Berk (2009) discovered that minority clients working with culturally dissimilar counsellors valued active engagement, culturally specific knowledge, and cultural competency. While some studies argue that hat shared racial and ethnic backgrounds between service provider and user do not impact the effectiveness of treatment, this may be different for CSA survivors as it does help develop trust, an often critical barrier for CSA survivors in treatment.

Therapeutic Alliance. The significance of the therapeutic alliance between the service provider and user was frequently mentioned by participants in the study and has been consistently highlighted by academics and professionals as foundational to the therapeutic experience (Olio & Cornell, 1993). Clinical Psychologist Christine Baker (1993) similarly discusses the therapeutic alliance, noting that working with survivors of sexual abuse has "made [me] aware that my general manner, demeanour, and verbal interaction can be of great significance in the development of a positive therapeutic relationship" (p. 88). A strong therapeutic alliance enhances treatment engagement and bonding while reducing the dropout rate (Keller et al., 2011). Given these benefits, developing a solid therapeutic alliance is essential for providing trauma-informed care. When working with CSA survivors, it is critical to forge a therapeutic alliance before leading the survivor to re-experiencing a traumatic event during their treatment, as it aids the provider's ability to foster containment within a session (Sanderson, 2006). Furthermore, strong therapeutic alliances between CSA survivors and service providers have been found to facilitate survivors' reconnection with themselves and provide a "correctional interpersonal experience" (Olio & Cornell, 1993, p. 512). The therapeutic alliance must be considered at every stage of planning and decision-making for mental health services for WCSAS.

Therapeutic Bond. Scholars have held differing views on the definitions of the therapeutic alliance. Most definitions, however, typically contain three themes: "the collaborative nature of the relationship, the affective bond between patient and therapist, and both the patient's and therapist's ability to agree on treatment goals and tasks" (Stubbe, 2018, p. 402). While the bond between the service provider and the user is acknowledged as a component of the therapeutic alliance, it merits further recognition due to its impact on the participants of this study. Therapeutic relationships are often "taken for granted" and receive minimal specification from academics and professionals regarding their role in the therapeutic process (Baker, 2002, p. 87). Most of the women in the study referenced this bond and the influence it has had on their lives; in some instances, they described their relationship with service providers as crucial to their healing, as it provided them with new experiences that were absent from their childhood, including feeling heard, valued, or even safe.

Theme: Intersectionality

Lived Experience. A common element shared among the various sub-themes of intersectionality is lived experience. Participants also valued the lived experiences shared by service providers in connection to their own. For service providers with this lived experience, their presence within the mental health care system actively challenges epistemic injustice, a term that refers to the "devaluation of the capacity of individuals from stigmatized subgroups as holders of knowledge" (Okororji et al., 2023, p. 2). Epistemic injustice describes "how people from marginalized groups are denied opportunities to create knowledge and derive meaning from their experiences" (Okororji et al., 2023, p.1). The lived experiences of service providers serve to confront epistemic injustice within the broader mental health system.

Sub-Theme: Disability. Participants who reported having a disability described varying experiences of financial security and resource support in the study. Those who indicated they faced financial difficulties and encountered challenges in accessing support reflected a common situation of financial hardship among individuals with mental and physical disabilities across Canada. People living with a disability have 30% fewer non-housing assets compared to their counterparts; additionally, employed women with disabilities earn, on average, 13.7% less than those without disabilities, and for full-time employees with disabilities, the pay gap is estimated to be 16.6% (Maroto & Pettinicchio, 2020; McDiarmid, 2019). Disability-related barriers are often left up to the person experiencing them to express their needs to service providers, however, "in some situations a service provider may have a duty to inquire about an individual's needs in order to comply" with BC's Human Rights Code (Milne & Hamfelt, 2019, p. 21). Improving the public's understanding of disability related barriers is necessary to empower WCSAS.

Sub-Theme: Race. The majority of participants highlighted the importance of culturally informed care through the availability of BIPOC service providers and adequate education levels along with the development of multicultural competence among all service providers. Bathje et al. (2022) conducted a survey evaluating the impact of multicultural competence on the therapeutic relationship and service outcomes. Multicultural competence, often referred to as culturally informed care, is viewed as "applicable and essential to counselling across theoretical orientations and presenting concerns" (p. 2). Two study participants shared real-life examples of how racial and cultural similarities between themselves and their counsellors strengthened their therapeutic alliance and built trust. The experiences of these two women emphasize the significance of culturally responsive mental health care. Sodhi (2024) states that “becoming trauma-informed, anti-racist, decolonized practitioners is a lifelong learning process” (p. 211). This journey is more complex for white practitioners who lack the lived experience of being a person of colour. Lived experience is essential for clients' comfort. Despite these findings, while racial and ethnic matching can foster trust in the early stages of treatment, it has been shown to have no long-term benefits for psychotherapy outcomes (Chakraborty, 2017). Regardless of this, the critical element of developing trust must be considered when approaching this issue.

In the study by Bathje et al. (2022), client evaluations of service providers’ multicultural competence were strongly linked to their assessments of the “therapeutic relationship, perceived support, therapist quality, and hope/expectancy for change.” The research further suggests that an alliance between the service provider and client is improbable in the absence of cultural competence, indicating that effective therapeutic relationships are rare in cross-cultural situations when the service provider lacks such competence (p. 13). The Government of British Columbia has publicly shared links to databases containing the contact information of BIPOC service providers. However, BIPOC service providers are still underrepresented in the field of psychology (Cho et al., 2017). It is important to provide opportunities for more BIPOC individuals to seek careers in mental health.

Sub-theme: Mental Illness. Several participants noted experiencing concurrent mental illnesses alongside the trauma of childhood sexual abuse. In the literature review, Chouliara et al. (2011) recognize this pattern from their research. One type of mental illness frequently mentioned by both MHSP and WCSAS study participants was substance use disorder. Gibbons (1996) also found high rates of substance use disorder among CSA survivors in their study. Existing literature reaffirms the correlation between addiction and childhood sexual abuse. This study discusses how substance use disorder creates economic barriers for survivors and presents unique obstacles that hinder access to and acceptance into mental health programs. Participants who addressed this issue conveyed that WCSAS clients with substance use disorder in BC find that some essential services do not adopt a comprehensive approach to trauma and substance use disorder, opting instead to treat each diagnosis separately or in different stages. BC Mental Health and Substance Use Services (BCMHSU) state on their website that they recognize the linkages between trauma, mental illness, and substance use, and they have integrated these principles into their mental health and substance use programs province-wide (Provincial Health Services Authority, n.d.). Existing literature on this subject has determined that individuals with substance use disorder and PTSD should have access to evidence-based treatments for PTSD and should not be denied care due to the presence of substance use disorder (Roberts et al., 2023). This is especially prevalent, due to the high number of substance users who have PTSD and pre-existing traumas.

Theme: Key Actors

The actor’s map in Chapter 6 visually depicts study participants’ understanding and perspective on who facilitates and hinders access to mental health services for WCSAS (Figure 3). Most of the actors named in the study as hindering access fall within the government sector; this suggests distrust and disdain for government bodies among study participants. This also demonstrates a high level of awareness among study participants of the influence that provincial and federal governments have in BC's mental health care system and in providing access to services. Depictions of the government as preventing access to care are common in Canada; however, a new study shows that 87% of Canadians want universal mental health care (CMHA BC, 2023).

Among the group of impeding actors, medical doctors were frequently mentioned by study participants. Canadians are generally taught that seeking advice from a physician is the first step in treating mental health issues or concerns. Psychotherapy training is not included in the official curriculum for family residents in Canada, despite estimates suggesting that incorporating psychotherapy services in primary care reduces overall medical costs by up to 30% (Alhawshani et al., 2019). Physicians typically address mental health inquiries from patients through diagnosis, prescriptions, and/or referrals. In a survey conducted by Alhawshani et al. (2019), 89% of the physicians who participated felt that psychotherapy should be integrated into family medicine, with 74% expressing interest in learning psychotherapy for their practice. In addition to limitations regarding psychotherapy training, there is currently a shortage of family physicians in British Columbia (Li et al., 2023, p. 1). This shortage has caused a ripple effect on specialists such as psychiatrists by increasing wait lists, burnout, and the erosion of patient/doctor relationships (Mason et al., 2024).

Most of the facilitating actors mentioned by study participants can be found in the quadrants labelled Private Sector and Community Members. Participants often identified their friends as key facilitators in providing access. Examples include friends offering information about resources, emotional support, and referrals to service providers. In a study by Powers et al. (2009), researchers discovered that strong support from friends can reduce the development of depression and other mental illnesses experienced by WCSAS. Other actors mentioned in the Community Members category include fellow survivors, support groups, women, and public spaces. It is important to recognize that these areas work to destigmatize CSA for survivors by providing spaces free from judgment and shame. All these actors share a lack of authoritarianism, as study participants maintain full control in their interactions with them, and the risk of rejection or support failure is minimal.

Frequently mentioned reciprocal actors include counsellors, non-profit organizations, and schools. The term reciprocal describes actors that study participants find both hinder and facilitate access to services. While study participants expressed differing experiences with these three actors, this is partly due to the high volume of interactions WCSAS typically has with them. Although study participants note complexity, there is an acknowledgment that these actors facilitate access more often than they hinder it.

Unanticipated Results

The first unanticipated result of this study was the seemingly low level of awareness among study participants regarding the Crime Victim Assistance Program. While this program is positioned in BC as a foundational funding resource to connect CSA survivors with private service providers, none of the WCSAS study participants mentioned it in the study. However, the program was mentioned multiple times by the MHSP study participants, who spoke highly of recent changes made to it. The general lack of awareness of this program raises concern, as it is one of BC's most heavily funded public resources for CSA survivors.

The second unanticipated result was that WCSAS study participants showed greater preference for online counselling services than in-person counselling services. While studies have shown that virtual and in-person sessions do not generally differ in effectiveness, some have shown that virtual counselling programs have a higher dropout rate (Torous et al., 2020). A study by Erbe et al. (2017) found the opposite.

Thirdly, Several participants in the WCSAS study indicated that it was crucial for their therapeutic alliance that their service provider understood and supported the sex work industry. In one instance, Participant H felt that an excessive focus on sex work support hindered the sessions, as it seemed performative and insincere.

Another unexpected result was that some participants' personal experiences with medical doctors have shaped an outlook on the profession that lacks trust and confidence when working with women. Participants often recalled experiences where they felt unheard and unsupported by medical doctors.

Lastly, the study's results showed that participants frequently referred to the duration of service as a barrier. Only one participant in the WCSAS study mentioned the duration of services as an obstacle. Participant MHSP expressed similar concerns, suggesting that CSA survivors should be offered a minimum of 24 fully subsidized counselling sessions. The lack of treatment duration as a barrier among WCSAS study participants indicates that they have not seen this as a major obstacle to access. This finding contradicts similar studies where CSA survivors have highlighted the significance of continuity and consistency (Chouliara et al., 2011).

Conceptual Framework Revisited

Upon reflection of the conceptual framework, the data collected in this study suggest an alteration. Two additional indicators, highlighted in yellow, have been added to the framework (Table 3). First, in terms of informational accessibility, a key construct that emerged during data collection was **prior knowledge of resources**. Participants described how outdated, inaccurate, or culturally irrelevant information often discouraged them from pursuing help. Prior knowledge and interpretations of resources can significantly impact how an individual progresses and what they seek to learn or unlearn. An individuals beliefs also impact informational accessibility. Cultural beliefs and family dynamics can heavily impact the ways and desires a WCSAS seeks out information, and influence what information is considered trustworthy and what help-seeking behaviors are encouraged or stigmatized. Thus, informational accessibility is not only about the availability of accurate information but also about how power, culture, and identity shape access to and interpretation of that information.

In addition, regarding psychological accessibility, another key construct that has been added is the **level of training and education of MHSP**. Data that exists within and outside of the bounds of this study suggests that certain treatment models, strategies, and therapeutic approaches can be attributed to a higher level of education on the topic of child sexual abuse, trauma-informed care, and culturally safe practice. Participants found themselves at times being matched to counsellors who were unable to treat them due to a lack of experience and education. An intersectional lens reveals that gaps in training often result in the misrecognition or dismissal of trauma that is racialized, gendered, or shaped by colonial and systemic violence. These disparities in provider capacity reflect broader systemic inequities—such as underfunding, professional gatekeeping, and a lack of intersectional education in mental health training programs.

Together, these new constructs underscore the importance of recognizing how interlocking systems of power—including racism, sexism, colonialism, ableism, and classism—shape both the accessibility and quality of care. Updating the conceptual framework to reflect these dynamics allows for a more comprehensive and equity-centered analysis of barriers to psychotherapeutic access for WCSAS.

Table 2. *Revised Conceptual Framework*

Concept	**Definition**	**Indicators**
Geographic Accessibility	Availability of services in proximity to service users.	• **Geographic location** (where does the WCSAS and MHSP live) • **Travel cost** (price of travelling to service) • **Availability of transportation** (What type of transportation is available, if any)
Informational Accessibility	Availability and awareness of information regarding services.	• **Source of information** (public, private, personal, government, educational) • **Type of resource** (print, online, poster, brochure, email, meeting, PSA) • **Comprehensiveness of resource** (how detailed is the resource) • **Prior knowledge or beliefs**
Financial Accessibility	Affordability of services.	• **Cost of service** (price of each session to the user) • **Income of service user** (how much the service user makes) • **Cost of living**
Psychological Accessibility	Willingness and ability of WCSAS to seek out services and feel connected to service providers	• **Therapeutic alliance** (trust and collaboration between MHSP and WCSAS) • **Treatment model** (type of therapy) • **Role of stigma** (how the negative connotations surrounding CSA impact accessibility to services) • **Level of MHSP training/education**
Temporal Accessibility	Availability of high-quality services when WCSAS need them.	• **Wait times** (time it takes to receive services) • **Flexibility** (ability for WCSAS to access services when they need them) • **Frequency/Consistency** (ability to access services routinely)
Cultural Accessibility	Services tailored to diverse cultural backgrounds.	• **Language barriers** • **Culturally informed care** (appropriate treatment models, awareness and knowledge of WCSAS culture, self awareness of MHSP)

Chapter 7. Conclusion & Recommendations

At the beginning of the research study, I asked four questions. By reflecting on the information provided by participants, the data analysis, and conducting extensive background research on the topic, this study aims to answer those questions and offer further insight into how we can work to bridge existing gaps between WCSAS and mental health services.

Q: What types of barriers do WCSAS experience in BC when trying to access psychotherapy treatment?

This research found that WCSAS in BC face significant economic, social, structural, and service-related barriers to accessing services. A comprehensive list of these barriers is shown in Table 4. While the prevalence of each barrier varies among participants, similar results have been observed in studies outside of Canada. Although 16 barriers were identified in this study, the most common ones are affordability, stigma, and professional training. Participants most frequently cited the high cost of psychotherapy services as a major barrier, which is a fundamental reason for the inaccessibility of services for WCSAS. The expensive nature of private counselling, combined with insufficient funding for free or low-cost options, forms the basis of many barriers experienced by WCSAS, as illustrated in Figure 9. Limited funding for accessible psychotherapy services also reduces awareness of programs like CVAP and contributes to structural and service-related barriers. Participants often experienced long wait times due to a lack of available services. This, along with the difficulty in finding resources, maintains a cycle within BC's mental health system where WCSAS tend to seek public care only during crises, exposing them to additional barriers such as negative hospital and medical doctor experiences. Participants reported encounters where both health and mental health professionals lacked the necessary training and experience to meet their specific needs, as shown in the feedback loop in Figure 16. This results from financial inaccessibility and the absence of culturally informed care. Without adequate training, MHSPs struggle to develop effective therapeutic approaches, reinforce negative stigmas, and may interrupt services by terminating treatment. Another major root cause of service inaccessibility is stigma, which is perpetuated by financial barriers, insufficient training, and lack of information. Reflecting on the feedback loops in Figures 14 and 16, we can reduce stigma by improving CSA training and increasing government funding for public mental health services.

Table 3. *List of Barriers*

Economic
1. Cost of private psychotherapy services.
2. Inadequate government funding for programs and services that provide free or low-cost psychotherapy options.
3. Low rates of awareness for the CVAP program.
Social
1. <u>CSA stigma</u> For survivors, CSA stigma manifests as internal shame and self-blame. It also negatively impacts survivors' disclosure experience and works to promote secrecy and a general lack of communication within familial, public, and private sectors. WCSAS experience stigma from organizational bodies and

health providers through misdiagnosis and being led through routes within the health care system that are unnecessary and unlikely to be trauma-informed.
2. Sex work stigma Maintaining negative beliefs and perspectives of sex work was found to inhibit the therapeutic alliance between some survivors and service providers. Due to this experience, some survivors feel most comfortable working with a service provider who has lived experience of sex work.
3. Substance use stigma WCSAS who experience substance use disorder face unique barriers when trying to access mental health services. This stems from systemic ignorance of the strong correlation between childhood trauma and substance use.
Structural
1. Difficulty locating resources WCSAS often do not know where to go to get help and experience challenges locating resources. This barrier begins in adolescence and extends into adulthood.
2. Long wait times Individuals seeking mental health services in BC commonly face long wait times to see mental health care professionals and to use publicly accessible services through non-profit organizations and clinics.
3. Absence of services Due to funding shortages, there are not enough services to provide FACAS with free or low-cost services and providers who are adequately trained to meet their needs.
4. Poor hospitalization experience WCSAS commonly rate their hospitalization experiences as poor when trying to access mental health services. They experience long wait times, dismissal by staff, separation from community support, and poor resources for counselling.
Service
1. Therapeutic approach WCSAS commonly meet service providers with whom they do not connect with and often experience counsellors pushing them to discuss topics that they would not like to.
2. Professional Training WCSAS commonly experienced service providers who lacked adequate training to work with survivors of childhood sexual abuse.
3. Political and Personal Views A misalignment of faith and politics prevents survivors from feeling comfortable with their service provider.
4. Medical doctors Medical doctors were seen as a barrier to accessing services. Participants consistently mentioned not feeling heard or prioritized by medical doctors, in addition to feeling that they were not provided with adequate resources.
5. Service disruption WCSAS experience being cut-off from receiving services and a service provider with the skillset needed to help them.
6. Duration of services Low number of sessions provided by subsidized service providers was a barrier to survivors as it inhibits survivors from building a strong therapeutic alliance and promotes feelings of abandonment for survivors.

Q: From the perspective of WCSAS, what do they recommend to improve their access to mental health care?

The list shown in Table 5 addresses both stigma and financial barriers faced by women who are survivors of child sexual abuse (WCSAS) through a systemic, multi-pronged approach. The recommendations provided by WCSAS participants in this study can be categorized into Access to Services and Quality of Services. Including mental health services under universal healthcare and increasing government funding directly tackles affordability, making counselling more accessible regardless of income. Government funding is a crucial intervention point, where an increase can significantly impact the rest of the system (Figure 14). Simultaneously, improving public education and provider training helps reduce stigma by fostering understanding of childhood sexual abuse (CSA), trauma-related behaviours, and the structural inequalities impacting survivors, such as criminalization and racial disparities. CSA-specific training is another intervention point targeting symptoms like stigma and trauma (Figure 16). Incorporating culturally informed care and alternative therapies like EMDR ensures services are not only accessible but also relevant and effective for diverse populations. This can be achieved by modifying protocols of public services, another key intervention point (Figure 13). By leveraging public spaces to share information and embedding trauma-informed practices into policies and healthcare protocols, the strategy normalizes help-seeking and reduces symptoms like survivor shame. Overall, these recommendations create systemic feedback loops that increase service utilisation, decrease early termination of care, and shift public and institutional attitudes to better support WCSAS through a human-centred approach.

Table 4. *WCSAS Recommendations*

Access to Services
1. Increase affordability of counselling services by including mental health services under universal healthcare.
2. Increase provincial and federal funding for mental health services and programs treating WCSAS.
3. Increasing public education on available services and recognizing the symptoms of childhood sexual abuse.
4. Improve education of topics such as childhood sexual abuse, sex work, substance use, and other criminalized behaviours for health care and mental health care providers.
5. Incorporate alternative therapy models for severe trauma, such as EMDR, into fundamental training for mental health service providers.
6. Diversify the types of therapeutic treatments available publicly for WCSAS.
7. Use public spaces such as schools, libraries, and leisure centres to disseminate information and resources to CSA survivors and the public.
8. Improve policymakers' understanding of the relationship between CSA, trauma, and physical illness.
9. Work to decrease CSA survivor stigma.
10. Prevent and reduce service termination for WCSAS.
11. Increase psychotherapy recommendation into physician protocol.
Quality of Services

1. Improve and increase training for service providers to include CSA specific material.
2. Increase and build upon culturally informed care principles for mental health service providers.
3. Increase opportunities for BIPOC service providers.

Q: According to MHSP in BC, what recommendations do they have for increasing access to WCSAS mental health services and what kind of treatment model is currently recommended?

Participant MHSP shared several recommendations during their interview to improve access to mental health services for WCSAS, which can be found in Table 6. The recommendations made by the MHSP participant largely align with those of WCSAS participants; however, two key suggestions were made that were not mentioned by the rest of the group. Participant MHSP recommended increasing provincial and federal funding for mental health programs and services to support the development of a new government initiative aimed at replacing CVAP for CSA survivors. This recommendation targets the intervention point of public services (Figure 13). Ideally, it would address issues such as the affordability of private services, treatment methods, and duration. This addresses the root cause of financial barriers by advocating for increased funding for a specific program. Another suggestion was to increase collaborations between non-profit organisations and private service providers. For example, participant MHSP proposed seeking MHSP volunteers to offer free or subsidised services through non-profit organisations. This recommendation targets intervention points related to trauma and CSA-specific training, as it would increase the affordability of service providers with specialised skills if successful and help reduce trauma within the WCSAS population. It addresses both the root causes of stigma and financial barriers.

Table 5. *MHSP Recommendations*

Exclusive MHSP Recommendations
1. Develop a new government program to replace CVAP for adult CSA survivors.
2. Increase collaborations between non-profit organizations and private service providers
MHSP and WCSAS Recommendations[7]
1. Increase provincial and federal funding for mental health services and programs treating WCSAS.
2. Increasing public education on available services and recognizing the symptoms of childhood sexual abuse.
3. Incorporate alternative therapy models for severe trauma, such as EMDR, into fundamental training for mental health service providers.
4. Diversify the types of therapeutic treatments available publicly for WCSAS.
5. Improve policymakers' understanding of the relationship between CSA, trauma, and physical illness.
6. Work to decrease CSA survivor stigma.
7. Improve and increase training for service providers to include CSA specific material.
8. Increase psychotherapy recommendation into physician protocol.
9. Prevent and reduce service termination for WCSAS.

Q: How can we improve access to adequate psychotherapy treatment for WCSAS in BC?

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[7] The recommendations highlighted in yellow are recommendations made by both participant groups.

Within the conceptual framework of this research study, six categories of access were identified: geographical, financial, cultural, psychological, informational, and temporal. During this study, recommendations derived from primary and secondary data can be organized into these six categories. To enhance access to mental health services for WCSAS, we must address and mitigate the barriers highlighted by both the participants of this study and external resources. This can be achieved by systematically improving each type of access, as WCSAS face ongoing obstacles related to one or more access types depending on their background and socio-economic status. Insights from study participants inform final recommendations for enhancing these access types, the Canadian Mental Health Association BC, and background research on this topic.

Financial Access

- Universalize access to publicly funded and delivered mental health care. Some key steps include amending the Canada Health Act to include mental health care services and increasing federal health transfers.
- Develop a new partner program exclusively for CSA survivors with CVAP. This will reduce the wait time for CVAP applicants and provide CSA survivors with the resources they need for long-term help.
- Increase and provide stabilized funding to non-profits that provide counselling services to WCSAS.
- Ensure Health Authorities in BC consistently allocate 10% of their budget to mental health and substance use services.
- Increase British Columbia disability assistance rates to $2100 per month to reduce WCSAS rate of poverty, homelessness, starvation and mental health issues.

Psychological Access

- Mandate training and skills development of trauma-informed treatment models and ideologies for professionals working with WCSAS.
- Include professionals and women with lived experience of CSA in program design, policy decisions, and feedback.
- Work to eliminate CSA stigmatization and internalization by publicly funding awareness campaigns, increasing school education, and creating safe resource access points in public spaces.
- Create a publicly available database for available services and resources related to CSA.
- Regulate counselling in BC to increase public safety and consistency of care and provide service users with an informed choice.
- Work to eliminate substance use stigma by investing in evidence-based harm reduction informed public education and professional training and skills.
- Work to eliminate sex work stigma by mandating sex work positive skills training for professionals.
- Increase public availability of specialized treatment models for PTSD, such as Prolonged Exposure, EMDR, and CPT. Invest in providing training in these methods to professionals free of cost with adequate supervision post-training.

- Continue to develop and fund partnerships between non-profit organizations and private service providers to bridge the gap between WCSAS and experienced professionals.

Cultural Access

- Increase and provide stable funding to BIPOC-centred mental health programs and non-profit organizations.
- Mandate multicultural competence training for all mental health service providers.
- Promote equitable access to services for BIPOC WCSAS by increasing the number of BIPOC professionals.
- Support the diversity of executive teams in public policy, non-profit, and community initiatives.
- Improve language accessibility within mental health programs and services.
- Invest in public awareness campaigns of BIPOC-centred mental health services and resources.
- At each stage of public funding, program development, training, and policy adaptation for WCSAS – political, organizational, and community leaders must collaborate with respective local Indigenous communities on all changes.

Informational Access

- Develop publicly funded CSA awareness campaigns. Within these campaigns, promote CVAP or equivalent.
- Annually collect data from mental health programs for WCSAS. Ensure this data is publicly accessible and offer service users and professionals feedback surveys.
- Develop a province-wide database that provides information regarding wait lists, available professionals, program availability, and other resources.
- Mandate annual CSA resource training for physicians to ensure their knowledge of current local services and referral options.

Temporal Access

- Reduce wait times and extend the number of available sessions by increasing funding to programs serving WCSAS.
- Reduce stress on BC's primary care health system by investing in retaining family doctors in BC and reducing the income gap between primary and specialized care.
- Designate mental health professionals in all public schools.
- Continue to invest in and promote professionally facilitated group therapy programs.
- Increase post-secondary seats for mental health professionals, social workers, psychiatrists, and psychologists.

Geographical Access

- Develop and invest in mobile mental health clinics for rural and underserved areas.
- Conduct needs assessments for services in rural and underserved areas.
- Expand on virtual services to connect WCSAS to professionals. Create safe spaces where those without access to technology can take their virtual appointments or provide technology to those in need for the duration of their service use.
- Provide financial incentives to professionals working in remote regions.
- Utilize collaborative models of care.

Strengths, Limitations & Areas for Further Research

Strengths

This study offers several benefits to participants, our society, and the overall state of knowledge on this topic. For WCSAS participants, this study offered an opportunity for participants to voice their concerns on this topic and discuss their personal experiences. In addition, this study allowed for CSA survivors to feel connected to their community and feel empowered by taking part in academic activism. Both MHSP and WCSAS participant groups expressed their pleasure in taking part in this study, with some sharing feelings of satisfaction and gratitude. Study participants also expressed that the positionality of the primary researcher (as being a WCSAS) aided in overall comfortability during the interviews.

Outside of the participant experience, the main benefit of this study is the contribution it poses to improving mental health service access for WCSAS. The developed maps and final recommendations will act as a resource for organizations and policymakers, improving community wellness. This study also works to spread awareness of the unique barriers that WCSAS face in BC. The overall state of knowledge on this topic has been improved as a study on this topic with the perspectives of WCSAS is widely confined. This study works to close that gap and lay the foundation for future research on this topic.

Weaknesses

This research study holds multiple limitations. Due to the small sample size, the results of this study may not accurately represent the broader population of WCSAS in BC. The current study recruited eight participants, seven of which were WCSAS. In addition, this study predominately highlighted the perspectives of survivors. The disproportionate representation of survivors to professionals within this study may encourage bias in readers. It also may not accurately depict the complexity of BC's mental health system. This study also holds the risk of supporting participant bias due to the emotional and personal nature of the research topic. Other limitations include complications with Zoom software and video quality.

Areas for Further Research

A key area for future research is developing up to date statistics on provincial rates of CSA. Province-wide anonymous surveys are recommended to foster an accurate depiction of the number of survivors in BC. From there, larger qualitative and quantitative studies on this topic should be devised. These studies should be led by BIPOC individuals and should include the consultation of CSA survivors to ensure trauma-informed practice and deliberative democracy. There is also a wide gap in research on CSA perspectives from the LGBTQI2+ community. Studies focusing on these voices should be supported and developed in BC.

Lastly, the perspectives of MHSP on this topic should be studied and gathered as they are crucial to understanding and mitigating the issue of inaccessibility. Further research should be conducted on effective treatment models and their availability for WCSAS.

Final Thoughts

Understanding access from WCSAS perspectives is crucial for mitigating the barriers that women in BC face when healing from historical child sexual abuse. It is important to hold space for all CSA survivors, as their pain and suffering resonate across multiple sectors of our society and have devastating long-term effects. The Canadian Health Act (1984) states that the "primary objective of Canadian health care policy is to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (c. 6, s. 3). Despite this acknowledgment, the link between trauma and physical impairment is constitutionally overlooked. Child sexual abuse is directly associated with many long-term physical and mental impairments. The barriers women encounter when trying to access mental health services in BC represent a failure and obstruction of our basic rights and freedoms.

Regarding the existing body of knowledge on this topic, this study highlights the prevalence of CSA and how the secrecy surrounding this issue affects individuals, systems, and policy. This study demonstrates that this research is both possible and necessary to initiate a conversation that has long been overlooked by provincial and federal government bodies. Many participants in this study conveyed feelings of abandonment by healthcare professionals, politicians, organizations, and family members. This study serves as a call to action to ensure that the women in our communities feel supported, cared for, and valued by the systems they interact with. The health of BC's communities is dependent on the understanding that the strongest societies are ones in which individuals can thrive and heal from their childhood trauma.

Reflecting on the conceptual framework of this study, there are two core parts: what we can define and what we can understand. We now know that WCSAS face specific barriers similar to those mentioned in other countries. The question that remains is: how do we, as a society, move forward? It is crucial to address not just one but all of the differentiating types of access that WCSAS do not receive. The intervention points identified in this study guide us toward where we can begin. The level of government funding for mental health services (particularly WCSAS-specific services) in BC needs evaluation. Understanding how our current funding model impacts public services and moving to critically readjust it will affect the rest of the system and reduce financial inaccessibility, which is the most common barrier WCSAS face. Providing CSA-specific training for counsellors that diversifies treatment models will positively impact psychological access while promoting, retaining, and valuing racial and ethnic diversity if MHSP works to improve cultural accessibility. Continuing to develop our understanding of the relationship between addiction and trauma and translating that understanding into policy and funding initiatives will increase temporal accessibility. Lastly, working to improve awareness of the CVAP program or creating a partner program specific to CSA survivors will enhance informational accessibility.

The recommendations provided in this study also serve as a guide for policymakers, community leaders, and other organizations. These recommendations advocate for change and recognition of women, aiming to transform perspectives in a way that acknowledges the diversity of survivors and the intersectional nature of child sexual abuse (CSA) and its effects. Stigma silences policy change, impact, healing, and understanding; to realize these recommendations, we must, as a society, work together to remove shame from a survivor's healing experience.

As a final remark, this thesis is fundamentally dedicated to CSA survivors of all genders, not just women and femmes. One participant in this study expressed the essence of this work, and I could not articulate it better myself.

"Don't give up. If I can give that. Don't give up. Don't give up. Tell them don't give up. They're gonna find the right person." (Participant F)

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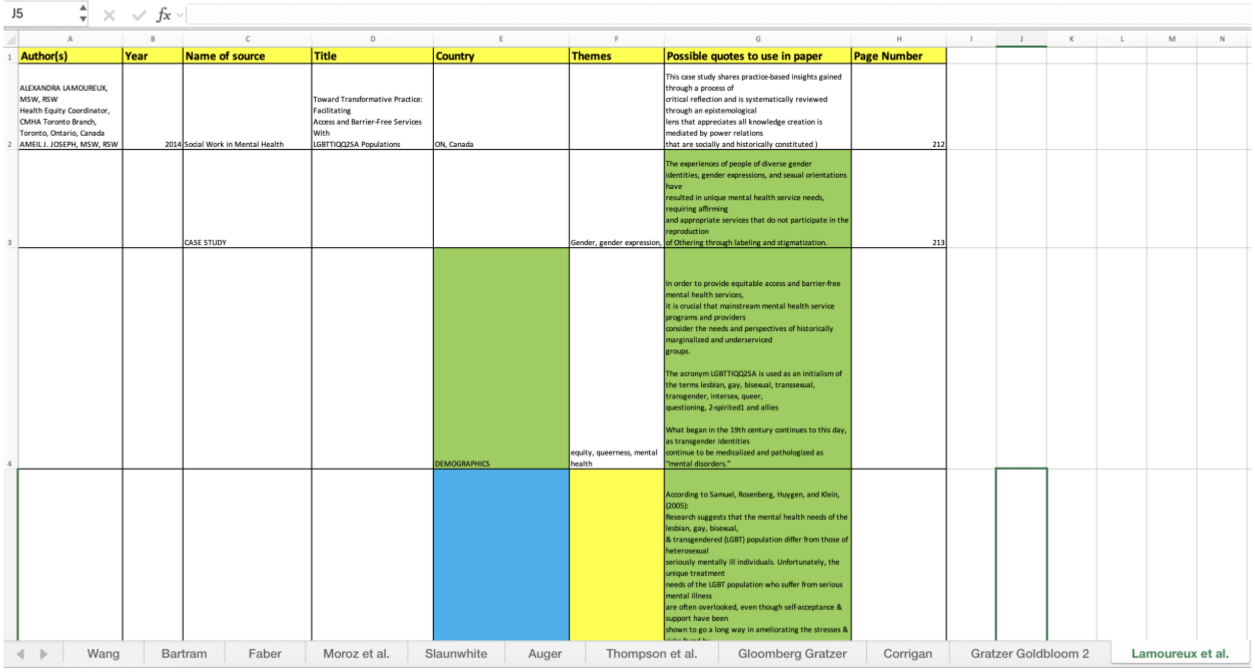
Appendices

Appendix A

Logframe Matrix



Author(s)	Year	Name of source	Title	Country	Themes	Possible quotes to use in paper	Page Number
ALEXANDRA LAMOUREUX, MSW, RSW Health Equity Coordinator, CMHA Toronto Branch, Toronto, Ontario, Canada AMEIL J. JOSEPH, MSW, RSW	2014	Social Work in Mental Health	Toward Transformative Practice: Facilitating Access and Barrier-Free Services With LGBTTIQQ2SA Populations	ON, Canada		This case study shares practice-based insights gained through a process of critical reflection and is systematically reviewed through an epistemological lens that appreciates all knowledge creation is mediated by power relations that are socially and historically constituted)	212
		CASE STUDY			Gender, gender expression,	The experiences of people of diverse gender identities, gender expressions, and sexual orientations have resulted in unique mental health service needs, requiring affirming and appropriate services that do not participate in the reproduction of Othering through labeling and stigmatization.	213
				DEMOGRAPHICS	equity, queerness, mental health	In order to provide equitable access and barrier-free mental health services, it is crucial that mainstream mental health service programs and providers consider the needs and perspectives of historically marginalized and underserviced groups. The acronym LGBTTIQQ2SA is used as an initialism of the terms lesbian, gay, bisexual, transsexual, transgender, intersex, queer, questioning, 2-spirited1 and allies What began in the 19th century continues to this day, as transgender identities continue to be medicalized and pathologized as "mental disorders."	
				🟦	🟨	According to Samuel, Rosenberg, Huygen, and Klein, (2005): Research suggests that the mental health needs of the lesbian, gay, bisexual, & transgendered (LGBT) population differ from those of heterosexual seriously mentally ill individuals. Unfortunately, the unique treatment needs of the LGBT population who suffer from serious mental illness are often overlooked, even though self-acceptance & support have been shown to go a long way in ameliorating the stresses &	

Appendix B

Interview Questions

Interview Questions – WCSAS

1. What do you perceive as the most significant barriers or challenges, if any, in accessing psychotherapy services in British Columbia? Could you provide specific examples from your personal experience?

2. Who are the key actors (e.g., individuals, groups, healthcare providers, organizations, government entities) that either facilitate or hinder access to mental health treatment in BC? Can you provide examples of how these actors influence access?

3. When searching for a mental health service provider (MHSP) in BC, what qualities or characteristics are most important to you? Have you been able to find a provider that meets these criteria? If not, what challenges have you faced?

4. Have you explored online therapy options? If so, how would you compare the accessibility, effectiveness, and overall experience of online therapy versus in-person psychotherapy services in British Columbia?

5. Drawing from your experiences, what specific recommendations would you offer to policymakers, healthcare providers, or other stakeholders to improve access to psychotherapy services in British Columbia, particularly for individuals who are part of marginalized groups such as WCSAS?

Follow up

7. Can you share your personal experiences or observations related to accessing psychotherapy services in British Columbia? How have these experiences impacted your mental health and overall well-being?

Interview Questions - MHSP

1. What do you perceive as the primary barriers or challenges that survivors of childhood abuse (FACSAS) face when attempting to access psychotherapy services in British Columbia? Could you provide specific examples from your experience or observations?

2. Who are the key actors (e.g., individuals, groups, healthcare providers, organizations, government entities) that either facilitate or hinder access to mental health treatment in BC? Can you provide examples of how these actors influence access?

3. What specific training or skills do you believe therapists need to effectively support women with a history of childhood abuse, particularly in addressing their unique trauma-related needs?

4. How can mental health systems in BC ensure that psychotherapy services are both affordable and accessible to survivors of childhood abuse, especially for those in underserved or marginalized communities?

5. In your view, how could mental health services in British Columbia be better tailored to meet the specific needs of women who experienced sexual abuse in childhood? What kinds of programs or approaches would be most effective in addressing their needs?

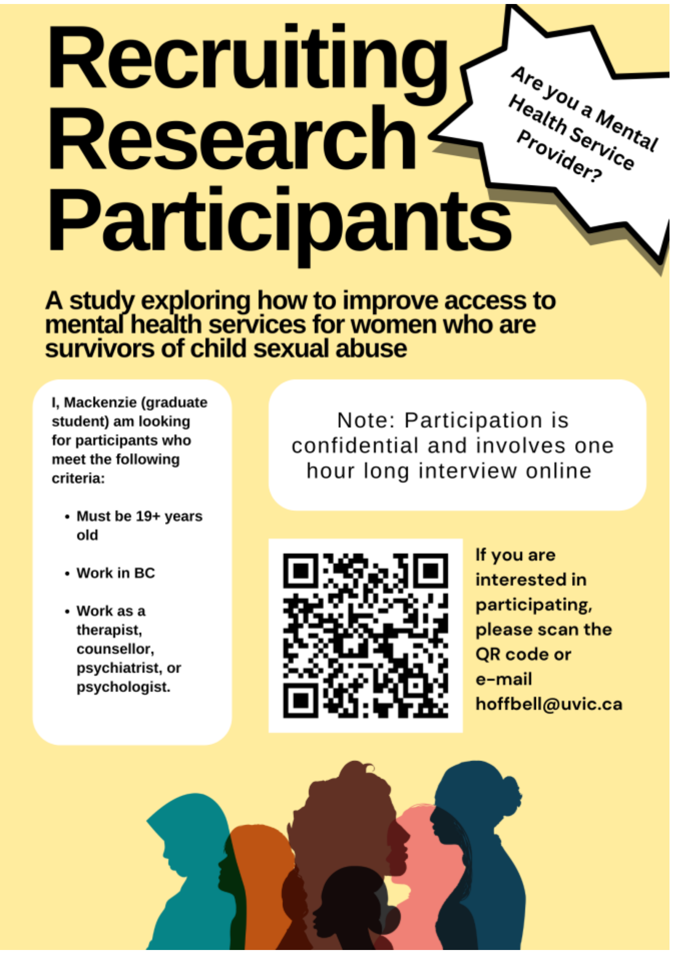
6. Based on your insights and experiences, what specific recommendations would you offer to policymakers, healthcare providers, or other stakeholders to enhance FACSAS access to psychotherapy services in BC?

Follow up

7. In your opinion, how could collaboration between mental health professionals and other community services (e.g., social services, legal support, housing) improve access to psychotherapy for survivors of childhood abuse? Can you provide examples of how such collaborations have or could work in practice?

Appendix C

Recruitment Posters



Recruiting Research Participants

Are you a Mental Health Service Provider?

A study exploring how to improve access to mental health services for women who are survivors of child sexual abuse

I, Mackenzie (graduate student) am looking for participants who meet the following criteria:

- Must be 19+ years old
- Work in BC
- Work as a therapist, counsellor, psychiatrist, or psychologist.

Note: Participation is confidential and involves one hour long interview online

If you are interested in participating, please scan the QR code or e-mail hoffbell@uvic.ca

RECRUITING

RESEARCH PARTICIPANTS

A confidential study exploring how to improve access to mental health services for women who are survivors of child sexual abuse

I, Mackenzie (masters student) am looking for participants who meet the following criteria:

- Live in BC
- Must be 19+ years old
- Identify as female
- Have experienced sexual abuse under the age of 16

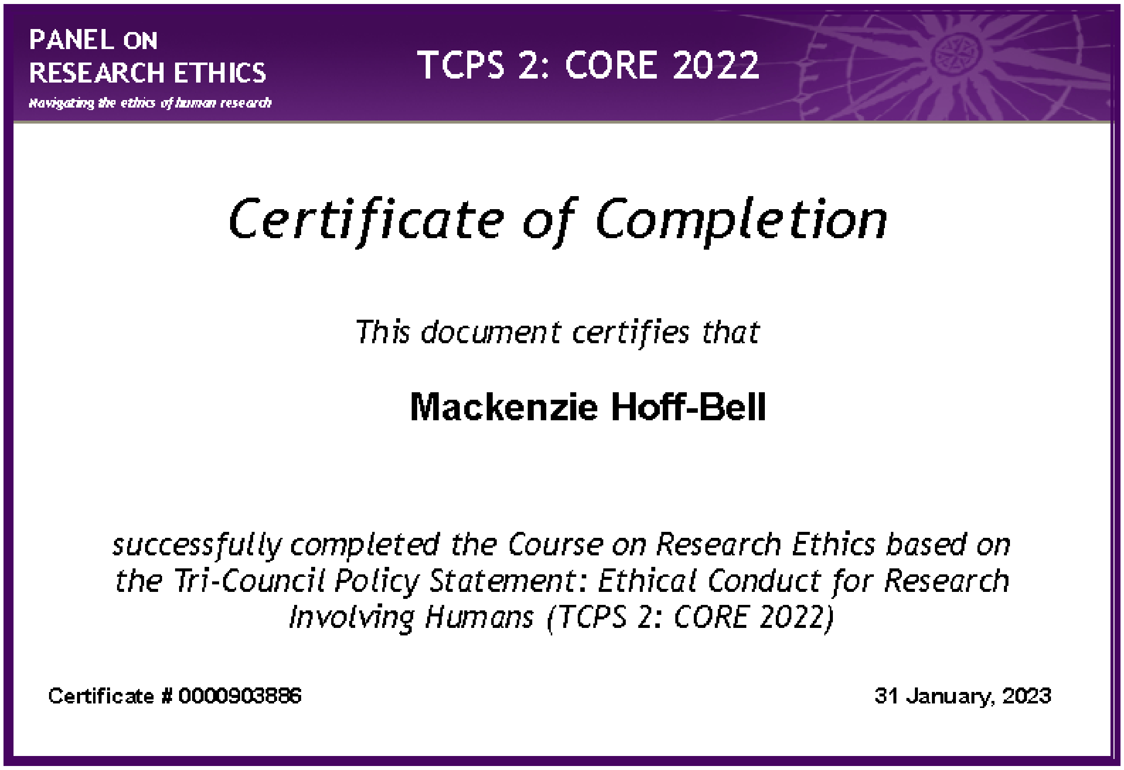
Note: If you are currently receiving services, you will not be impacted if you decline

Participation is confidential and involves one hour long interview online

If you are interested in participating, please scan the QR code or e-mail hoffbell@uvic.ca

Appendix D

TCPS 2: CORE 2022 Certificate of Completion



PANEL ON
RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE 2022

Certificate of Completion

This document certifies that

Mackenzie Hoff-Bell

successfully completed the Course on Research Ethics based on the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE 2022)

Certificate # 0000903886

31 January, 2023

Appendix E

Mental Health Resource Package

Mental Health Resources for Women Survivors of Child Sexual Abuse (WCSAS)

Name	Description	Link
Crime Victim Assistance Program (CVAP)	Funding for long term therapy – They provide up to 48 sessions with any counsellor who accepts CVAP	https://www2.gov.bc.ca/gov/content/justice/criminal-justice/bcs-criminal-justice-system/if-you-are-a-victim-of-a-crime/victim-of-crime/financial-assistance-benefits
Ending Violence Association of Canada	Resources for crisis lines	https://endingviolencecanada.org/sexual-assault-centres-crisis-lines-and-support-services/
Ending Violence Association of BC	Resources for free short-term therapy	https://endingviolence.org/services-directory/?filter_9&filter_2&filter_3=Community-Based%20Victim%20Services&gf_search
RAINN	Resources for WCSAS	https://www.rainn.org/articles/adult-survivors-child-sexual-abuse
Canadian Victims Bill of Rights	Information for victims rights	https://www.victimsfirst.gc.ca/serv/vrc-dvc.html
Call 8-1-1		BC Call line to connect you to local services
Free or Low Cost Counselling Services	BC counselling service directory	https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/virtual-mental-health-supports#counselling
Adult Survivors of Child Abuse	Resources for WCSAS	https://www.ascasupport.org/
VictimLink BC	Resources for survivors	https://www2.gov.bc.ca/gov/content/justice/criminal-justice/victims-of-crime/victimlinkbc
The Gatehouse	Online support group for survivors	https://thegatehouse.org/adult-support-program/
Counselling BC	Database for counsellors in BC	https://counsellingbc.com/counsellors/practice/child-stress-and-trauma-109
Adverse Childhood Experiences Summit	Resources and information for survivors	chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://sharedcarebc.ca/sites/default/files/ACEs_SummetPosterPresentations_WEB_Nov6.pdf
Complex Trauma Resources	Treatment information for survivors	https://www.complextrauma.org/treatment/complex-trauma-treatments-for-adults/
Pathways Community	Community service database for BC	https://pathwaysbc.ca/community

Service Directory		
Adult Survivors of Childhood Abuse - Meetings	Online support group for survivors	https://www.ascasupport.org/meetings/
Tapestry Counselling Centre – Online Support Group	Online support group for survivors	https://www.tapestrycentre.ca/group
National Association of Adult Survivors of Childhood Abuse	Resources for survivors, online support groups.	chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://www.naasca.org/Groups-Services/BRITISHCOLUMBIA.pdf http://naasca.org/ **NAASCA's daytime self-help Recovery Group** Tuesday; ZOOM at 5pm EST Thursday, Sunday; ZOOM at 2pm EST **ZOOM Meeting ID # :** ...769 832 8303
Saprea	Is an organization that offers free retreats to survivors in addition to other resources	https://saprea.org/
First Nations Mental Health Provider List	Resources for support groups, therapy, and crisis lines.	chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.fnha.ca/Documents/FNHA-First-Nations-Health-Benefits-Mental-Health-Provider-List.pdf
Hope for Wellness Helpline	Crisis line	Call toll-free 1-855-242-3310
Indian Residential School Crisis Line	Crisis line	Call toll-free 1-866-925-4419.
Kuu-Us Crisis Line Society	Crisis line	Adults/Elders line 250-723-4050; youth line 250-723-2040. Or call toll free 1-800-588-8717
Métis Crisis Line	Crisis line	Call 1-833-MétisBC (1-833-638-4722).
SNIWWOC	Free/low cost therapy	https://www.sniwwoc.ca/services

Black Mental Health	Free group counselling for black women	https://blackmentalhealth.ca/
NACCA	Free counselling for black women	https://www.naccacommunity.ca/mental-health.html
Vancouver Black Therapy Foundation	Free counselling for black women (10 sessions)	https://vancouverblacktherapyfoundation.com/programs/intake-schedule.html
MOSAIC	Free counselling for newcomers	https://mosaicbc.org/our-services/health-and-counselling/