

EDITORIAL: Critical Psychology Perspectives on LGBTQ+ Mental Health: Current issues and interventions

Joanna Semlyen and Poul Rohleder

Sexual and gender minorities continue to face inequalities, discrimination and hostility, and in some parts of the world, significant threat. While in a country like the United Kingdom, many equalities for gay, lesbian and bisexual (LGB) individuals have been won (less so for trans individuals), homonegativity and transnegativity remain significant issues. In other parts of the world, homosexuality is still considered a pathology and a crime, and LGBTQ+ individuals are actively persecuted. In the UK, research has shown that LGB individuals manifest greater prevalence of poor mental health, health risk behaviours and psychological distress, as compared to their heterosexual counterparts (Semlyen, King et al. 2016). Despite improvements in matters of equality and inclusion in the UK, and, seemingly, general societal acceptance, comparisons between epidemiological surveys from 2007 and 2014 indicate that the proportionately poorer mental health among lesbian, gay and bisexual people, compared to the heterosexual population, has not improved (Pitman, Marston et al. 2020).

Such epidemiological data highlight the urgent need to address impoverished mental health experiences of LGBTQ+ individuals but do not in and of themselves provide evidence of causal pathways, made possible with longitudinal study designs. Moreover, it is important to understand how LGBTQ+ intersectionality impacts the determinants of poorer mental health as doing so allows us to design suitable interventions that are accessible across a range of sexual and gender minority identities. Studies that look at the breadth of identities focusing on subgroups is much needed. Diversity within LGBTQ research is critical; even large-scale studies find reporting on LGBT diversity challenging (Semlyen 2017, Russell, Bishop et al. 2020)

The collection of seven papers in this special issue takes a closer examination of these issues across multiple identities. They explore issues for samples of transgender individuals (Tan et al.), queer and gender diverse young people (Cowie and Braun) queer and neurodiverse young people (Oswald et al), sexual minority adults (Lim et al., Marshall et al., and Vance et al.), and LGBTQ asylum seekers and refugees (Mulé). The collection of papers come from different English-speaking countries: Australia, Canada, New Zealand, and the United States of America. While this represents a Western perspective, some of the papers focus on minority ethnic populations within the LGBTQ communities of the respective countries (Marshall et al., Vance et al.), and one paper (Mulé) includes participants of different nationalities. The papers adopt a broadly critical approach, utilising diverse methodologies (case study, survey studies, focus group and interview studies) across understanding experience, service access and service use. All of the papers use different ways of considering intersectionality, either through comparing different groups statistically or making comparisons along demographic factors, or examining converging and/or diverging narratives.

In the first paper, Cowie and Braun interview queer and gender diverse adolescents in Aotearoa New Zealand, exploring how they make sense of their own psychological distress, and what they feel would be useful in supporting their wellbeing. Participants reported being aware of cisgenderism and experiencing it as a threat to mental health. Although many participants seemed to position themselves as 'outside' bad experiences, many nevertheless describe experiences of bullying and prejudice, and mental distress. Furthermore, many described their experiences being dismissed and invalidated by others, and against this experience, many wished to emphasise the realness of their

distress by likening it to a physical illness, thus finding validation in a biomedical model and diagnosis.

In the next paper, Mulé explores the experiences of LGBTQ+ asylum seekers, refugees and refugee claimants in Canada. As would be the case for other non-LGBTQ asylum seekers and refugees, participants described an arduous settlement process, involving needing to access a number of legal, employment, living, social support and health resources. Layered on these systemic challenges, were particular concerns and feelings of isolation and fear related to being a sexual or gender minority and an asylee. This is also against the background of having been persecuted for their sexual and gender identity in their country of origin and having to hide their identity for the sake of survival. Negotiating settlement, and disclosing their sexual and gender minority status was a re-traumatising process, with many of the professionals they encountered and had to work with (e.g., lawyers) not necessarily understanding LGBTQ issues.

In the third paper, Gerhard, Avory and Fine conduct a survey study, using participatory methods, to explore the personal and mental health struggles of 1800 racially diverse young people in the USA identifying as queer and neurodiverse. The paper discusses how the participants reported feeling often oppressed and limited by diagnostic labels and experiences or fear of homonegativity and transnegativity as well as ableism and racism. Participants expressed a desire to be recognised and validated for who they were, in all their intersectional identities, recognising and advocating against injustices, and challenging stereotypes. Many respondents found a sense of belonging and agency in online communities. The authors introduce the notion of “intersectional expansiveness” to challenge normalcy and embrace complexity and ambiguity in identities and sense of self.

In the fourth paper, Marshall, Vargas and Mahalingam use the minority stress model (Meyer 2003) to examine pathways to psychological health. Sexual minority persons of colour were measured on levels of perceived stigma and received discrimination with either mastery (control over lives) or authenticity (i.e., congruence between inner and outer self) as mediator. Lower mastery was linked with higher reported minority stressors and poorer psychological health in this sample whereas authenticity did not mediate the observed associations between minority stress and mental health. This intersectional research study reflects particular experiences of the participants linked to their own, “combined identities” and linked to received manifestations of oppression through power. To further understand, greater focus is needed on research examining pathways to mental health in diverse samples of the LGBTQ population. Implications for the continued development of the role of resilience in this population are detailed.

The remaining three papers focus on issues of interventions in addressing LGBTQ mental health. Tan and colleagues examine the reported experiences of transgender individuals’ access to mental health services in Aotearoa/New Zealand. Participants reported many struggles in accessing affirming medical and mental health care and experienced a number of unmet needs, which had a negative impact on their mental health. Many reported difficulty accessing a system which often does not feel like it recognises or accepts their gender diversity, and where they perceived various prejudices. The support of family was reported as an important aspect of better mental health, with those estranged from their family reporting more distress.

In the penultimate paper in this special issue, by Lim and colleagues, a survey study was conducted with 248 respondents, exploring the experiences of gay, lesbian and bisexual people accessing crisis telephone helplines in Australia. Many respondents reported on periods of crisis related to minority stress, abuse or violence. Although intuitively appealing, as helplines offer the protection of anonymity, the study found that, while 78% of LGBQ respondents were familiar with crisis helplines,

only 30% had accessed a crisis helpline service in the past. (The majority of the latter, however, reported a positive experience.) Negative experience reflected microaggressions not overt prejudice, but these were sufficient to detract from the quality of care received. Intersectional analysis showed that for minority ethnic LGBTQ respondents, they reported more pessimism about their needs related to intersecting identities being met.

In the final paper, Vance, Lodge and Farvid provide a framework for mental health intervention that is inclusive and responsive to the needs of sexual minorities of African descent. They report on a case study, drawing on an African-centred approach using Optimal Conceptual Theory. Their paper shows, with rich detail, how an affirmative, collaborative psychological process can be achieved, offering an alternative to dominant “Western” frameworks of psychological intervention usually favouring White recipients in successful outcomes.

Each of the papers report on important areas of consideration, and make for engaging and interesting reading. In this editorial, we focus further on a few dominant themes that we feel are important.

Many of the papers address some tensions around the use of labels and categories. When conducting research on mental ill-health, the psychiatric diagnostic categories, for example of the Diagnostic and Statistical Manual on Mental Disorders (DSM-5), are typically used. The papers problematised the power and dominance of categories of mental ‘disorders’ and the medicalisation of experience, arguing that they do not always meaningfully capture the experiences of distress linked to oppression and discrimination. Diagnostic categories in themselves may be experienced as oppressive. We argue that it is important to contextualise this within the history of treating homosexuality and transgenderism as a psychiatric pathology; a diagnosis in the earlier editions of the DSM. For LGBTQ individuals, there is a long and problematic history with the medicalisation and pathologisation of their distress. Thus, diagnostic categories such as depression and anxiety are seen through a critical lens. But the views of participants varied. For example, for transgender participants, a diagnosis acted as a powerful gatekeeping mechanism for accessing care and treatment (Tan et al.). For some queer and gender diverse young people, such diagnostic labels were experienced as validating, making their distress ‘real’ (Cowie and Braun). In the paper by Oswald and colleague, participants had a range of views about labels and categories. As the authors state in their paper, “We ended with a sample of those who wrap themselves in labels applied by professionals, those who reject the same labels, those who feel understood and well represented by these diagnoses, and those who feel repulsed by the medicalization of their selves.” Thus diagnostic labels have different meanings for different individuals.

With regards labels and identities of sexuality and gender, this seems a more contested terrain for the different papers. Many papers referred to an aversion and resistance to categorising sexuality and gender. The paper by Mulé, on the experiences of LGBTQ asylum seekers and refugees, brings this tension to the fore very vividly. For the participants, the labels around sexuality and gender were the basis for persecution in their home countries, and thus associated with experiences of trauma. There was expressed resistance and fear about using such labels to identify themselves; yet, these very labels were the basis on which they were allowed to access asylum. The necessity to prove their identity and, thus, their persecution were a re-traumatising process.

Thus labels – mental health diagnosis, sexual and gender identity – can be considered as both restrictive as well as facilitative. Many studies made space for participants to self-identify, recognising that labels and categories may be an imposition. This allowed for an inclusive, participatory approach. Imposing a label on someone is more of an issue when it comes to identity.

While such participatory approaches are important, the use of self-identification creates a range of different labels that might make it complicated, if not impossible, to analyse epidemiological data that can be used for policy change and funding, or to develop much-needed resources. We would argue that a pragmatic approach may be needed. Researchers may develop spaces for the rationale for the use of labels and categories to be explained and discussed.

Largely unfunded, research in LGBTQ mental health commonly focuses on repetitive analyses of impoverished mental health in small scale quantitative studies using surveys on non-representative (i.e., convenience) samples and offering findings with minimal prospect of effecting much needed resource and policy change.

Existing representative research evidence in the UK shows clear levels of impoverished mental health largely unaffected by any possible improvement in societal attitudes (Pitman, Marston et al. 2020) so the focus must be on ways to effect change through intervention design and development. Tailored services can go a long way to encourage access and reduce levels of poor mental health in the LGBTQ community especially where LGBTQ people have played a part in the design.

There is a lack of evidence and understanding about causal pathways to mental health inequalities in LGBTQ people. Large-scale, robust quantitative research is required to evaluate the causal mechanisms and efficacy of proposed interventions. Any research strategy to consider addressing this significant and ongoing mental health inequity needs underpinning with resources.

Data on LGBTQ health also are unavailable. Improving methods for recording LGBTQ identities are required, both in national surveys and within primary care and mental health services to allow monitoring data to inform policy, intervention, and research development. Moreover, research where sexual and gender minority demographics are collected as standard should be as commonplace as other demographics.

There is a tension between developing unique services for LGBTQ mental health and improving existing services. This is a tension between taking a pragmatic approach to tailoring well-funded mainstream services, and making them more accessible to LGBTQ individuals, thus maximising existing resources rather than reinventing the wheel in LGBTQ umbrella type services that may fail to take into account the differences between groups of people. While a uniquely responsive approach, as outlined by Vance et al., is to be commended and brings into focus the biases that may be entrenched in our ways of working, there is a question about scaling up and how this collaborative-intense way of working can be incorporated into existing health care systems, or alongside them. Making services accessible to the needs of LGBTQ individuals needs to involve more than just training service providers on 'diversity issues' (as is so common-place). Of importance is access to different forms of services and interventions (Lim et al) and culturally appropriate and affirming interventions (Vance et al). One of the ways that services can be made accessible is through successful outreach to minorities to dispel negative perceptions and assumptions (as suggested by Lim et al). The accessibility of services can be improved not just by enhancing the knowledge of professionals in the services, but actively communicating/connecting with the LGBT community to increase acceptability.

These papers do not provide all the answers, but they do offer a glimpse into what we hope will become a significant body of work helping to shed light on the pathways to poor psychological health in sexual and gender minority individuals with studies collecting data across disaggregated subgroups within the LGBTQ initialism and with designs nuanced in nature to capture intersectional experiences.

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