Chapter 3
Global LGBTQ Mental Health

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3.1 Differences in Mental Health Between LGBTQ Individuals and Cisgender Heterosexual Individuals

Research studies from many parts of the world, including countries in Europe, North and South America, Asia, Africa, and Oceania, have demonstrated significantly elevated risk of poor mental health among lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals as compared to cisgender and heterosexual individuals (Blondeel et al., 2016; Mendoza-Perez & Ortiz-Hernandez, 2019; Meyer, 2003a; Mueller et al., 2017; Mueller & Hughes, 2016; Ploderl & Tremblay, 2015; Valentine & Shipherd, 2018). Earlier reports tended to come from small studies that used nonrepresentative samples and self-report measures of mental health concerns. More recent studies, including from the Netherlands, New Zealand, Sweden, the United Kingdom, and the United States, that used stronger research designs and representative samples have confirmed these findings and increased our knowledge about sexual orientation and gender identity-related mental health disparities (Bränström, 2017; Bränström et al., 2018; Bränström & Pachankis, 2019; Cochran et al., 2003; Sandfort et al., 2014; Semlyen et al., 2016; Spittlehouse et al., 2019).

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3.1.1 Types of Mental Health Problems

Depression, anxiety, suicidality, general distress, and substance use show the largest disparities by sexual orientation and gender identity based on a variety of studies from the United States, Latin America and the Caribbean, Australia, Southern Africa, the United Kingdom, and New Zealand (Bostwick et al., 2010; Caceres et al., 2019; Hughes et al., 2010; Mueller et al., 2017; Ploderl & Tremblay, 2015; Semlyen et al., 2016; Spittlehouse et al., 2019; Valentine & Shipherd, 2018). The results of representative surveys in Sweden and New Zealand show that compared with heterosexual and cisgender people, LGBTQ people are about two to three times as likely to experience depression, anxiety, and substance abuse (Bränström, 2017; Bränström et al., 2018; Lucassen et al., 2017). A considerable number of studies from across the globe have also found substantially elevated risk of suicidal thoughts and suicidal behavior among LGBTQ people, with the majority of studies coming from North America and Europe (di Giacomo et al., 2018; Haas et al., 2010; Hottes et al., 2016; Ploderl et al., 2013; Ploderl & Tremblay, 2015; Salway et al., 2019; Valentine & Shipherd, 2018). Substance use, another area of health disparities affecting LGBTQ individuals, is described in greater detail in Chap. 8.

3.1.2 Cultural Differences in Understanding Mental Health

Understanding of mental health and mental disorders differs by cultural settings. The manifestations of mental illness vary across cultures, with culture-specific expressions of psychological distress and suffering. This variation makes it harder to uniformly assess symptoms, develop and implement effective mental health treatments, and conduct cross-cultural mental health research globally.

There is also a growing body of research on cross-cultural, transcultural, and global psychiatry spearheaded by organizations such as the World Association of Cultural Psychiatry and the Society for the Study of Psychiatry and Culture, which, respectively, publish the peer-reviewed journals *World Cultural Psychiatry Research Review* and *Transcultural Psychiatry* (Society for the Study of Psychiatry and Culture, 2020; World Association of Cultural Psychiatry, 2020). This body of research often emphasizes Global South contexts and mental health constructs, such as culture-bound syndromes, collectivistic coping, interdependent self-construal, and decolonial interventions and service delivery (Crozier, 2018; Hickling, 2019; Joe et al., 2017; Mascayano et al., 2019; Prakash et al., 2018; Roldán-Chicano et al., 2017; Yeh & Kwong, 2008).

It is important to note, however, that much of the existing LGBTQ mental health research and treatment development work to date has been conducted in the Global North. Consequently, there is currently limited research contextualizing LGBTQ populations within Global South mental health constructs in various parts of the world. In this chapter, we focus on available scientific information about LGBTQ

mental health and its determinants. Because of the relative dearth of research conducted in the Global South, all references will refer to Global North countries/contexts unless otherwise specified.

3.2 Differences in Mental Health Across Diverse Populations of LGBTQ Individuals

Because the LGBTQ population reflects the demographic diversity of the global population, it is of great importance to understand how various sociodemographic characteristics affect the health and lives of LGBTQ people, how such characteristics interact with sexual orientation and gender identity, and which LGBTQ subpopulations are most vulnerable to negative mental health outcomes. An intersectional perspective can help address this. The section below describes sociodemographic characteristics that intersect with LGBTQ identities that are commonly investigated in global LGBTQ mental health research.

3.2.1 Age and Sex

The increased risk of poor mental health among LGBTQ people begins early in life (Irish et al., 2019) and often persists across the life course (Fredriksen-Goldsen et al., 2013, 2015; Yarns et al., 2016). For instance, a study comparing mental health disparities in sexual minorities and heterosexuals across age groups in the United Kingdom found disparities among both younger (age <35) and older (age 55+) sexual minority individuals (Semlyen et al., 2016). In contrast, a large multi-site study of women enrolled in a US interagency HIV study found no differences in mental health disparities between sexual minority and heterosexual women at mid-age or older (Pyra et al., 2014). Similarly, a community-based study of sexual minority women found that self-perceived mental health was significantly better among older (age 55+) sexual minority women than among their younger age counterparts (Veldhuis et al., 2017). Studies of suicidality have shown that the sexual orientation disparity in this particular mental health risk peaks for LGBTQ individuals around adolescence and young adulthood (Fish et al., 2018; Irish et al., 2019).

3.2.2 Sexual Identity and Gender Identity

Many studies of sexual minority mental health do not disaggregate gay/lesbian and bisexual individuals when analyzing data and presenting results, but there is growing evidence of substantial variability across sexual minority subgroups. For

example, a number of studies have found higher rates of depression, anxiety, and suicidality among bisexuals compared to gay men and lesbian women (Bostwick et al., 2010; Bränström, 2017; Bränström et al., 2018; Huang et al., 2018a; Hughes et al., 2010; Ross et al., 2018; Salway et al., 2019). There are indications that this heightened risk is particularly strong for bisexual women (Salway et al., 2019). It is not completely clear why the mental health status of bisexuals differs from that of gay men and lesbian women, although possible explanations include experiences of bisexuality-specific discrimination, bisexual invisibility/erasure, and lack of bisexual-affirmative support (Colledge et al., 2015; Hughes et al., 2014; Ross et al., 2018).

Although the large majority of studies on LGBTQ mental health has focused on sexual minorities, an increasing number of studies indicate that transgender individuals are at even greater risk of mental health problems, such as depression, anxiety, suicidality and self-harm, and eating disorders as compared to both non-LGBTQ individuals and sexual minority cisgender people (Calzo et al., 2017; Connolly et al., 2016; Jones et al., 2016; McNeil et al., 2017; Millet et al., 2017; Mueller et al., 2017). Transgender people may be at risk for gender dysphoria, which is significant psychological distress arising from an incongruence between the assigned birth sex and gender identity (American Psychiatric Association, 2021).

3.2.3 Socioeconomic Status

There is currently strong scientific evidence linking lower socioeconomic status (SES), often defined based on income and level of education, with mental and physical health (Adler et al., 1994; Link & Phelan, 1995). In research concerning the health of LGBTQ people, socioeconomic factors tend only to be used as control variables so as to isolate the effects of LGBTQ status and associated determinants as predictors of mental health disparity by LGBTQ status (McGarrity, 2014). There are, however, reasons to investigate the specific effects that socioeconomic status (e.g., income, education) might have on LGBTQ people's experience of social stress and their ability to cope with such stress. For example, McGarrity (2014) found that openness about one's sexual orientation was associated with positive physical health among gay/bisexual men with higher socioeconomic status in the United States, but the opposite appeared to be true for gay/bisexual men with lower socioeconomic status. Although certain subgroups within the LGBTQ population have been shown to have higher levels of education, particularly gay men (Bränström & Pachankis, 2018; Conron et al., 2018), higher levels of education do not necessarily translate to higher levels of income. Sexual minority women are typically burdened with the gender disadvantage facing women in general, which becomes compounded in same-sex female couples (Badgett, 2009). The ability of SES to both be eroded by LGBTQ-related

discrimination and to moderate the ability of LGBTQ people to cope with such stigma is an important area for future research.

3.2.4 Race/Ethnicity

A good deal of research into the intersection of ethnic minority status and LGBTQ identity has been conducted in the United States, with a focus on the consequences of possessing a double minority status as both a person of color and an LGBTQ individual (Toomey et al., 2017; Trygg et al., 2019). Studies have shown that racial/ethnic minority LGBTQ people may experience stigma and discrimination due to their LGBTQ identity, skin color, and racial/ethnic identity (Toomey et al., 2017; Vu et al., 2019; Wade & Harper, 2017) and that these associated stressors can come both from their racial/ethnic minority communities as well as from white LGBTQ people (Balsam et al., 2011). Studies examining mental health prevalence among ethnic minority LGBTQ individuals compared to ethnic majority LGBTQ individuals present varied results (Rodriguez-Seijas et al., 2019; Toomey et al., 2017). Some studies have found higher levels of mental illness among ethnic minority LGBTQ people (Hwahng & Nuttbrock, 2014; O'Donnell et al., 2011), whereas others have found lower levels of mental illness among this group or no difference (Bostwick et al., 2014; Rodriguez-Seijas et al., 2019; Toomey et al., 2017). Globally, the role of race/ethnicity in mental health varies greatly depending on the country, world region, and migration pattern (Arndt & Hewat, 2009; Toomey et al., 2017; Wade & Harper, 2017). There is a great need for additional research to understand the mental health implications of multiple minority statuses more fully.

3.2.5 Migration Status

Given the wide regional variation in stigmatizing environments and cultural norms globally, LGBTQ people might be particularly likely to migrate in order to escape persecution or to seek freedoms not available to LGBTQ people living in high-stigma global regions. Of course, LGBTQ people are also part of the substantial general global population that migrates across national borders within any given year (Luibhéid, 2008). The mental health of LGBTQ migrants remains relatively unstudied, although the LGBTQ- and migrant-specific support available in LGBTQ migrants' sending and receiving countries appears to be an important determinant of this population's health (Pachankis et al., 2017). Other factors shaping LGBTQ migrants' mental health include violence and acculturation (Alessi et al., 2016, 2017; Alessi & Kahn, 2017; Piwowarczyk et al., 2017).

3.2.6 Geographic Variations in LGBTQ Mental Health

3.2.6.1 Central and South America

Although there have been few representative studies of LGBTQ mental health conducted in Central and South America, one study from Mexico among high school students showed a higher risk of mental health problems among sexual minority individuals compared to heterosexuals, confirming the global pattern (Mendoza-Perez & Ortiz-Hernandez, 2019). The disparity was strongest among sexual minority men and was mediated by exposure to violence. In addition, several non-probability studies from Central and South America (e.g., Brazil and Jamaica) suggest a high prevalence of mental health problems among sexual minority individuals in these regions (Caceres et al., 2019; Ghorayeb & Dalgalarrondo, 2011; Teixeira & Rondini, 2012; White et al., 2010). Similar elevations in mental health morbidity have been found among transgender women in Argentina, Brazil, and the Dominican Republic (Budhwani et al., 2018; Lobato et al., 2008; Marshall et al., 2016).

3.2.6.2 Middle East/North Africa

Information about the prevalence of mental health problems among LGBTQ individuals living in the Middle East and North African region is very limited. Some studies using non-probability samples from Israel and Lebanon have shown increased risk of mental health problems (i.e., depression and suicidality) among sexual minority men compared to matched heterosexual controls (Shenkman et al., 2019; Shenkman & Shmotkin, 2011; Wagner et al., 2018). Further, a few studies of transgender individuals receiving gender-affirming surgical treatment in Iran and Lebanon have found elevated prevalence of mental health problems (e.g., anxiety, post-traumatic stress symptoms, and suicidality) among this population both before and after surgery (Gorjian et al., 2017; Havar et al., 2015; Ibrahim et al., 2016; Kaplan et al., 2016). Some of these studies suggest that mental health problems are more common among male-to-female transgender individuals compared to female-to-male transgender individuals, possibly as a result of cultural gender roles and status (Havar et al., 2015; Ibrahim et al., 2016).

3.2.6.3 Sub-Saharan Africa

Few studies using representative samples have been conducted in sub-Saharan Africa. However, several non-probability studies from this region, mostly with men who have sex with men (MSM), have been reported. For example, high levels of depression symptoms have been reported among MSM in Tanzania and South Africa (Ahaneku et al., 2016; Mgopa et al., 2017; Stoloff et al., 2013); high prevalence of psychological distress among gay men, lesbian women, and bisexual women and men in Botswana (Ehlers et al., 2001); and lower quality of life among gay, lesbian, and bisexual students compared to their heterosexual peers in Nigeria (Boladale

et al., 2015). Studies have also found a high prevalence of suicidal ideation among MSM living in the Gambia, Burkina Faso, Togo, and South Africa (Stahlman et al., 2016; Stoloff et al., 2013). One study using a heterosexual comparison group found almost three times higher prevalence of depression among gay male university students in Nigeria compared to heterosexual students (Oginni et al., 2018). A review of the literature on the health of sexual minority women in Africa (Mueller & Hughes, 2016) highlighted the impact of heteronormativity and social exclusion on mental health, particularly related to psychological distress and elevated rates of depression. In this study, experiences of hate speech, sexual violence, and religion-based stigma and discrimination were associated with mental distress and suicidal ideation among sexual minority women. In the only published study of lesbian and bisexual women's health in Rwanda, Moreland and colleagues (Moreland et al., 2019) found high levels of interpersonal trauma and minority stressors.

3.2.6.4 South, East, and Southeast Asia

Although there are few studies of LGBTQ mental health reported from South, East, and Southeast Asia using representative samples, a few population-based studies of Chinese sexual minorities have shown an increased risk of suicidality compared to Chinese heterosexuals (Huang et al., 2018a; Lian et al., 2015). Additionally, a large number of non-probability studies have been conducted with sexual and gender minorities, mostly MSM and transgender individuals, from South, East, and Southeast Asia. For example, recent studies have reported high levels of depression symptoms among MSM and transgender women (hijra) living in India (Chakrapani et al., 2017a, b; Logie et al., 2012; Parikh-Chopra, 2019; Sivasubramanian et al., 2011; Tomori et al., 2016). There are reports of elevated depression and suicidality among MSM and transgender individuals living in Nepal (Deuba et al., 2013; Kohlbrenner et al., 2016), gay/bisexual men in Japan (Hidaka & Operario, 2006), and gay/lesbian and bisexual youth in India (Singh & Srivastava, 2018). High risk of suicidality has been identified among transgender individuals in China (Chen et al., 2019); lesbian/bisexual women in Taiwan (Kuang et al., 2003); and gay men, lesbian women, and MSM in South Korea (Cho & Sohn, 2016; Kim & Yang, 2015). A lower degree of psychological well-being has been reported among transgender men (toms) and transgender women (kathoeys) in Thailand (Gooren et al., 2015); elevated risk of suicidality among sexual minority women in Taiwan (Kuang et al., 2003) and among LGBTQ Filipinos (Reyes et al., 2017); and high levels of depression among transgender women in Cambodia (Yi et al., 2018).

3.2.6.5 Oceania and the Pacific Islands

Few representative studies have been reported from Oceania and the Pacific Islands, but one national population-based study among young women in Australia reported increased risk of depression and anxiety among sexual minority women, especially women who identified as bisexual or mostly heterosexual, compared to exclusively

heterosexual women (Hughes et al., 2010). Non-probability studies from Australia and New Zealand similarly report higher rates of mental health problems (e.g., depression and suicidality) among sexual minorities (Cantor & Neulinger, 2000; Lucassen et al., 2015; Mathy, 2002; Skerrett et al., 2014, 2015).

3.2.6.6 Europe

Because of the existence of national health registries in many Northern European countries, some of the earliest population-based studies of LGBTQ mental health came from that region (Sandfort et al., 2001). Europe continues to produce population-based insights into LGBTQ mental health largely not available elsewhere, including studies from the Netherlands, Sweden, and the United Kingdom (De Graaf et al., 2006; King et al., 2003; La Roi et al., 2016; Meads et al., 2007; Sandfort et al., 2001, 2006, 2014). These studies support findings from earlier European research and more recent population-based studies from North America of higher rates of mental health problems such as depression, anxiety, substance use, and suicidality (Bränström, 2017; Bränström et al., 2018; Bränström & Pachankis, 2019; King et al., 2008; Sandfort et al., 2001, 2014; Semlyen et al., 2016; Wang et al., 2012).

Recent European studies have also taken advantage of the wide diversity of social acceptance of LGBTQ people to predict variations in mental health. Indeed, LGBTQ legal rights and protection (e.g., same-sex marriage rights and inclusion of LGBTQ status in hate crime legislation) and population attitudes and acceptance of LGBTQ individuals vary greatly across European countries (Bränström & van der Star, 2013). Studies have shown a clear link between a European country's stigmatizing legislation and attitudes and the life satisfaction of LGBTQ individuals living in that country (Bränström et al., 2021; Pachankis & Bränström, 2018). Preliminary evidence suggests that this association exists due to LGBTQ individuals living in high-stigma countries perceiving a need to conceal their sexual identity to avoid discrimination and victimization.

3.2.6.7 North America

As mentioned above, the majority of studies on LGBTQ mental health, especially earlier studies (i.e., those published in the 1990s and early 2000s) were conducted in North America. These earlier studies typically used small, nonrepresentative samples and self-report measures of mental health. The results pointed to greater risk of psychiatric morbidity among sexual minorities than among heterosexuals; the mental health of transgender populations was rarely examined (Cohen-Kettenis & Van Goozen, 1997). However, more recent studies from North America employ representative samples and stronger methodologies and have largely confirmed these early findings (Bostwick et al., 2010; Cochran et al., 2003, 2007; Cochran & Mays, 2000, 2009; Hottes et al., 2016; Meyer, 2003b; Pakula et al., 2016; Pakula &

Shoveller, 2013). There has also been increasing attention to transgender mental health (Cogan et al., 2021; McGuire et al., 2021; Nuttbrock et al., 2010; Samrock et al., 2021). Recent population-based studies show that LGBTQ people in North America have between two- and three-times greater risk of depression, anxiety, and substance abuse problems compared to heterosexual, cisgender individuals (Cochran & Mays, 2009; Meyer, 2003b; U.S. Institute of Medicine, 2011). LGBTQ people in North America also have a severely heightened risk of suicidal thoughts and suicidal behavior (di Giacomo et al., 2018; Fish et al., 2018; Hottes et al., 2016; Salway et al., 2019).

3.3 Determinants of LGBTQ Mental Health

Increasing evidence from around the world suggests that the elevated mental health risk among LGBTQ people can be attributed to, at least in part, the greater stigma-related stress that LGBTQ people are exposed to compared with heterosexual and cisgender individuals (see Stigma chapter, Chap. 2). Stigma-related stress among LGBTQ people is described in minority stress theory, originally developed to explain differences in mental health based on sexual orientation (Meyer, 2003a), but in recent years expanded to facilitate understanding of the increased risk of mental health problems among transgender people as well (Operario et al., 2014; White Hughto et al., 2015). According to minority stress theory, LGBTQ people experience specific stressors (e.g., discrimination, violence, threats, social isolation, and identity concealment) that are unique and linked to their sexual or gender identity. Exposure to these stressors across the life course compounds the burden of general life stress to generate higher rates of stress-related mental health concerns (Meyer, 2003a). In the sections below, we review evidence for the cross-cultural relevance of minority stress theory (Sect. 3.1) and possible culturally distinct factors that might extend or challenge the relevance of minority stress theory to certain cultural contexts (Sect. 3.2), barriers to LGBTQ people's societal integration across countries (Sect. 3.3), and the potential impact of LGBTQ conversion therapy on sexual and gender minority individuals' mental health (Sect. 3.4).

3.3.1 The Cross-Cultural Relevance of Minority Stress Theory

Because the majority of research linking minority stress exposure to increased risk of mental health among LGBTQ individuals comes from North America and Europe, and the fact that "minority stress" is a construct originating from the Global North, it is not completely clear how applicable these findings might be to non-Western countries and countries in the Global South. However, during the past several years, an increasing number of studies have explored the cultural relevance of minority stress theory to LGBTQ mental health in different parts of the world,

including Central and South America (e.g., Budhwani et al., 2018; Dunn et al., 2014); Middle East/North Africa (e.g., Kaplan et al., 2016); sub-Saharan Africa (e.g., Mgopa et al., 2017; Polders et al., 2008; Stahlman et al., 2015); as well as South, East, and Southeast Asia (e.g., Hu et al., 2016; Sattler & Lemke, 2019). Studies conducted in those global regions have found support for the generalizability of factors proposed by minority stress theory as predictors of mental health problems among LGBTQ individuals. This section reviews those experiences, including victimization, discrimination, concealment/openness with LGBTQ status, lack of social support, and internalized stigma.

Victimization and discrimination, when measured generally, have been found to predict higher risk of mental health problems across countries (Albuquerque et al., 2018; Budhwani et al., 2018; Lyons et al., 2019; Parikh-Chopra, 2019). However, the particular expression and frequency of victimization and discrimination can vary greatly across countries. Examples include the corrective rape experiences of lesbian women in South Africa (Anguita, 2012), exposure to torture and murder attempts of transgender women in the Dominican Republic (Budhwani et al., 2018), and family and school violence among gay and lesbian youths in Mexico (Ortiz-Hernandez & Valencia-Valero, 2015).

In the global literature, the mental health consequences of concealment and openness about LGBTQ identity show significant cross-cultural variation. For instance, in high-stigma settings, being open about one's LGBTQ status has been found to increase the risk of discrimination and victimization, which in turn increases the risk of poor mental health (Bränström et al., 2021; Dunn et al., 2014; Pachankis & Bränström, 2018; Sattler & Lemke, 2019). Therefore, in high-stigma countries where all or most LGBTQ people are unable to be open about any aspect of their sexual orientation, concealment of LGBTQ status serves a protective function and has been found to ameliorate the negative impact of stigma-related stress exposure on mental health problems (Pachankis & Bränström, 2018). For example, a study among sexual minority men and women in Jamaica found a more than five-fold increased risk of current Axis I mental disorders (such as anxiety, mood, and eating disorders) among those who were open about their sexual orientation compared to those who were not (White et al., 2010). However, in lower-stigma countries (i.e., those containing protective legislation and acceptance of LGBTQ individuals) where LGBTQ individuals have the possibility of choosing when and to whom to disclose their sexual orientation, not being open with one's LGBTQ identity appears to increase the stress of making decisions around concealment as well as increase associated social isolation and psychological strain (Lawrenz & Habigzang, 2019). At the same time, protective effects of disclosing one's sexual orientation have been found even in some high-stigma settings such as China and South Africa (Liu et al., 2018; McAdams-Mahmoud et al., 2014), and more research is needed to disentangle the complex relationship between openness/concealment of LGBTQ status and mental health in various cultural contexts.

Social support has been found to buffer the effect of stigma-based stress exposure in numerous studies globally (Huang et al., 2018b; Kaplan et al., 2016; Shilo & Savaya, 2011; Wagner et al., 2018). For instance, the negative effect of

victimization on suicidality among sexual minority youth in Chinese schools (Huang et al., 2018b), transgender women in Lebanon (Kaplan et al., 2016), and young middle eastern MSM (Wagner et al., 2018) has been found to be moderated by supportive interpersonal peer and family connections.

Internalized stigma (e.g., internalized homophobia and transphobia), has been less explored outside of the Global North. However, internalized homonegativity has been found to predict depressive symptoms among sexual minority men in Brazil (Dunn et al., 2014) and Nigeria (Oginni et al., 2018), as well as suicidality among sexual minority men in Chile (Pinto-Cortez et al., 2018). Internalized homophobia has also been shown to vary widely across European countries, with gay and bisexual men living in more LGBTQ-supportive countries showing lower endorsement of internalized homophobia than those living in more stigmatizing countries (Berg et al., 2013).

Additional support for the cross-cultural relevance of minority stress as a predictor of LGBTQ mental health comes from a cross-country study conducted online in Western Europe, Eastern Europe, India, the Philippines, and Thailand. This study, limited to gay and bisexual men, specifically found evidence for the cross-cultural relevance of the factors described in minority stress theory (e.g., victimization, internalized homophobia, concealment) as predictors of life satisfaction across these groups (Sattler & Lemke, 2019).

3.3.2 Cross-Country Variation in Structural Stigma

Despite major changes in societal attitudes, laws, and policies affecting LGBTQ people in several countries in recent years, LGBTQ people still face discriminatory legislation and limitations in the fulfillment of fundamental human rights in many parts of the world (International Lesbian Gay Bisexual Trans and Intersex Association, 2019). The legal climate influencing the lives of LGBTQ individuals varies from the criminalization of consensual same-sex sexual acts in some countries to protecting against discrimination based on LGBTQ status in others. Studies have shown that stigmatizing legislation seems to go hand-in-hand with stigmatizing population attitudes (Flores & Park, 2018; Hooghe & Meeusen, 2013). Stigma at a societal level is referred to as structural stigma (Hatzenbuehler, 2014). Research on structural stigma demonstrates that LGBTQ individuals' mental health is strongly influenced by where they live. For example, in US states with more discriminatory laws and policies and fewer equal protections for sexual minorities, the disparity in poor mental health based on LGBTQ status has been found to be greater than in more supportive structural contexts (Hatzenbuehler et al., 2010). LGBTQ youth living in municipalities without protective school policies and support have been found to be at greater risk of suicidality than those who live in more supportive contexts (Hatzenbuehler, 2011). Variation in structural stigma also predicts LGBTQ mental health across countries. For instance, life-satisfaction among LGBTQ individuals varies greatly across European countries largely as a function of structural stigma

and associated demands to conceal one's sexual identity to avoid discrimination and victimization (Bränström et al., 2021; Pachankis & Bränström, 2018). See the chapter on Stigma, Chap. 2, for a more detailed discussion of the impact on the lives of LGBTQ individuals and communities.

3.3.3 Barriers to Societal Integration Across Countries

Although the stigma-based psychosocial stressors described above are most frequently explored as determinants of LGBTQ mental health, some studies have tried to identify less-examined sociological factors that contribute to sexual and gender minority mental health disparities. These studies have been guided by the assumption that a person's lack of integration within society and a lack of societal attachments and commitments can increase their risk of mental health problems. The section below reviews those experiences, including the mental health impact of societal trust and participation, unemployment, lack of stable housing, living without children, and religious affiliation.

A number of studies from the Global South have recently found support for the importance of societal integration in reducing mental health disparities affecting LGBTQ populations. For example, a study from Lebanon found that barriers to societal integration, in the form of unemployment and lack of legal resident status, predicted poor metal health in a sample of young MSM in Beirut (Wagner et al., 2018). In another study, lack of access to stable housing among transgender individuals in Argentina was linked to increased suicidality (Marshall et al., 2016). A study of MSM in three West African countries (i.e., the Gambia, Burkina Faso, and Togo) reported that lower degree of social participation with the broader community was associated with higher likelihood of suicidal ideation (Stahlman et al., 2016). In one study from Kenya, being married to an opposite-sex partner was found to be protective against depression among MSM, possibly by both providing a source of social support and facilitating the concealment of sexual orientation (Secor et al., 2015).

In one of the few studies applying this perspective in the Global North, a study from Sweden found elevated risk of suicidality among sexual minority women and men, which was partially explained by this group's greater lack of societal integration, including being unmarried or living without a partner, not having children, being unemployed, and experiencing low societal trust, compared to heterosexuals (Bränström et al., 2023). In line with these results, a study among Israeli gay fathers found elevated levels of both subjective well-being and meaning in life compared to gay men without children (Shenkman & Shmotkin, 2014). This indicates that raising children may allow for greater integration within Israeli society.

In some cultural contexts, such as the United States, religious affiliation functions as a facilitator of societal integration among people (Lim & Putnam, 2010; for more information see the Community and Social Support chapter, Chap. 6). However, there are several studies showing that religiosity contributes to

detrimental coping and poor mental health among LGBTQ individuals. For example, one study showed an increased negative impact of stigma-based violence on depression among gay men in Tanzania who perceived religion to be important (Ross & Anderson, 2014). The authors conclude that living in a context of religiously motivated anti-gay religious beliefs can have a detrimental effect on coping with stigma-based violence among religious gay men. Similar reports of religiosity as an enhancer of stigma-based stress among religious sexual minority men have been reported among Polish Roman Catholics (Zarzycka et al., 2017) and religious US young adults (Lytle et al., 2018). In a study of sexual minority women in the United States, researchers found that the impact of religiosity and spirituality on depression and substance use differed by race/ethnicity (Drabble et al., 2018). Also in the United States, personal religiosity has been shown to exacerbate suicidality risk among sexual minorities, but not for heterosexuals (Lytle et al., 2018), suggesting that this common global indicator of societal integration can be harmful to sexual and gender minorities in at least some contexts.

3.3.4 LGBTQ Conversion Therapy

Conversion therapy has predominately been practiced in the United States and other parts of the Global North (Haldeman, 2002a) but is gaining increasing prominence in other global regions such as China (Beijing LGBT Center, 2014). Conversion therapy refers to any kind of treatment with the intention to change an LGBTQ sexual orientation or gender identity to a heterosexual orientation and/or cisgender identity (Drescher et al., 2016; Substance Abuse Mental Health Services Administration, 2015). There is not only a lack of evidence that conversion therapy treatments can be effective in changing sexual or gender identity (Adelson & Child, 2012; American Psychiatric Association, 2000), but substantial research has shown that it harms the mental health of LGBTQ individuals (Beckstead, 2012; Haldeman, 2002a, b; Shidlo & Schroeder, 2002). The spread and reach of conversion therapy globally are hard to assess, and the overall impact of conversion therapy on the mental health of LGBTQ populations from a global perspective is largely unknown and warrants further research, given its potential for significant harm.

3.4 Interventions to Improve LGBTQ Mental Health

3.4.1 Interventions to Reduce LGBTQ Stigma

As noted above, the degree to which LGBTQ individuals around the world are exposed to stigma-related stress is highly dependent on structural factors at national, regional, or state/provincial levels, such as discriminatory laws and policies and negative societal attitudes (Hatzenbuehler et al., 2009, 2012; 2018). In many parts

of the world, societies' views of LGBTQ individuals have changed a great deal over a relatively short period (Flores & Park, 2018). For example, in Europe, a number of countries have passed same-sex marriage legislation, which has been found to go hand-in-hand with improvements in population attitudes toward LGBTQ people (Hatzenbuehler et al., 2012; Hooghe & Meeusen, 2013). In India, the recent decision to decriminalize homosexuality is expected to be followed by an improvement in societal attitudes and a greater acceptance of same-sex relationships.

In addition to country- or state/provincial-level interventions, a number of interventions targeting the school environment (Hatzenbuehler & Keyes, 2013; Mayberry et al., 2013) and work environment (Button, 2001) have shown promising results in reducing the mental health burden of LGBTQ individuals. These results suggest that community action and other efforts to reduce stigmatizing national laws, policies, and attitudes in cultural settings where LGBTQ individuals have limited legal rights can be expected to yield improvements in LGBTQ individuals' mental health.

3.4.2 Interventions to Promote Coping with Stigma

There is a clear need for evidence-based prevention and treatments specifically tailored to LGBTQ people. However, few such programs exist partly due to insufficient research on the efficacy of such interventions (Fisher & Mustanski, 2014). Sexual orientation and gender identity are typically not monitored in research evaluating the efficacy of mental health treatments (Heck et al., 2017), and few mental health intervention studies have been conducted with LGBTQ people. It is therefore unknown if mainstream treatments currently offered are effective in reducing LGBTQ individuals' mental health problems, although existing evidence suggests a mixed pattern (Pachankis, 2018).

There is a small but growing literature focusing on mechanisms underlying LGBTQ people's increased risk of mental illness, with implications for interventions with this population (Hatzenbuehler & Pachankis, 2016; Meyer, 2003b). Some of the factors believed to contribute to higher rates of poor mental health among LGBTQ people are elevated experiences of universal risks for psychopathology, such as poor emotion regulation, social isolation, and maladaptive cognitive processes. Such factors are believed to be more common among LGBTQ people than among heterosexual and cisgender people (Hatzenbuehler & Pachankis, 2016). For several of these more general risk factors, effective evidence-based psychological treatments exist, including cognitive behavioral therapy and emotion-focused approaches (Elliott et al., 2004; Farchione et al., 2012). Other mechanisms that underlie the heightened risk of poor mental health outcomes are specific to LGBTQ people, such as stress related to sexual or gender identity non-disclosure, expectations of rejection, and internalization of society's negative attitudes (Pachankis, 2015). Because these risk factors are specific to LGBTQ people, they are likely to require tailored treatment strategies to be optimally effective.

Research into effective psychological treatments to reduce mental illness among LGBTQ people remains limited (Chaudoir et al., 2017; Public Health Agency of Sweden, 2018). In fact, two recent literature reviews identified only one evidence-based mental health treatment specifically developed for LGBTQ people in the United States that had been tested in a randomized controlled trial. This treatment was specifically designed to affirm gay and bisexual men's sexual identities and help them cope with minority stress (Pachankis et al., 2015). In this trial, the intervention showed initial promise for improving gay and bisexual men's mental and sexual health. This treatment focuses on building LGBTQ individuals' capacity to cope with minority stress through strategies such as normalizing the negative impact of minority stress; facilitating emotional awareness and acceptance; reducing avoidance; building self-affirming communication styles; restructuring thoughts relating to minority stress; affirming unique strengths; and encouraging a healthy, rewarding expression of sexuality (Pachankis, 2014). A recent extension of this research shows its preliminary efficacy for sexual minority women as well (Pachankis et al., 2020). Several other studies have examined LGBTQ-affirmative treatments based on these general LGBTQ-affirmative principles but have lacked a comparison group and have included relatively brief monitoring periods (Chaudoir et al., 2017; Public Health Agency of Sweden, 2018).

3.5 Future Directions

3.5.1 Improved Research Methodologies for Global LGBTQ Mental Health

As mentioned above, the majority of studies on global LGBTQ mental health have been conducted using non-probability samples. Although such samples have allowed researchers to recruit large numbers of otherwise hard-to-reach LGBTQ individuals, such as those living in high-stigma settings, there are clear limitations to this approach. First, non-probability samples yield nonrepresentative results and prohibit population estimates of mental health prevalence. Second, individuals recruited using non-probability methods are more likely to be open about their LGBTQ identity, tend to be younger, and otherwise might not represent the full spectrum of diversity within the LGBTQ population (Hottes et al., 2016; Kuyper et al., 2016). Additionally, a disproportionately high number of studies have focused on the mental health of MSM (possibly due to funding streams that favor addressing HIV), and the great majority of studies have been conducted in the Global North. To better understand the mental health of LGBTQ individuals, higher-quality studies are needed that use representative samples of the full spectrum of LGBTQ populations from different parts of the world, including sexual minority women and transgender individuals.

3.5.2 Comparative Research to Identify Cultural Variation in LGBTQ Mental Health

The best way to explore geographical and cultural differences in LGBTQ mental health is to conduct studies using identical research methodologies across countries. Because the structural climate surrounding LGBTQ individuals varies widely across the globe, and recent studies have demonstrated that variations in structural stigma are likely associated with variations in mental health (Hatzenbuehler et al., 2011; Pachankis & Bränström, 2018), more extensive cross-country research is warranted. The few current studies that have been replicated across countries have produced important information. One such study demonstrated the cross-cultural relevance of factors described in minority stress theory in understanding the determinants of LGBTQ mental health (Sattler & Lemke, 2019). Another cross-European study demonstrated the impact of country-level variations in discriminatory legislation and societal acceptance on life satisfaction among LGBTQ people (Pachankis & Bränström, 2018). Compelling arguments have been made against hegemonizing the sexual and gender minority experience worldwide (Massad, 2002), while at the same time, country-specific variation in experiences of those identities has been argued to vary around common themes (Sullivan, 2001). A recent systematic review of global mental health also emphasized learning from and supporting mental health in Global South countries (Rajabzadeh et al., 2021). To the extent these arguments also apply to the mental health experience of sexual and gender minority individuals, they suggest the need to further understand the shared and distinct experiences of identity and mental health in cross-cultural studies while striving to privilege local understandings.

3.5.3 Dissemination of LGBTQ-Affirmative Mental Health Interventions

Future research is needed to develop efficient means of distributing LGBTQ-affirmative treatment to LGBTQ populations that most need them. One strategy that has shown initial promise involves training mental health providers to deliver LGBTQ-affirmative mental health treatment in high-stigma, low-resource global settings. For instance, after participating in a 2-day training in LGBTQ-affirmative mental healthcare, 110 mental health professionals in Romania reported significant reductions in stigmatizing beliefs and significant increases in LGBTQ-affirmative clinical skills (Lelutiu-Weinberger & Pachankis, 2017). That half of the trainees participated in the training online and did not differ from the half who attended in-person suggests that delivering remote training and supervision in LGBTQ-affirmative mental healthcare represents an efficient means to provide needed mental health support to a large segment of the global LGBTQ population. In addition, a recent systematic review and meta-analyses found digital interventions to be

effective in Global South countries (Fu et al., 2020). Remote delivery of LGBTQ-affirmative mental health services directly to LGBTQ people living in high-need global regions thus represents a potentially efficient means for reaching these population groups (Leluțiu-Weinberger et al., 2018). Finally, psychosocial interventions, including social capital interventions (such as community engagement and education programs, cognitive processing therapy, sociotherapy, and neighborhood projects), have been effective in both Global South and Global North countries (Barbui et al., 2020; Flores et al., 2018) and could be adapted for LGBTQ populations.

3.5.4 Aging-Related Dementia and Cognitive Decline

The situation for middle-aged and older LGBTQ populations and the unique aging-related stressors they face is an understudied area and a growing global public health priority. Given the increasing concerns about aging-related dementia and cognitive decline in the general population, more knowledge about the specific needs and concerns of LGBTQ people is warranted (Barrett et al., 2015; McGovern, 2014; Witten, 2014). The current small body of literature on aging-related concerns among LGBTQ people has also been conducted in cohorts who have lived much of their lives before the start of the global LGBTQ rights movement (McGovern, 2014). This research needs to consider the great regional variation in legal rights and population acceptance of LGBTQ people globally, as well as the rapidly changing social realities in some global regions.

3.6 Conclusion

As is apparent based on the amount of research included in this chapter, the mental health of LGBTQ individuals is being studied in some places in the world but not in others. There are clear disparities in mental health for LGBTQ people, especially when disaggregating the data by sexual orientation and/or gender identity. Additionally, when examining mental health through the intersections of sexual orientation, gender identity, race, socioeconomic status, and more, it becomes notable that this disproportionate burden of mental health challenges that LGBTQ people face. Globally, minority stress and social integration barriers greatly impact LGBTQ people and their ability to cope with their mental health, although the interaction between the two is widely unknown. While some geographic areas have more research, large gaps still exist in other areas, especially when studying LGBTQ subpopulations in non-Western countries. Evidence is also missing on the impact of interventions that go beyond the traditional Western ideas of therapy and counseling to include other cultural factors within the Global South and low- and middle-income countries. More in-depth studies of intervention dissemination are also necessary to begin to address the extreme disparities that exist and allow LGBTQ people to both survive and thrive in the world.

Sweden map showing major cities as well as parts of surrounding countries and the Baltic Sea. (Source: Central Intelligence Agency, 2021)

3.7 Case Study: LGBTQ Mental Health in Sweden

The burden of mental illness for the LGBTQ population in Sweden is high, with young LGBTQ people having approximately twice the risk of depression, anxiety, and substance abuse problems as young heterosexual people (Bränström, 2017). Additionally, transgender individuals who seek mental health treatment and have a diagnosis of gender dysphoria are up to six times more likely than cisgender people to be treated for depression and anxiety (Bränström & Pachankis, 2019). The outlook for the mental health of LGBTQ people seems bleak; however, over the past several decades there has been a push to improve LGBTQ mental health through several initiatives. For instance, LGBTQ people are included in the Swedish Mental Health Strategy and the global Sustainable Development Goals. Policymakers are making an effort to utilize legislative changes, and continued pressure comes from key nongovernmental organizations focused on equality for LGBTQ people.

A number of studies have examined the mental healthcare of LGBTQ individuals in Sweden (Bränström, 2017; Bränström & Pachankis, 2019; Tholin & Broström, 2018; Zeluf et al., 2016). One longitudinal, prospective, population-based study found that LGBTQ people were at significantly higher risk than heterosexual people for mental health disorders, with especially high risk identified for bisexual women, gay men, and young lesbian women (Bränström, 2017). The study also found that LGBTQ individuals, because of their increased rates of mental disorders, had an elevated rate of mental healthcare usage (Bränström, 2017). This utilization difference is important to note because, according to another study, transgender individuals had elevated rates of mental illness compared to cisgender individuals (Tholin & Broström, 2018). Transgender individuals also believed that healthcare practitioners lacked competency around treating transgender patients (Tholin & Broström, 2018), which needs to be addressed.

Over the past 25 years, Sweden has worked to deinstitutionalize their mental healthcare system and transition to community-based care in order to better serve the people utilizing mental health services. Several major policy changes were adopted between 1995 and 2012 toward this goal (Bergmark et al., 2017). However, most recently, the government's National Mental Health Strategy for 2016–2020 identified, as one of their five foci for 5 years, an area of attention on vulnerable populations that includes LGBTQ people (EuroHealthNet Magazine, 2017; Nationell samordnare, 2016), as they are at disproportionate risk of mental illness in their lifetimes (Bränström, 2017; Bränström & Pachankis, 2019). Additionally, the global Sustainable Development Goals (SDGs), which apply to Sweden and which Swedish organizations have subsequently strived toward, were created in 2015 (Weitz et al., 2015). The SDGs focus on the principle "leave no one behind," which is repeated throughout. This includes sexual and gender minorities, who are some of the most marginalized and vulnerable people throughout the world. Certain SDGs, like number three, "Ensure healthy lives and promote well-being for all at all ages," would necessarily include LGBTQ people (Weitz et al., 2015). If Sweden is to address this goal, and others, there need to be strategies that aim to combat the

discrimination, violence, and other minority stress that negatively impact LGBTQ people in Sweden and across the world.

Not only has Sweden worked to improve mental health and protect people who have a mental illness, but they have also broadly defended the rights of LGBTQ people through a series of legislation that addresses discrimination in employment, hate speech, and marriage rights (Swedish Code of Statutes, 1999, 2003, 2009). Many initiatives similar to those advanced in the United States that have shown positive effects on the mental health of LGBTQ people (Buffie, 2011; Hatzenbuehler et al., 2009, 2010; Riggle et al., 2010; Rostosky et al., 2009) have also been introduced in Sweden. One study using data from 23,000 respondents to population-health surveys from 2005, 2010, and 2015 found that decreases in Sweden's structural stigma were associated with lower levels of psychological distress for gay men and lesbian women. However, mental health disparities still persist in the levels of psychological distress experienced by gay men and lesbian women as compared to heterosexuals (Hatzenbuehler et al., 2018).

Along with the structural and governmental changes that have helped improve mental health outcomes for LGBTQ people, one nongovernmental organization has helped to influence several decades of policy and legislative changes that protect LGBTQ rights and improve the accessibility of community-based mental health services. This organization is called Riksförbundet för homosexuellas, bisexuellas, transpersoners och queeras (RFSL) or the National Organization for Lesbian, Gay, Bisexual, and Transgender Rights (in English), and its goal is for LGBTQ people to have the same rights as everyone else—locally, nationally, and internationally (RFSL, 2018). The RFSL published an analysis of the mental health action plans for the various regions and municipalities of Sweden, including whether LGBTQ people were explicitly included. They found that out of the 21 regions of Sweden, only 11 explicitly included LGBTQ people in the programmatic analysis, and only 1 region, Stockholm, explicitly included LGBTQ people in their action plan (RFSL, 2016). Additionally, the report incorporated recommended strategies to ensure that future action plans involve LGBTQ people and their mental health needs (RFSL, 2016). The RFSL has a dedicated website and resources for transgender Swedes, and their webpage includes a variety of information on the unique mental health needs of this population (RFSL Ungdom, 2019).

Although significant disparities still exist, through the work of this organization as well as the sustained efforts of legislators and other activists in Sweden, the mental health outlook for LGBTQ people is improving. As research has demonstrated, structural change and support for LGBTQ rights have an extremely important effect on making LGBTQ people feel accepted and valued in society. Work needs to continue in this direction to create the best possible future for this population.

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