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Experience of LGBTQs with Mental Healthcare Practitioners of India: A cross- sectional study

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KEYWORDS

LGBTQs mental health, LGBTQs and discrimination, mental health and India.

ABSTRACT:

Background: This study explores the experiences of LGBTQs individuals with mental health professionals (MHPs) in India, with a focus on accessibility and barriers to service. Despite the increasing recognition of LGBTQ+ rights, significant healthcare disparities persist.

Methods: A cross-sectional study was conducted involving LGBTQs participants over the age of 18. Data were collected using a semi-structured, self-designed questionnaire designed specifically for this study, The questionnaire consisted of 56 questions including the ones on participant's demographic. the structured questionnaire was constructed consisting of dichotomous (Yes/No) items, with selected follow-up questions inviting participants to elaborate on the reasons for their responses. The data collected was tabulated and descriptive data was analyzed using percentage for categorical variables. 85 participants approached out of which 30 reported seeking help in relation to their sexual orientation. 26 out of these completed the full questionnaire.

Results: Findings show that 80.8% of respondents felt comfortable discussing their sexual orientation with MHPs, and 73.1% believed their MHPs were accepting. However, only 36.8% felt adequately informed about internalized homophobia, and 43.8% believed necessary information was provided to reduce family stigma. Discrimination was reported by 23.1% of respondents, 15.4% were advised to change their sexual orientation, and 3.8% experienced breaches of confidentiality.

Conclusion: These findings highlight the need for enhanced MHP training to address the specific challenges faced by LGBTQs individuals, ensuring equitable, respectful, and confidential care.

INTRODUCTION

Homosexuality is defined as "an enduring pattern of emotional, romantic and/or sexual attraction to people of same sex"[1]. In 1952, when American Psychiatric Association (APA) published its first Diagnostic and Statistical Manual of Mental Disorders (DSM) homosexuality was included as disorder. In recognition of scientific evidence, APA removed homosexuality as disorder from DSM in 1973[2]. In 1977, ICD-9 had listed homosexuality as mental illness. However, it was removed from ICD-10, endorsed by forty third World Health Assembly on 17th May 1990[3]. Several studies have proven that LGBTQ people are at higher risk of mental health disorder, suicidal ideas and substance use disorder[4].'Conversion therapies' worsen the mental health of LGBTQ individuals[5].Despite the statement of Indian Psychiatric society (IPS) and decriminalization of homosexuality by Supreme court of India, conversion therapies are still preferred in India[6,7].Despite Medicine and Psychiatry arguing that homosexual orientation is normal variant of human sexuality many Mental health practitioners continues to possess negative and hostile attitude towards LGBTQs[8].These kind of attitude and practices are causing barriers to health care access and widening treatment gap in LGBTQs[9]. To our knowledge there is no study in India till now that assessed experience of LGBTQs with Mental healthcare practitioners. So, we planned to conduct the study with the aim of assessing experience of LGBTQs with Mental healthcare practitioners and understand the attitude of mental health care practitioners towards homosexuality from the perspective of LGBTQ clients.

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MATERIALS AND METHODS

Ethical Approval: Ethical clearance was obtained from the Institutional Ethics Committee. All participants provided informed consent electronically before inclusion. The study adhered to the ethical standards of the Declaration of Helsinki.

Study Design and Setting: This cross-sectional, web-based closed survey study which was conducted over a period of one month to assess the experiences of LGBTQ+ individuals with mental health practitioners (MHPs) in India. Data were collected using a self-designed, semi-structured online questionnaire administered via Google Forms, developed following the CHERRIES (Checklist for Reporting Results of Internet E-Surveys) guidelines to ensure methodological rigor and data protection.

sample size: A total of 85 participants identifying as LGBTQ+ were approached through community- based organizations, self-help groups, and NGOs. Eighty-three participants consented and completed the questionnaire. Of these, 51 had previously sought mental health care, and 30 reported that their consultation was related to their sexual orientation. Convenience sampling was used for recruitment. 26 out of these completed the full questionnaire.

Inclusion and Exclusion Criteria

Inclusion criteria:

- Individuals aged **≥18 years** who self-identified as LGBTQ+.
- Residing in India or NRIs who had sought care from MHPs registered in India.
- Proficiency in English and ability to provide informed consent.

Exclusion criteria:

- Individuals below 18 years of age.
- Inability to use Google Forms or lack of English literacy.
- Those who had **never consulted** a registered MHP in India.

Materials and tools used:

Self-Developed Instrument: "LGBTQ+ Mental Health Experience Questionnaire"

A self-developed semi-structured questionnaire titled *LGBTQ+ Mental Health Experience Questionnaire* was created for this study to evaluate psychosocial experiences, barriers, and attitudes encountered during mental health consultations.

Item Development and Structure: A questionnaire was initially developed based on comprhensive a litrature review. It was then circulated to expert peer groups including psychiatrists, clinical psychologists, LGBTQ+ individuals, LGBTQ+ allies. Questions were modified, removed or added based consensus (defined as responses more than 50% of the reviewers). However, the final instrument was not subjected to standard psychometric validation. The final instrument included **56 items**, including demographic questions. There were 2 pages in the questionnaire, one was consent the other was the questionnaire. Most items were **dichotomous (Yes/No)**, some had multiple choices. with selected follow-up questions prompting participants to explain their responses. Some responses were mandatory to answer, and answers could be changed before submission.

Pilot Testing: A **pilot study** with **10 participants** was conducted to test the functionality, clarity, and feasibility of the questionnaire. Minor modifications in phrasing and sequence were made before final deployment.

Data Collection Procedure: LGBTQs more than 18 years, who can give consent to participate, who were residing in India or NRIs who has taken consultations from Mental health Practitioners (MHP) registered in India, who can read and understand English. Psychiatrists and Clinical Psychologists are the primary source of data collection. A QR code was sent to head of NGOs for LGBTQs who sent it to participants through WhatsApp. The Google Form contained a study introduction, consent form, and investigator contact details, followed by sociodemographic questions and the main questionnaire. Participation was voluntary and anonymous; names and contact details, IP address were not collected. Duplicate entries were prevented by limiting one response per email ID (email addresses were not recorded). Participants could review and revise their responses prior to submission. Completed responses were stored securely on a password-protected, two-factor authenticated cloud account, accessible only to the investigators. Data completeness was manually verified before analysis.

Data Analysis

Data collected through Google Forms were exported into Microsoft Excel for initial cleaning, coding, and tabulation. Descriptive statistics, including frequencies and percentages, were generated using Python (version 3.11) with the pandas library. The results were summarized in tables and figures to represent the distribution of responses across variables.

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RESULTS

A total of 85 individuals were approached, and 83 consented to participate in the study. Of these, 56 (67.5%) identified as gay, 22 (26.5%) as bisexual, and 5 (6%) as pansexual. Among all participants, 51 (61.4%) expressed a need to seek help from a mental health professional (MHP), and 30 (58.8%) reported that this need was directly related to their sexual orientation. However, only 33 (64.7%) of the 51 participants who needed care had actually consulted an MHP. Among those who consulted, 26 (78.8%) disclosed their sexual identity to the practitioner. Among participants who felt the need for psychological support but did not consult an MHP, the most frequently cited reason was stigma related to sexual orientation, reported by half of the group. Additional barriers included other personal reasons (38.9%), difficulty accessing an MHP (33.3%), and fear that the MHP would not accept their sexual orientation (27.8%). Stigma surrounding mental health conditions (16.7%) and concerns about the cost of services (11.1%) were less commonly reported but still relevant deterrents. Among those who consulted an MHP but chose not to reveal their sexual identity, reasons varied. Some participants stated that their parents were in contact with the MHP, while others withheld disclosure to maintain confidentiality. Several felt that their sexual orientation was not relevant to the issue for which they sought consultation, whereas others feared judgment. A few participants reported that they were still exploring or unsure of their orientation at the time, and some stated that their concern was unrelated to sexuality altogether, Out of 26 responses regarding the designation of MHP, majority were clinical psychologists(14) followed by psychiatrists(12). Among whom 18 were males, 8 were females. All 26 participants are Indians who are residing in India and all belong to age group of 21-40 years. We could not get mean or median age of participants as proforma did not mention the 'individual age' option. Participants belonging to other age groups, either have not consulted MHP or not revealed their sexual orientation to MHP. Hence, they weren't included in the final data analysis. Most of the patients who disclosed their sexual identity to MHPs were Hindus. There were participants belonging to religions other than that mentioned in Table.1, but either they have not consulted MHP or revealed their sexual orientation during consultation. Hence, they were excluded in final analysis. Most of the participants are single (80.7%), had attained a postgraduate degree (53.8%), belonged to middle socio-economic status (84.6%) and majority were gays (69.2%).

Most participants reported that they were comfortable revealing their sexual orientation to the MHPs and adequate attention and services was given to their problems. Internalized homophobia was reported by quite a number of people. A minor portion of the participants (23.1%) faced discrimination. 11.1% faced hostility. No patient was refused service due to their status. Unnecessary interventions were done by some of the MHPs, 15.4% advised to change sexual orientation. 11.5% asked to opt for conversion therapies.

Figure.1. shows that in the responder's experience most of the MHPs felt homosexuality was normal (69.2%) while others felt that it was a phase that would pass, lifestyle choice or a sin. Participants' emotional experiences following their consultation with MHPs varied. While 42.3% reported feeling satisfied, others described being neutral, sad, or unsatisfied with the interaction. This distribution highlights variability in the quality of care received, with a sizable proportion indicating that their experience fell short of expectation. A majority of those who disclosed their sexual identity felt comfortable speaking with their MHPs and believed that adequate attention and services were provided for their concerns. Internalized homophobia was reported by several participants, though not uniformly addressed in clinical encounters. Discrimination was experienced by 23.1%, and 11.1% reported hostility. No participant reported outright denial of services. Some MHPs engaged in unnecessary or harmful interventions, with 15.4% advising participants to change their orientation and 11.5% recommending conversion-oriented approaches. Instances of confidentiality breach were also reported by a small number of participants. Figure.2. shows that most participants had a positive experience with mental health practitioners, which increased their motivation to seek future consultations and to recommend mental health services to others. A smaller proportion reported only motivation for future help-seeking or no significant impact, while relatively few participants experienced loss of trust in mental health practitioners. Overall, the findings suggest that MHP consultations were largely beneficial for LGBTQ participants, though a minority reported neutral or negative experiences, highlighting the need for consistently affirming and sensitive care.

DISCUSSION

Sexual and gender minorities in India have historically been overlooked by the healthcare system, resulting in disparities in access to services[9]. This study provides important insight into how LGBTQ+ perceive their interactions with health care providers and urgently highlights the need for healthcare worker training on LGBTQ+ healthcare rights and the challenges LGBTQ+

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patients face due to provider bias. The LGBTQ+ face challenges accessing healthcare due to discrimination[13]. Stigma within healthcare settings discourages LGBTQ+ individuals from seeking or utilizing necessary services[14] Fearing negative judgment based on their sexual orientation or gender identity, many LGBTQ+ people avoid disclosing this information, potentially hindering the quality of care they receive[15,16]. These studies provide valuable insights into the gaps in treatment for LGBTQ individuals and aid in developing more effective strategies to address and reduce these disparities[14].

The experiences reported by participants in this study can be better understood when viewed through the lens of Meyer's Minority Stress Model, which explains how sexual minority individuals face ongoing stressors because of their social environment[17]. Several participants avoided seeking help or hesitated to disclose their orientation to mental health professionals due to fears of judgment, being misunderstood, or concerns about confidentiality. These reactions reflect key minority stress processes such as anticipating rejection and the need to conceal one's identity in situations perceived as unsafe. In addition, those who encountered insensitive remarks, suggestions to change their orientation, or breaches of confidentiality were exposed to external stressors that can worsen emotional distress and discourage future help-seeking. Similar themes were described in the article shared by the reviewer, which highlighted how Indian LGBTQ individuals experienced increased vulnerability when stigma, lack of supportive environments, and disruptions in access to affirming care intensified their psychological burden during the COVID-19 period. Taken together, these findings show how interactions with mental health professionals—whether affirming or negative—can either buffer or heighten minority stress for LGBTQ individuals in India.

Most of the participants in our study reported not disclosing their sexual orientation to their health care providers, either because they had not found it relevant to the clinical encounter or because they were concerned about bias. Sterzing *et al.* Negative experiences with healthcare providers may be linked to microaggressions. Microaggressions are subtle, everyday interactions that communicate negative messages about a person's identity, even if unintentional[15]. Furthermore, a study published in 2018 found that a significant portion of healthcare workers seldom discussed sexual orientation or gender identity with their patients. The reasons behind these included concerns about patient discomfort, a lack of experience with these topics among healthcare workers, and uncertainty about how to use appropriate language[16]. Similarly, in our study some MHPs referred to homosexuality being a passing phase, a lifestyle choice, deviant behaviour or as far as sin on disclosure of sexual orientation. The participants felt many of the MHPs did not give adequate attention, alleviate anxiety, or try to decrease the internalised homophobia. Thus, revealing the need for MHPs to be trained in catering the need of the LGBTQ+ group. A 2013 study found a high percentage of LGBT individuals reported experiencing verbal abuse (47%) or physical violence (19%) due to their sexual orientation and gender identity[18]. However, in our study very few individuals faced hostility due to their status by MHPs and no incidence of physical violence was reported. Our findings also aligned with a study done by Naxane *et al.*[19], who similarly identified financial barriers, discrimination, and inadequate healthcare training as critical issues affecting LGBTQ healthcare access. Furthermore, major perceived barriers to coming out included familial reactions (78.9%), social discrimination (59%), job prospects (37.8%), and finding a life partner (19.1%). Other barriers, such as financial instability, legal discrimination, fear of honor killings, and homelessness were also reported. In our study, respondents reported financial constraints (11.1%), fear of discrimination by healthcare personnel (50%), fear of acceptance of status and additionally, a paucity of psychological support groups and mental health counsellors were noted as major obstacle, as it made it difficult for individuals to reach trained MHPs since the one's that were there were might be too far. The study has a small sample size, and is not representative of experiences of transwomen, transman and lesbian community. Most of the participants are well-educated and belonged to the creamy layer. The participants in the study are between 21- 40 years. Therefore, the study results cannot be generalized. A limitation of this study is also that the majority of the sample was drawn from an NGO that specifically serves the LGBTQ+ community with psychological services. Consequently, many participants may have already had positive experiences with mental health professionals, potentially biasing the results.

CONCLUSION

This study highlights the ongoing challenges faced by LGBTQ+ communities in India, despite legal advances like the decriminalization of Section 377 and the recognition of transgender rights. Social stigmas, discrimination, and violence continue to impact mental health, employment, and quality of life. Economic marginalization underscores the need for inclusive policies. The study calls for stronger anti-discrimination laws, improved education to foster acceptance from a young age, tailored healthcare services, and supportive

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community networks. Future research, including qualitative studies, is needed to better understand the needs of the LGBTQ+ community. Awareness activities should educate healthcare workers on the unique healthcare burdens faced by LGBTQ+ individuals, encouraging a non- discriminatory and inclusive approach in clinical practice. States must implement laws to remove barriers to healthcare access and ensure affordability. Addressing these deep-rooted inequalities is essential for creating a society where LGBTQ+ individuals can live openly and authentically without fear of discrimination

Table 1: Sociodemographic details of participants who consulted MHP and revealed their sexual identity.

Sociodemographic Variable	Category	n (%)
Gender	Cisman	23 (88.4)
	Ciswoman	2 (7.6)
	Others	1 (3.8)
Educational Qualification	Postgraduation	14 (53.8)
	PhD / Super specialty	7 (26.9)
	Graduation	5 (19.2)
Occupation	Medical & health sector	13 (50.0)
	Service sector (banking, hotel management & others)	6 (23.0)
	Professionals	3 (11.5)
	Engineering & technology sector	2 (7.6)
	Student	2 (7.6)
Relationship Status	Single	21 (80.7)
	Partnered with same sex	4 (15.4)
	Partnered with opposite sex	1 (3.8)
Socioeconomic Status (Self-declared)	Middle	22 (84.6)
	Upper	3 (11.5)
	Lower	1 (3.8)
Religion	Hinduism	17 (65.38)
	Jainism	3 (11.5)
	Christianity	3 (11.5)
	Others	3 (11.5)
Sexual Orientation (Self-declared)	Gay	18 (69.2)
	Bisexual	7 (26.9)
	Pansexual	1 (3.8)

Table 2: Patient Experiences with Mental Health Professionals (MHP)

Domain	Yes, n (%)	No, n (%)
Healthcare & Access		
• Were you comfortable discussing your sexual orientation with MHP?	21 (80.8%)	5 (19.2%)
• Did you feel your MHP was accepting of your sexual orientation?	19 (73.1%)	7 (26.9%)
• Did you feel your MHP was giving adequate attention to your problems?	18 (69.2%)	8 (30.8%)
• Did you feel your MHP provided you adequate treatment & services specific to your problem?	17 (65.4%)	9 (34.6%)
• Did you feel your MHP provided required information to alleviate fear & anxiety related to internalized homophobia?*	7 (36.8%)	12 (63.2%)
• Did you feel your MHP provided	7	9

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necessary information to your family members or other significant caregivers to alleviate stigma & homophobia?**	(43.8%)	(56.3%)
• Did you feel your MHP provided adequate referral services required for the specific problem?***	10 (55.6%)	8 (44.4%)
Discrimination & Exploitation		
• Have you faced any discrimination by MHP because of your sexual orientation?	6 (23.1%)	20 (76.9%)
• Have you faced hostility from a MHP because of your sexual orientation?	3 (11.1%)	23 (88.5%)
• Has a MHP made negative remarks or comments on your appearance, clothing choice, etc?	1 (3.8%)	25 (96.2%)
• Has MHP made negative remarks or comments about your speaking tone/body language?	2 (7.7%)	24 (92.3%)
• Has MHP refused to provide services to you because of your sexual orientation?	0 (0%)	26 (100%)
• Have you experienced verbal abuse by MHP because of your sexual orientation?	1 (3.8%)	25 (96.2%)
• Have you experienced emotional abuse by MHP because of your sexual orientation?	2 (7.7%)	24 (92.3%)
• Have you experienced physical abuse by MHP because of your sexual orientation?	0 (0%)	26 (100%)
• Have you experienced excessively friendly behaviour from MHP because of your sexual orientation?	3 (11.5%)	23 (88.5%)
• Has MHP touched you unnecessarily and/or inappropriately because of your sexual orientation?	0 (0%)	26 (100%)
• Has MHP tried to seek sexual favours from you because of your sexual orientation?	1 (3.8%)	25 (96.2%)
• Has MHP threatened to reveal your sexual orientation to others?	0 (0%)	26 (100%)
Unnecessary Intervention		
• Has MHP advised you to change your appearance and/or choice of clothing?	1 (3.8%)	25 (96.2%)
• Has MHP advised you to change your body language or speaking tone?	1 (3.8%)	25 (96.2%)
• Has MHP advised you to change your sexual orientation?	4 (15.4%)	22 (84.6%)
• Has MHP advised you to opt for	3 (11.5%)	23 (88.5%)

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"orientation conversion therapies"?		
• Has MHP advised or offered medication to change your sexual orientation?	0 (0%)	26 (100%)
• Has MHP advised you painful & aversive techniques to change your sexual orientation?	0 (0%)	26 (100%)
Confidentiality		
• Has a MHP revealed your sexual orientation to others (except the treating team) without your consent?	1 (3.8%)	25 (96.2%)
• Has MHP revealed your personal identity & clinical details to others (except treating team) without your consent?	1 (3.8%)	25 (96.2%)
• Did MHP reveal your sexual orientation to your family members without your consent?****	2 (9.1%)	20 (90.9%)

*19 participants (out of 26) reported internalized homophobia & 7 denied internalized homophobia.

** Only 16 responses observed. 13 participants (out of 26) reported that they have revealed their sexual orientation to family.

*** 18 participants reported that they were in need of referral to other specialty.

**** Only 22 responses were observed.

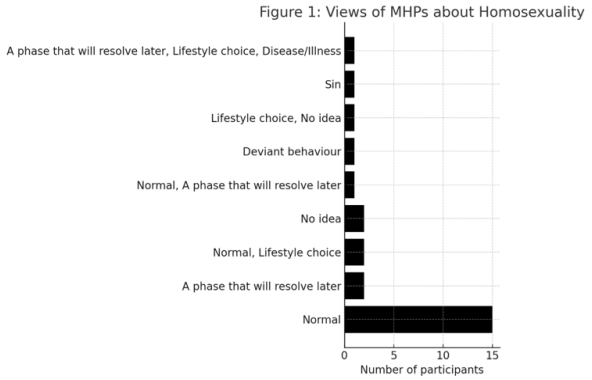

Figure 1: Views of MHPs about Homosexuality

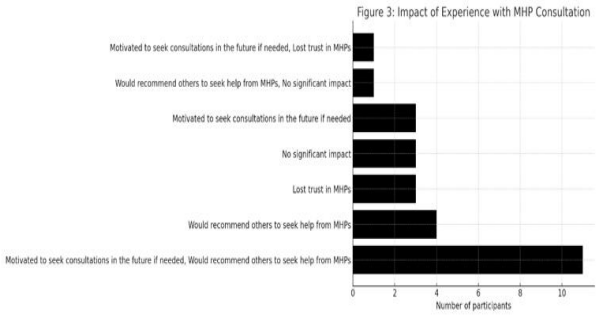

Figure 2: Impact of experience of consultation with MHP on participants

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