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Education and practice developments: Addressing the psychosocial concerns and support needs of LGBT+ people

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ABSTRACT

Background: There has been recent interest in the unique healthcare needs and concerns of diverse groups from human rights, social inclusion and healthcare access and utilisation perspectives. However, the distinct psychosocial experiences and needs of LGBT+ people remains under-researched.
Aims: The aim of the study was to examine the experiences of people who identify as LGBT+ in relation to their distinct psychosocial support needs.
Design: An exploratory qualitative study.
Settings: Hospital and community mental health services.
Participants: A total of 20 people identifying as LGBT+ who had used mental health services participated in the study.
Methods: Data were collected using individual semi-structured interviews. Participants who consented to take part were recruited to the study and undertook an interview of between 45 and 60 min.
Results: Thematic analysis was utilised to systematically highlight the emerging themes within and across the participant interviews. The main themes were: social aspects and help-seeking; concerns around supports; psychological treatment options; and LGBT+ culturally competent services.
Conclusions: The study findings inform the discussion and the implications for nursing practice, education and research are presented.

1. Background

There is a sustained international focus on the need to ensure equality of access to healthcare for all (Fullman et al., 2018). Health inequalities and barriers to accessing healthcare continue to exist due to interrelated factors including, gender, race, ethnicity, income, employment and housing, and are apparent in many sub-populations (Barber et al., 2017). These include people with mental health problems, older people, individuals with cognitive impairments and other disabilities. Therefore, it is necessary to have clear and sustained policy foci and investment, to promote equality of access to services that reduce health inequalities (Bakhtiari et al., 2018; M.B. Cooper et al., 2018, S.A. Cooper et al., 2018; Frasquilho et al., 2015; Oertelt-Prigione and Maas, 2017; Pongiglione et al., 2015; Sakellariou and Rotarou, 2017). Health service access can present significant barriers for some populations including people who identify as lesbian, gay, bisexual and transgender plus (LGBT+) (plus incudes queer, questioning, intersex, asexual) (Hickson et al., 2016; Hudson-Sharp and Metcalf, 2016; McCann and Brown, 2018). This is concerning and needs to be addressed given the global and national attention regarding the recognition and promotion of equality, human rights and reducing health inequalities (Hafeez et al., 2017; World Health Organization, 2013). Comprehensively addressing these concerns is necessary to continue to reduce the significant health inequalities that exist for many LGBT+ people (Stevens et al., 2018; Charlton et al., 2018). Although appropriate access to assessment, treatment, interventions and supports is an important goal, there is clear research-based evidence that this is not a reality for many and are issues that should be addressed though legislation, policy, education and service developments (Caceres et al., 2019).

There is a well-established body of research evidence regarding the health and service needs of LGBT+ people. However health access and sexual orientation disclosure remains an issue, impacting negatively on outcomes (Brooks et al., 2018). In addition to general health needs experienced by LGBT+ people, specific sub-populations have higher incidences of conditions such as obesity, arthritis, asthma and sexual

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health issues (Ritter and Ueno, 2018; Simoni et al., 2017). From a psychological and social perspective, many LGBT+ people experience and live with the consequences of minority stress, internalized homophobia and transphobia (Frost et al., 2015; Meyer, 1995; Testa et al., 2015). In terms of mental health issues *per se*, many LGBT+ people, across the life span, can experience anxiety, depression, trauma, suicidality, substance misuse and eating disorders (Kim et al., 2017: Russell and Fish, 2016). From an assessment, treatment and intervention perspective, health services, including mental health providers, responsive to the distinct requirements of LGBT+ people has been recognised as a concern (McDowell et al., 2019; Smith et al., 2018; Steele et al., 2017). For some, they may experience social isolation and loneliness with an opportunity to provide social spaces that maintain and develop social networks and community connectedness (Currin et al., 2018). Despite all of these concerns and the myriad of health needs, there is lack of attention within the education of healthcare professionals to ensure that they prepared to respond appropriately to the unique health requirements of this population (Bonvicini, 2017; Singer, 2015).

In a recent systematic review of 22 research studies, focusing on the inclusion of LGBT+ health concerns within undergraduate health professional education, it is apparent that there is a lack of meaningful attention paid to LGBT+ issues. A number of gaps were identified including cultural competence and inclusivity, limited knowledge of LGBT+ health-related needs, with significant shortcomings in relation to LGBT+ health concerns within the curriculum (McCann and Brown, 2018). Therefore, many health professionals, including nurses, lack the necessary knowledge, skills and confidence to work effectively with this population. Consequently, the current study seeks to more fully understand the specific psychosocial needs of LGBT+ mental health patients in community and inpatient settings and identify necessary education and practice development responses.

2. Methods

2.1. Aim

The aim of the study was to examine the experiences of people who identify as LGBT+ in relation to their distinct psychosocial support needs. The questions were:

1. What are the psychosocial experiences of people who identify as LGBT+?
2. What are the specific support needs of people who identify as LGBT+?

2.2. Design

The study was an exploratory qualitative design utilizing semi-structured interviews.

2.3. Settings

The study was conducted in the Republic of Ireland among people whom identified as LGBT+ who had experience of mental health services in community and inpatient settings.

2.4. Participants

A total of 20 people who identified as LGBT+ participated in the semi-structured interviews with ages ranging from 21 to 54 years (mean age: 34.1 years). A significant number (75%) were from Ireland. Many of the participants were not currently in a relationship (70%). The sexual identity of participants was gay (45%), lesbian (45%) and bisexual (10%). Gender identity was male (40%), female (45%) and transgender (15%). To recruit a wide and diverse sample in an often hidden and hard-to-reach population, a convenience 'snowballing' sampling strategy was employed. The inclusion criteria involved LGBT+ people 18 years and over and had used mental health services in the past 5 years in Ireland.

2.5. Data collection

Data were collected using individual semi-structured interviews and the final data set was completed by February 2014. LGBT+ and mental health service providers, including community and inpatient services, were sent information regarding the study. Key independent sector LGBT+ and mental health organisations were also provided with information for dissemination *via* social media and email distribution lists. Interested participants contacted the principal investigator by email or by phone for further information. Participants who consented to take part were recruited to the study and undertook an interview of between 45 and 60 min. The semi-structured interview schedule was developed from the existing research literature and within the research advisory group. The schedule was piloted and minor amendments made.

2.6. Ethical considerations

Ethical approval was provided by the relevant research ethics committee. All research ethics and governance procedures were adhered to throughout. During the data collection process, additional considerations were undertaken due to the potentially sensitive nature of the subject area. A list of national mental health support organisations and helplines were provided to enable participants to access additional support if indicated. Written consent was provided by all study participants.

2.7. Data analysis

All interviews were transcribed verbatim, anonymized and pseudonyms allocated. Thematic analysis was utilised to systematically highlight the emerging themes within and across the participant interviews. Transcripts were analysed individually and then collectively by the research team to facilitate the identification of the key themes (Clarke and Braun, 2017). A systematic approach to the analysis of the dataset was undertaken using *QSR NVivo 11* software (QSR International, 2015).

2.8. Rigour

To ensure trustworthiness of the findings, the principles of qualitative rigour were applied and maintained throughout data analysis (Lincoln and Guba, 1985; Noble and Smith, 2015). Robust methods of data collection, analysis and synthesis was undertaken to ensure the credibility of the data. The research team enhanced the dependability of data analysis by cross checking and confirming the themes. Throughout the research process, a clear and transparent decision-making procedure was systematically adopted to ensure the confirmability of the findings. Rich description of the participants experiences of their psychosocial and support needs were identified to establish the transferability of the findings (Graneheim et al., 2017).

3. Results

Following analysis of the data, four key themes emerged: (i) social aspects and help-seeking (ii) concerns around supports (iii) psychological treatment options and (iv) LGBT+ culturally competent services.

3.1. Social aspects and help-seeking

The wider social context of initially seeking help for their mental

health concerns was seen to have a potential impact on participants' experiences and future confidence. For the participants, there appeared to be a presumption by mental health professionals that all people were heterosexual, and this position created additional distress for some participants when they shared their sexual and gender identities. The challenges faced by some participants in relation to whether to disclose or withhold their sexual and gender identity was apparent. For many participants, there was the view that the disclosure of their identity was over stated by some mental health professionals and placed within the context of their presenting mental health issue, and that following treatment their distress would be ameliorated. As a consequence of effective treatment of their mental health issue, they would cease to have their 'gay feelings' and assume a 'normal' heterosexual existence. After declaring their status, the reaction from some healthcare professionals, such as the psychiatrist or general practitioner, often created surprise or incredulity:

> He just said…things will get better…you might even find a nice man…
>
> (Ciara, Lesbian)

> …I go to the doctor and like, he dismissed the whole thing immediately, the lesbianism bit. He just said it's to do with depression…it's to do with being disabled, it's all to do with that.
>
> (May, Lesbian)

Three participants highlighted issues related to conversion 'therapy,' often provided by counsellors. One participant, who was in contact with a religious order, explained:

> …I will never get to heaven as a lesbian, just don't act on it…I got a phone call from them saying that they had a counsellor that could basically convert me to straight…
>
> (Siobhan, Lesbian)

Another participant spoke about his families' intention to send him to the priest "so I can be fixed."

Conversely, some participants, had positive encounters when seeking help. One gay man spoke about feeling regarded and understood:

> …I feel very comfortable with my GP, I always make sure I get him as he really understands me…
>
> (Conor, Gay)

Some participants highlighted barriers to access for people with disabilities when attempting to participate in community supports, activities and events that would benefit their mental health. The access to community facilities presented a major challenge:

> I do know a few gay people in wheelchairs…if you want to enter the building…you need to be carried in…it's ridiculous…if there is a meeting all the way upstairs, there is no way they can get access to it…
>
> (Jack, Gay)

A major concern for some people who identify as LGBT + is stigma-related prejudice that can lead to further maginalisation and social exclusion. Stigma and discrimination and feelings of oppression and vulnerability were expressed by one participant:

> …yeah and even on the idea of stigma, there are people I don't tell, and that's I your identity basically, even the fact that you have to manage your identity in front of one person and not in front of another means the stigma still exists. Somewhere in society. I mean it's blatantly still around. You know, I wouldn't hold hands in the street.
>
> (Sean, Gay)

Discriminatory experiences can have a detrimental effect of a person's well-being and can result in higher incidences of mental health issues such as depression and suicidality, yet there is a reluctance in people to accessing and using appropriate mental health services. For one person, the intense feeling of social isolation related to being unable to get the necessary supports was apparent:

> You feel totally isolated and I think if there's one word that would sum it up, me sitting here today, it would be isolation. You're isolated in your own world growing up, because you don't feel part of anything, you feel isolated, and then when you're going through your processes, you're still, isolated…
>
> (Felicity, Trans)

3.2. Concerns around supports

For some, there did not appear to be a logical response to the individual needs of the person based on a comprehensive and holistic assessment of all the presenting history that appropriately contextualised their issues and concerns. It demonstrated the range of diverse needs and concerns experienced by many participants, beyond the presenting mental health issue. One participant eloquently captured some of the pertinent issues for services:

> I just said to myself one day, thank God I'm not black…you know… disabled, gay and mentally ill, because I'd be rightly f*cked within mental health services…
>
> (Muriel, Trans)

One young gay man, on first admission to the mental health unit, was being assessed by the psychiatrist who enquired about his sexuality. The young man said "I'm gay." The psychiatrist said, "really, does your dad know!?" Reflecting upon the experience, the young man said:

> …I was in shock! I couldn't even process it, I didn't know what was happening…the psychiatrist went …wow! wow!…and just laughed…
>
> (Patrick, Gay)

From the participants perspectives, responding appropriately to all of the concerns that people bring when entering mental health services, can impact upon their trajectory through the care system and their confidence when they may be at their most distressed and vulnerable:

> I would like to see no division between mental health and general health….I would love to see where people's physical health is linked to what's going on in their emotional and spiritual health.
>
> (Tracy, Trans)

> The fact that there are very few counsellors that are able to deal with transgender issues, also the fact that there are a number of counsellors… they're letting their religious beliefs affect their judgement…and I find that quite disturbing…that they're extremely unsupportive….
>
> (Agnes, Trans)

3.3. Psychological treatment options

Having access to a range of treatment modalities, not only medication, was seen as important for many participants. Consistency in assessment, treatment and care was a concern for some participants and seeing the same psychiatrist with one participant stating that she, 'must have seen about 20 different doctors.' For some, the only treatment option provided was prescribed medication:

> I am the doctor, you will do this…I know best…it's ridiculous, it's like they think they're infallible, and instead they just end up making people walk around like zombies. I don't want to be a zombie, which is why it bothers me that they just throw this medicine at me.
>
> (Mícheál, Gay)

Many participants spoke about the unavailability and limited access to psychological therapies. Many highlighted that in the public healthcare system, there was long waiting lists to access psychological therapies with the only alternative being to privately fund treatment. Being offered another treatment choice was a welcome offer for this person:

> ….that wasn't my GP making false promises…be referred to this cognitive-behavioural therapist and all that, and it made me feel, for a minute, that there might be some way out of this…
>
> (Patrick, Gay)

However, for many this was not viewed as a viable option. Some participants were only able to access private psychological therapy with the support of parents and partners. For others, there was limited support for children and families:

> there's nothing for transgender people, there's nothing for their families, there's nothing for the children…we've started a group to support trans families…
>
> (Mary, Trans)

3.4. LGBT+ culturally competent services

Participants wanted to be regarded, respected and to have their individual needs and concerns responded to appropriately. They expected to experience mental health practitioners who were self-aware, empathic, knowledgeable and could create an environment that was culturally sensitive and person-centred. A recurring theme apparent across participant responses was the need to ensure that mental health professionals are prepared with the appropriate knowledge, skills and competence necessary to recognise and respond to all the facets of their circumstances, including their LGBT+ specific needs:

> …to get rid of the dead weight doctors…like they need to completely retrain the staff, like a lot of them think so negatively, they need to treat people like humans…not numbers, not a condition, not depression just walked into the room or schizophrenia just walked into the room…
>
> (Leo, Gay)

Some participants highlighted the need to challenge and address, within mental health services, the predominant presumption of heteronormativity that still pervades many services. The assessment and care planning process should be fully comprehensive and developed collaboratively with the individual. For one person in training to be a health practitioner, suitable access for all was important:

> you know because if you go into this profession, you're there to help people, you don't think I'm going into this to help hetero-normal people…it's everybody, everybody deserves help, prisoners deserve help. You know, everybody who wants help should be able to get it…
>
> (Theresa, Lesbian)

The relevance of knowledge and the value of early intervention strategies and accessing appropriate support services was highlighted by one participant:

> …education, education, education…mental health issues are…life, nothing to be afraid of…shouldn't have a stigma…there is treatment there…how to recognise it as quickly as possible and realise what services are there, because the help is there…
>
> (Simon, Gay)

For one gay man diagnosed with HIV, he was hoping for services that were responsive, tailored to specific needs and seamless:

> …that there is a marrying, a marriage between the HIV clinical, the medical services, and mental health services…that people can access easily…and get the treatments they deserve….
>
> (Jim, Gay)

4. Discussion

The aims of the study were to examine the psychosocial experiences of people who identify as LGBT+ and determine their support. What has become evident from the findings of the current study is the challenges individuals face in accessing appropriate healthcare services that are responsive to their distinct health, psychological, emotional and social support needs. Overall, participants had great difficulty navigating and accessing the limited publicly funded services that were sometimes available and negative experiences related to the approaches and attitudes of some practitioners. Appropriate education and training and the development of necessary competencies was a fundamental consideration for many study participants. The implications in relation to practice, education and future research have become increasingly apparent for people who identify as LGBT+.

Globally, governments need to be committed and responsive to addressing health inequalities and tackling human rights issues for LGBT+ people. Examples of these directives include appointing an LGBT Health Adviser and introducing legislation to end conversion 'therapies.' (Government Equality Office, 2018). The experiences of LGBT+ people in accessing and using available supports and services was clearly articulated in the study interviews. Reactions from health personnel were often problematic with inappropriate responses and reactions demonstrated towards a person's sexual or gender identity. This can lead to LGBT+ being reluctant to disclose their sexual identity, thereby potentially limiting access to supports or use mental health services thus increasing the risks associated with socially exclusive practices and further maginalisation (Obedin-Maliver et al., 2011; Parameshwaran et al., 2017). The publicly funded treatments and supports available in health services were often limited, with psychopharmacological approaches prevailing over psychotherapies. For those seeking psychological therapy, it was sometimes necessary to pay for psychological therapies, with significant financial cost implications for some. Further, children and families of trans people continue to lack the necessary psychosocial interventions and supports, further highlighting the need for education and practice development in this area (Sharek et al., 2018).

In order to adequately address the social inclusion policy agenda, there needs to exist culturally competent and effective education and training programmes at undergraduate, postgraduate and CPD levels for health professionals, including nurses. There needs to be greater clarity about what already exists within the current curriculum and the identification of opportunities to embed LGBT+ specific issues within curricula (Echezona-Johnson, 2017). In terms of policy, practitioners should be able to discuss historical, political, institutional and sociocultural issues and factors (Kortes-Miller et al., 2019). Additionally, educational objectives should address how social determinants of health impact on the potential care and supports available to people who identify as LGBT+. Topics such as stigma, homophobia, transphobia, biphobia, heterosexism, identity across the lifespan and health risks should be included in education and training initiatives (M.B. Cooper et al., 2018, S.A. Cooper et al., 2018).

The international literature has shown that health practitioners often lack the necessary confidence and competence in dealing with sexuality issues, including LGBT+ requirements and concerns (Bidell, 2017; Echezona-Johnson, 2017; Grosz et al., 2017). Establishing baseline assessments determining values, attitudes and knowledge is fundamental in education and training developments (McCann and Brown, 2018). Several teaching and learning strategies have been proposed in the delivery of an LGBT+ focused curriculum and the development of LGBT+ specific education materials and the use of e-learning and

problem-based approaches and to widen participation and increase learning opportunities (Vance et al., 2017). Furthermore, clinical practice placement situations allow for the development of skills in eliciting sexual histories, enhancing collaborative care planning, and evaluating the delivery of sensitive and appropriate care and support (M.B. Cooper et al., 2018, S.A. Cooper et al., 2018). Continuing Professional Development (CPD) opportunities can allow practitioners to develop cultural competencies and address issues connected to their own values and beliefs such as stigma, discrimination, stereotypes, prejudice and social exclusion. Educational approaches and resources may include experiential workshops, skills simulation and online-learning materials thus enabling flexible learning strategies (Bidell, 2017). Systematic education and training evaluations are necessary at particular points to assess the impact or efficacy of specific learning outcomes such as competencies, beliefs, attitudes and aptitudes in meeting the identified requirements of LGBT+ people (Hirschtritt et al., 2019).

4.1. Future research directions

The researchers acknowledge the non-homogenous nature of the study populations and sub-groups. They also recognise that there are distinct experiences and unique needs within the wider LGBT+ community deserving for further elucidation and empirical research. Through conducting the study it has become evident that multiple minority challenges exist for LGBT+ people in relation to disability, culture and gender and addressing their psychosocial needs that require further investigation.

4.2. Strengths and limitations

The study presents the views and experiences of people who identify as LGBT+ in Ireland and the authors recognise the variation in service provision and experience internationally. Despite best efforts to include all sub-populations in the study, no bisexual people were recruited. The researchers were unable to recruit participants from diverse ethnic backgrounds, older people or people in hospital or residential care and these limitations are ackowledged.

5. Conclusion

Nurses are in an excellent position to influence future services, supports and interventions for people who identify as LGBT+. Nurses and nurse educators are well placed to lead and co-ordinate education and practice development initiatives that will assist in developing culturally competent and confident practitioners that possess the relevant knowledge and skills to enable them to empower and support individual who identify as LGBT+, their families and loved ones.

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Author contributions

EM and MB designed the study, conducted data analysis, reported the findings and reviewed drafts and prepared and finalised the paper for publication.

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