The Lesbian, Gay, Bisexual and Transgender (LGBT) community's mental health care needs: An integrative literature review

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Acknowledgements

Abstract

Objective

The mental health needs of the Lesbian, Gay, Bisexual and Transgender (LGBT)community have been often overlooked in health research, and there is an essential to understand the experiences of this community has when accessing mental health care, as it is known they are often exposed to a combination of stigma and discrimination because of their sexual or gender identity. Although publications have identified specific health needs for the cohorts within the community, they do not address the health disparities experienced by gender and sexual minorities. The objective of this integrative literature review is to identify the needs and experiences of the LGBT community when accessing mental health services.

Methodology

An integrative literature review was conducted using Whittlemore and Knafl's (2005) framework to review the contemporary literature surrounding the LGBT community's mental health needs and their experiences when accessing these needs. A total of 14 articles were selected for the integrative review which examined the qualitative data obtained by these studies. The data extraction and analysis process identified two key themes and five subthemes that are examined throughout the review.

Findings

Findings from the integrative review found that the LGBT community are exposed to unique social stressors that have a direct impact on their mental wellbeing. The findings indicated that the LGBT community have specific needs when accessing and engaging mental health services for these needs. The community is exposed to essentially a heterosexist international health system, and is frequently pathologised by health professionals because of the cultural differences, in particular when engaging with mental health services. The LGBT community's are generalised as a whole community, and not as individual cohorts, which creates additional barriers for specific needs, in particular those of the transgender community.

Conclusion

The recommendations and findings of this research demonstrates the need for health care systems to review their role in improving the health disparities of this minority population, and reduce the stigma and discrimination currently experienced by improving health policy and education development.

List of abbreviations

LGB - Lesbian Gay Bisexual

LGBT – Lesbian, Gay, Bisexual and Transgender

LGBTIQ - Lesbian, Gay, Bisexual, Transgender, Intersex and Queer

LGBTQ - Lesbian, Gay, Bisexual, Transgender and Queer

GLBIT -Gay, Lesbian, Bisexual, Transgender and Intersex

LQ - Lesbian Queer

WHO - World Health Organisation

MOH - Ministry of Health

NZ - New Zealand

USA - United States of America

UK - United Kingdom

Integrative literature review

Table of Contents

Chapter One Integrative Literature Review

Chapter Two Methodology and Method

Chapter One   Integrative Literature Review

1.1   Introduction

Internationally, the mental health needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) community has been generally overlooked in health policy development and health research. The health focus for the LGBT population group has been based on sexual health issues, primarily Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) (Neville & Henrickson, 2006). Even this focus has been limited by heterosexualism and homophobic bias, resulting in a lack of research around the health needs of the LGBT community (Treharne & Adams, 2017). Yet it is known that minority population groups that include LGBT and indigenous people (World Health Organization [WHO], 2013) are vulnerable and often exposed to poverty, chronic health conditions, neglect and maltreatment. These groups are associated with higher rates of mental illness than the general population (Cochran, Sullivan & Mays, 2003).

The literature shows that individuals of marginalised populations are at greater risk of disability, poorer health and even premature death (Fredriksen-Goldsen et al., 2014). Although being LGBT in itself does not increase the general health risk, the LGBT community's physical and mental health needs have often been ignored by primary health care, or associated with illness based on the population's sexual orientation group, rather than on general health (Neville & Hendrickson, 2006). LGBT people are not only at greater risk of contracting HIV (Treharne & Adams, 2017), but

also cancer (Harrell & Sassser, 2017), asthma, diabetes and increased rates of physical disability (Zelle & Arms, 2015), along with mental health and substance misuse problems (Taylor & Robertson, 1994).

The World Health Organisation (2013) defines health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (p. 7). In 2016 the New Zealand Ministry of Health (MOH) developed the New Zealand Health Strategy (MOH, 2016a), focusing on the needs of all New Zealanders: the strategy's philosophy is to ensure that all New Zealanders "live well, stay well, get well" (MOH, 2016b, p. 3). One of the underpinning principles of the document is to provide appropriate, accessible and affordable health care to every New Zealander (MOH, 2016b). However, although the policy acknowledges the specific concerns of populations such as Pacific, younger and older people, it does not capture gender or sexual minority individuals. These latter groups' health needs fall under the umbrella category of "disadvantage" (Adams, Braun & McCreanor, 2007 p. 201).

It is likely that a significant factor in the New Zealand Health Strategy's failure to identify the health needs of the LGBT community, particularly mental health, is the limited recent research available on this issue. The aim of this integrative literature review is therefore to capture the contemporary mental health needs of the LGBT community and their experience of seeking help for these needs, to provide evidence for future health policy and clinical practice to address the mental health of the LGBT population.

Over the past 30 years the term LGBT has become the standard acronym to refer to gender and sexual minorities (Smalley, Warren, & Barefoot, 2018). Recently this acronym has been considerably extended to become more fully inclusive of gender and sexual minorities. In this dissertation, however, the term LGBT is used as this is the one commonly found in the literature. The use of this term does not mean the perspectives of any gender and sexual minorities are overlooked in this dissertation.

The background sections that follow examine the mental health history of the LGBT community and identify how the health professions currently view the community. The chapter then discusses the implications of "coming out" as a process that is unique to LGBT individuals. Finally, the background explores physical and mental health disparities experienced by this minority group.

1.2   Background

1.2.1   The mental health history of the LGBT community

The history of the LGBT community is an essential starting point in acknowledging and addressing the community's needs. Historical events that occurred for members of the LGBT community continue to reflect how individuals currently perceive mental health care and are influenced when accessing mental health care, as before the mid to late 20th century homosexuality was illegal in most countries and in some remains a criminal act that is subject to harsh punishments (Dickinson, Cook, Playle, & Hallett, 2014). In 1952 homosexuality was first pathologised by psychiatrists as a sociopathic personality disturbance, and then in 1968 was reclassified as sexual deviation (McParland & Camic, 2016). Homosexuality was seen as a mental disorder

that was "curable" through a range of medical and psychological interventions (Uldall & Palmer, 2004), most commonly aversion therapy (James, 1962). Aversion therapy included medication induced nausea and vomiting by regular dosing intervals of apomorphine in combination with brandy (James, 1962). Other therapies included cardiazol treatment, insulin administration therapy, electroshock therapy, and leucotomy (Dickinson et al., 2014). These treatments were often in conjunction with visual or auditory erotic stimulation that was measured by a psychiatrist or psychologist to ensure the efficacy of the treatment (Dickinson et al., 2014). It was not until December 1973 that the American Psychiatric Association (APA) removed homosexuality as a mental disorder from its third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (McParland & Camic, 2016).

The catalyst for change was the 1969 gay and lesbian activist and civil rights movements challenging the APA and this movement questioned the APA classification of homosexuality as a mental disorder (McParland & Camic, 2016). Homosexuality was renamed Sexual Orientation Disturbance (SOD) with a broader definition that would encompass and capture individuals who saw their homosexuality as a distressing illness (Drescher, 2010). Changing the diagnosis was assumed to legitimise the practice of aversion therapy, so individuals would be reimbursed by health insurance companies for treatment. In 1980, the DSM dropped SOD and replaced it with "Ego Dystonic Homosexuality", which was later removed in 1987 following the republication of the DSM III-R (Drescher, 2010).

Despite some progress the transgender community continue to experience barriers that inhibit the ability to live a fulfilled life. During the gay, lesbian and civil

4

rights protests in 1969, transgender individuals were initially excluded as a minority of the lesbian, gay bisexual (LGB) community (Drescher, 2010).It was commonplace for LGB and transgender community to try to force political changes, where they later came together as political allies and united as one community. Following the gay liberation movement, there remained ongoing intercommunity political debates around the inclusion of transgender people, as their perceived human rights were the same, but their needs were significantly different from the LGB community (Drescher, 2010). However, in 1980 gender identity disorder was added to the DSM III to capture and medicalise transgender individuals (Hughes & Eliason, 2002).

Progression for the transgender community was slower than for the LGB; however, renaming of the diagnosis occurred, replacing the term gender identity disorder with gender dysphoria (Applegrath & Nuttall, 2016). Transgender people were victims of political, religious and medical bias as they did not fit within social norms of gender identity (Meyer, 2001). Health professionals continued to medicalise transsexualism, as psychiatrist's saw the transgender community as mentally disturbed. Although the APA considered the change in diagnosis was less pejorative, there remains a continuing discussion around the need for pathologising gender and sexuality. The APA acknowledges the impact of medicalising gender and sexuality, but continues to view transgender people as not fitting within social norms and as being mentally ill (Applegrath & Nuttall, 2016).

1.2.2 Coming out

Identifying as a member of a minority group is known to introduce a number of factors that contribute to an individual's mental health. The implications of disclosing as a sexual or gender minority are often overlooked, but are an important aspect of the mental health for this population (Meyer, 1995). Disclosing one's own sexual identity, commonly known as "coming out", is often a challenging time, particularly for adolescents (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). The term "coming out" has been described by Neville, Kushner and Adams (2015) as a process of acceptance of some degree of a sexuality that is different from that of the dominant group. "Coming out" is considered an integral part of developing a relationship, between validating an aspect of one's life and one's sexual identity (Cant, 2006). This process for some is known as a pathway of acceptance (Carastathis, Cohen, Kaczmarek, & Chang, 2017) but for others the experience can be traumatic (Neville et al., 2015).

Sexual minorities are exposed to unique risk factors compared to those who are heterosexual (Carastathis et al., 2017). Rejection, abandonment and ejection from family homes by parents can have detrimental effects on the health outcomes of LGBT adolescents (Ryan et al., 2010). Families are often the perpetrators in anti-LGBT behaviours by employing forms of rejection that include emotional, psychological and physical withdrawal, resulting in harmful behaviours towards the non-heterosexual family member (Carastathis et al., 2017). Families' ethnicity, occupation, gender and cultural norms, along with religious views, directly influence the acceptance or rejection of LGBT adolescents (Ryan et al., 2010). Religion and cultural stigmatisation of minority identity impacts significantly on the LGBT person's loyalty towards their

family, resulting in many LGBT individuals being left isolated and silent out of fear of humiliation or of shaming their family (del Pino, Moore, McCuller, Zaldivar, & Moore, 2014).

Adolescents who are rejected by their families have higher rates of development of post-traumatic stress disorder (Rivers, 2004); homelessness (Dysart-Gale, 2010); risk-taking sexual behaviors; negative sense of worth (Ryan et al., 2010); and substance misuse and suicidal attempts (Carastathis et al., 2017). In contrast, those who are accepted by their family have more positive outcomes including better general health, greater self-esteem, increased social supports and fewer self-critical behaviours (Carastathis et al., 2017). Coming out during adolescence is not only an internal self-acceptance process but also includes external acceptance within local communities, educational facilities and society as a whole (Rivers, 2004). LGBT youth often experience homophobia, defined as "the belief that hetero-sexuality is or should be the only acceptable sexual orientation" (Smith, 1993, p. 378). They can be victims of violent homophobic hate crime during their schooling years, resulting in poorer education outcomes and feeling alienated from mainstream society (Rivers, 2004).

Internalised homophobia is defined as the "LGB individual's inward direction of society's homophobic attitudes" (Newcomb & Mustanski, 2010, p. 1020); this is not just a self-negativity towards one's own sexual orientation but also includes homophobic societal views, a sense of discomfort with one's sexual identity and disconnectivity with fellow members of the LGBT community. Individuals often experience lower self-deprecating attitudes, self-regard, self-loathing or worthlessness (Newcomb & Mustanski, 2010). The risk of developing mental health problems as a

result of internalised homophobia has been well researched, as a primarily proximal minority stressor (Walch, Ngamake, Bocornusvakool, & Walker, 2016).

Homophobia manifests through a variety of negative attitudes and in different ways, including prejudice against homosexuals (Owen & Khalil, 2007), derogatory jokes, violence and disapproval by friends and family (Röndahl, Innala, & Carlsson, 2004). This can manifest in ether cognitive or emotional aspects of homophobia. Cognitive aspects reflect how people think about homosexuality that then influences their attitudes towards homosexual individuals. Emotional aspects are a sense of discomfort or non-specific dread associated with homosexual people and sexualities. People often project homophobia in ways such as guilt, awkwardness, embarrassment, shame and fright. Others may be more hostile towards homosexuality, showing anger, disdain and disgust (Röndahl et al., 2004). In particular, gay men and transgender people are often the victims of homophobic hate crime and are likely to experience physical violence as a result of their sexuality and gender (Meyer, 2003).

Multiple articles have found when accessing appropriate services, not only health, members of the LGBT community experience significant homophobia (Bakker, Sandfort, Vanwesenbeeck, van Lindert, & Westert, 2006; Corrigan et al., 2009) that includes social services (Dysart-Gale, 2010; Price, 2010) education (Rivers, 2004); housing (Bagley & Tremblay, 1997); and employment (Bostwick & Hequembourg, 2014). Seeking health care has often led to negative experiences and consequences for LGBT individuals because of forms of homophobic health practitioners' heterosexism, or common ignorance (Adams, McCreanor, & Braun, 2008). LGBT individuals are often challenged by any need to disclose their sexuality to health professionals as it

leaves them vulnerable to a power imbalance and risk of further rejection and poor care (Eliason & Schope, 2001).

Negative attitudes by health care professionals towards gender and sexual minorities remain a significant barrier to reducing health disparities and providing adequate effective care to the LGBT community (Dominguez, 2017; Jackson, 2000; Riggs & Bartholomaeus, 2016a). Discrimination and stigmatisation of the LGBT community continues to reflect the systematic cultural and structural barriers to achieving social and health equality (McClain, Thomas & Yehia, 2018). Fear of discrimination and prejudice has often led to individuals hiding their sexual orientation. Often people of ethnic minorities are reluctant to disclose their sexual identity to health professionals, which creates a further barrier for them in accessing and being provided holistic healthcare (Adams & Neville, 2018).

Minority stress is a theory that is used to explain the unique experiences by members of a minority group in society who are stigmatised and discriminated against (Meyer, 1995). Minority stress is explained as a combination of adversity based on the reason of minority (Meyer, 2003). For sexual minorities these include internalised homophobia, experience of prejudice and perception of stigma that results in increased psychological distress (Meyer, 1995). This compounding internalised experience of adversity can lead to alienation and a lack of social control, and often results in a negative self-view that increases social stress (Carastathis et al., 2017). If a member of a minority group is under chronic stress, they have an increased risk of developing mental health problems (Meyer, 2003). Meyer argues that building resilience and a relationship within the minority community can reduce the impact of minority stress.

Although the LGBT community is in a vulnerable position to experience negative attitudes and heterosexualism within society, it does, however, have a strong foundation of community resilience (Carastathis et al., 2017). Members of the LGBT community often access social support from one another to build strong relationships within the community as a whole (Corrigan et al., 2009). A sense of belonging to a community has been identified as a strong protective factor, and is seen as a buffer for those individuals who experienced rejection or adversity when coming out (Fenaughty & Harré, 2003). The LGBT community fosters the momentum for societal change and focuses on political agendas to combat the stigma and discrimination experienced by gender and sexual minorities (Corrigan et al., 2009). Although rejection has been identified as having significant adverse effects, the ability for individuals to develop resilience through learning, growing, and adapting to negative experiences provides a foundation to embed confidence, self-acceptance and pride in being who they are as individuals (Carastathis et al., 2017). The community has formed bridges between their differences and created safe spaces for individuals to develop norms and values where their identities and relationships are acknowledged and respected (Meyer, 2001).

"Coming out" is a unique experience for gender and sexual minority individuals that carrys significant risk of facing homophobia and rejection: at the same time the need to identify as a member of a community enhances and fosters meaningful relationships. Nonetheless, living in a society that is based on a heteronormative perspective does increase the risk of those who do not fit this norm developing poorer health outcomes (Meyer, 2001).

1.2.3 Health needs of the LGBT community

Each of the subgroups within the LGBT community is identified with unique and specific physical health needs. Health research into the LGBT community has generally focused on reducing the rates of contracting HIV/AIDs (Graham et al., 2017). However, recent research has been undertaken that acknowledges other needs for the sexual and gender minority community that include higher rates of sexually transmitted infections (Harrell & Sasser, 2017), cigarette smoking (Neville & Henrickson, 2006), obesity and cancers (Harrell & Sasser, 2017).

Gay men's health issues within New Zealand are often seen as invisible (Adams, McCreanor, & Braun, 2013) yet recent studies have shown that gay men have poorer health outcomes compared to the general male population in a range of health areas (Adams, Braun, & McCreanor, 2012; Adams et al., 2013). Heterosexualism continues to drive health care, reinforcing a negative view of gay men's health (Adams et al., 2013). There remains failure to explore the health needs of gay men from a personal, cultural and social aspect, and their health in particular remains generally unresearched (Adams, Braun et al., 2012).

The bisexual group fail to be distinguished as an individual group within sexual minorities (Flanders, Robinson, Legge, & Tarasoff, 2016). It is known that Bisexual individuals experience physical health disparities comparative with heterosexual individuals; however, the distinct difference remains unclear (Warren, Smalley, & Barefoot, 2018). One of the significant differences of the bisexual group is lack of acceptance within the LGBT community (Bostwick & Hequembourg, 2014; Flanders et

al., 2016). Bisexual individuals are discriminated against and ignored by the lesbian and gay community, as if "there is no such thing as bisexuality" (Bostwick, Boyd, Hughes, West, & McCabe, 2014, p. 489). Micro aggression from members of the gay and lesbian community has often resulted in the exclusion of bisexuals as a minority sexual orientation (Bostwick & Hequembourg, 2014). This leaves the bisexual group in a position of heightened stress levels and increased risk of developing stress related illness such as mental health problems (Flanders et al., 2016). Bisexual men's and women's health is often associated with gay or lesbian health needs; however, this approach fails to accept differences within the community group or consider the specific health needs of this cohort (Oswalt, 2009). There remains limited research around the health needs of the bisexual community, as data collected is generally captured within gay and lesbian health research (Warren et al., 2018).

The transgender community experiences a range of complex and diverse health needs that are associated with this population. Acceptance of gender expression and the sexuality of those who differ from assigned sex at birth continues to face strong prejudiced barriers especially within the western countries (Lo & Horton, 2016). Transgender people may identify as male, when born with female sex characteristics, and may identify as heterosexual, gay or even bisexual, which makes capturing health data difficult for the population as a whole (Reisner et al., 2016). Transgender people are at greater risk of health disparities than those of other minority groups (Wylie et al., 2016). Transgender people are devalued in social status because of percevied deviation from normative gender roles and are often involved in sex work, leading to poorer socioeconomic status (Winter et al., 2016). Transgender people also experience a wide

range of health concerns that are not adaquately adressed by health care (Reisner et al., 2016).

It remains the view of the transgender community that psychiatrists and psychologists, along with other medical disciplines, remain the gate keepers of medicalised therapy including hormone replacement and gender reassignment surgery (McCann & Sharek, 2016). There remains a clear power imbalance because of the need for the transgender community to be diagnosed with a mental disorder in order to receive medical intervention to live a fulfilled life (Vitelli & Riccardi, 2010). Controversially, only being diagnosed and labeled with gender dysphoria as a mental disorder allows access to medical interventions, along with complex issues regarding access tomedical insurance (dickey & Keo-Meier, 2018; Schuster, Reisner, & Onorato, 2016).

Over recent years public health has begun to adress the physical health needs of the LGBT community, but there remains limited quality research (Meyer, 2001). Meyer (2001) explains gender identity or sexual orientation may not have a direct relationship to the higher risk of health problems, and that such health problems are not specific to the LGBT community. Therefore, health research for the LGBT population requires careful consideration as it is impossible to generalise the physical health needs of such a diverse and complex cohort (Meyer, 2001).

1.2.4 Mental health of the LGBT community

The Ministry of Health have developed a strategic document for the mental health of New Zealanders known as *Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-2017* (MOH, 2012). The plan was developed to ensure all New Zealanders would have equal opportunity to access and receive appropriate mental health care, with guiding principles intended to influence health funding within District Health Boards in Aotearoa/New Zealand (MOH, 2012). One of the principles of this document is to respect cultural diversity. However, the document does not acknowledge the mental health needs of the LGBT community, although it does take into consideration other minority groups including refugees and people with disabilities (MOH, 2012). Yet, LGBT individuals are overrepresented among those with mental health problems which, indicates the importance of providing unique, but individualised, care for the needs of this group (Adams, Dickinson, & Asiasiga, 2012; Graham et al., 2017)

The mental health needs of the LGBT community are generalised with all populations who suffer mental illness. A person's mental health is influenced by multiple environmental and social factors that include education, income, housing, access to appropriate health care, employment and social status (Adams, Dickinson et al., 2012). The mental wellbeing of the LGBT community has been researched primarily by focusing on negative events, health issues and stress (Adams, Dickinson et al., 2012). It is readily acknowledged that repeated exposure to a range of psychological stressors associated with homophobic/transphobic attitudes, stigmatisation, violence and discrimination has a negative impact on the mental health of the LGBT community

(McCann & Sharek, 2014). There is a substantial amount of literature that identifies members of the LGBT community experiencing higher rates of depression (Bailey, 1999; Mays & Cochran, 2001; Newman et al., 2012; Ngamake, Walch, & Raveepatarakul, 2016; Persson & Pfaus, 2015) ; anxiety (Adams, Braun, et al., 2012; Bailey, 1999; Flanders et al., 2016; Mays & Cochran, 2001; Persson & Pfaus, 2015); substance and alcohol misuse (Adams, Braun, et al., 2012; Kecojevic, Wong, Corliss, & Lankenau, 2015; King et al., 2003; Newman et al., 2012; Persson & Pfaus, 2015; Rowan & Butler, 2014; Welch, Collings, & Howden-Chapman, 2000); body image and eating disorders problems (Duggan & McCreary, 2004; Russell & Kell, 2002; Silberstein, Mishkind, Striegel-Moore, Timko, & Rodin, 1989; Yelland & Tiggemann, 2003) and borderline personality disorder (Paris, Zweig-Frank, & Guzder, 1995) along with other mental health problems similar to the general population (Lucassen, Stasiak, Samra, Framptom, & Merry, 2017).

Aotearoa/New Zealand has one of the highest rates of suicide amongst developed countries (MOH, 2006) and Swannell, Martin, and Page (2016) explain that individuals who do not identify as heterosexual are at increased risk of suicidal ideation and suicide attempts compared to their heterosexual counterparts. There are risk factors associated with suicide that have been examined as both individual factors, and macrosocial factors. Individual factors include genetic predisposition, sexual orientation and personality, whereas macrosocial factors include presence of mental illness, unemployment, socioeconomic factors, trauma and culture (Fenaughty & Harré, 2003). Sexual and gender minorities have additional risk factors for suicide, some of which include the likelihood of experiencing depressive symptoms, social stress, and an internalised sense of shame focusing on their sexuality (King et al., 2008).

15

Psychiatry as a medical specialty continues to pathologise gender and sexual minorities as mentally disordered. This is clearly reflected amongst the transgender community. It is the view of modern society that there is a need to medicalise and pathologise differences that do not conform to social norms (Applegrath & Nuttall, 2016). Members of the LGBT community continue to be ostracised when accessing social services, including health care, because of their gender differences or sexuality. There is therefore a need to review the literature focusing on the experiences of the LGBT community when accessing mental health care to provide an evidential basis to address areas where health care services for this minority population require amendment and improvement to reduce disparities. The Australian and New Zealand College of Psychiatrists has recently highlighted the importance of more current research that identifies the mental health needs of the LGBT community (Lucassen et al., 2017).

1.3 Research aim

The aim of this research is to complete an integrated review to identify the mental health needs of the LGBT community and their experiences when accessing mental health care. The recognition of specific needs for this community will offer mental health care providers an in-depth understanding of the LGBT community's needs. This will promote a wider understanding of the barriers and limitations for the community when accessing mental health care. It is also hoped this research will enhance culturally safe practice amongst health professionals, including operational policy development and organisational health strategies to address the mental health disparities of the LGBT community.

Chapter Two   Methodology and Method

2.1   The integrative literature review

The integrative review utilises a specific methodology to summarise and analysis past empirical and theoretical research to provide a comprehensive understanding of the phenomenon or health problem (Whittemore & Knafl, 2005). Comprehensive literature reviews including integrative and systematic reviews and metaanalyses have been acknowledged as contributing to science by integrating research. The integrative review allows for a broad range of methodologies, including the simultaneous use of experimental and non-experimental research, to enable the full understanding of the phenomenon of concern (Whittemore & Knafl, 2005). The use of data sourced from studies using a range of methodologies can complicate the analysis of data; it does, however, enhance a larger variety of sampling that enables a comprehensive portrayal of the topic of interest (Whittemore, 2005). Whittemore and Knafl (2005) have described a framework for conducting an integrative review that includes problem identification, literature search, data evaluation, data analysis and presenting findings.

The problem identification stage is considered the initial part of the integrative review method, which should include a well-established and clear view of the problem that the review is addressing. Having a clear problem or purpose is the foundation of the review process, ensuring that the data extraction is well focused (Whittemore & Knafl, 2005). A well-developed problem or purpose for the review creates clear boundaries for the specific focus of the integrative review process (Whittemore & Knafl, 2005).

Literature search strategies are critical for any type of review for enhancing rigour, as incomplete or biased literature searches result in inaccurate findings of primary data (Whittemore & Knafl, 2005). A well executed and comprehensive search strategy helps to ensure all relevant literature on the topic or problem of interest is included within the review. This involves both electronic searching of databases and manual searching of reference lists to ensure the search conducted is as complete as possible. The search process requires the clear articulation of eligibility criteria that reflect the essence of the problem identified. After identifying the literature according to the pre-determined eligibility criteria, each study is then evaluated on its research quality. Assessment of the quality of the papers is conducted by at least two people using validated quality appraisal tools. The tools evaluate the methods used in each of the primary research papers, and because in an integrative review there may be multiple research methods, it will be necessary to evaluate each study with a method-specific quality appraisal tool (Whittemore & Knafl, 2005).

Data analysis involves the results/findings from each study being ordered, coded, categorised and summarised from the primary sources to combine and integrate the conclusion of the research problem (Whittemore & Knafl, 2005). It is the primary goal of the data analysis stage to remain unbiased and thorough during the interpretation of the primary sources data, along with remaining innovative when synthesising the evidence (Whittemore & Knafl, 2005). Using a consistent overarching approach to the method enhances the way data is converted and extracted, and therefore enables a systematic approach that facilitates the distinction of the themes, variations, relationships and patterns of the data extracted (Whittemore & Knafl, 2005). Once systematically coded and classified, the data is compared and grouped together to

enable the completion of the synthesis. Within the data analysis stage there are a number of sub-stages that contribute to the integrative review process: these include *data reduction, data display, data comparison, conclusion drawing* and *verification* (Whittemore & Knafl, 2005).

Data reduction involves developing an overarching classification system that is used for managing the data from the range of diverse methodologies. Primary sources used in the integrative review are required to be classified into subgroups that remain in a logical system used to facilitate analysis of the date (Whittemore & Knafl, 2005). Data reduction involves extracting and coding the data from the primary sources so that is simplified and organised into a manageable framework. It is fundamental that methodical rigour is ensured throughout the coding process to ensure reliability. The relevant data from each primary source subgroup, or classification, is then extracted into a spreadsheet or matrix. This provides a logical approach that facilitates the literature being accessed in a systematic way, which allows a comparison of the sources based on issues, sample characteristics and the variables (Whittemore & Knafl, 2005).

Data analysis involves converting the extracted data from the primary sources to a display that assembles the multiple sources into particular subgroups or variables, and this is completed during the data display. This can be completed in the form of graphs, charts, networks or matrices to allow comparison of all primary sources. This allows the patterns or relationships identified by the analyse to be visualised, enabling a starting point for the interpretation of data (Whittemore & Knafl, 2005).

Data comparison is a repetitive process that examines the data displays in order to elicit patterns, relationships and themes of the primary data. Once patterns are identified, often conceptual maps are used to indicate the majority of the themes or variables within the data. Similar relationships between the variables or themes are grouped together to be displayed, as this provides clarity to support the emerging empirical or theoretical interpretation. Critical and creative analysis of the data and displays of the data are key in the comparative and identification process, as they enhance the accuracy of patterns of themes identified (Whittemore & Knafl, 2005).

The final phase of data analysis is conclusion drawing and verification. This phase moves from the description of the relationships and patterns interpreted. The themes, patterns, relationships and conclusions are required to be verified with the primary source data to ensure confirmability and accuracy. It is essential this is done with care to avoid analytic closure or the exclusion of evidence that may be pertinent during this process. With all qualitative analysis, the entire process of data analysis should be recorded to capture the analytical hunches, analytic decisions, puzzles, thoughts, or alternative hypotheses that may directly influence the interpretation of the data (Whittemore & Knafl, 2005). At times conflicting evidence can be challenging when results are equally compelling. However, it is essential to analysis conflicting results by exploring the confounding influences that may contribute to variables in the findings. The final step of the integrative review data analysis is the synthesis of the identified key elements or subgroups into a summation of the phenomenon or topic. Integrating all subgroups allows a comprehensive and integrative portrayal of the research topic, therefore completing the review process (Whittemore & Knafl, 2005).

2.2   Research method

2.2.1   Problem identification

The needs of the LGBT community have been often overlooked in health research. Limited resources have been allocated to this community in health research following the HIV/AIDs epidemic. As a result, there is limited research that discusses their mental health needs and their experiences of seeking help for these needs, yet there remain health disparities amongst LGBT community. Given the growing rates of mental illness in New Zealand, there is a need to review the current literature to identify how best to address the current health inequities experienced by this minority community. There appeared to be only one systematic literature review on this topic (King et al., 2008), which hypothesised that LGBT people are at higher risk of mental disorders, but this study did not capture the community's mental health needs.

The aim of this integrative review to gain an understanding of the mental health needs for the lesbian, gay, bisexual and transgender (LGBT) community, and to understand their experiences of seeking help for these needs. The objectives include understanding the mental health needs of the LGBT community, and also to obtain a further understanding of their current experiences of accessing mental health care.

2.3   Literature search

A comprehensive search of the two electronic databases selected, CINAHL and PsychINFO was completed. Assistance from a medical librarian was obtained to ensure

the appropriate search terms were used throughout the databases. Specified search parameters were used and adjusted according to the database settings. These included: English language, peer reviewed journal, full text accessibility, qualitative studies, age range between 19-64 years old (CINHAL), age range 18-64 (PsychINFO) and publication dates between 1996-2018.

Inclusion criteria:

- Studies that examined the LGBT population and the phenomena of mental health needs and experiences of seeking help for these needs

- Publication range of 1996-2018

- Participants between the age of 18-65 years

- Written in English language

- Peer reviewed journal articles

- Including qualitative and mixed method design

Exclusion criteria:

- Studies completed in other languages

- Case studies

- Quantitative studies

- Mental health needs in the context of HIV/AIDS diagnoses

The initial search used terms relevant to the LGBT community on CINHAL data base and was completed using the database Boolean operator OR, which resulted in

13,207 articles. The key terms were: "GLBT", "gay", "LGBTQ", "gay lesbian and bisexual", "lesbian gay and bisexual", "lesbian gay bisexual and trans", "gay lesbian bisexual and trans", "gay lesbian bisexual and transgender", "lesbian gay bisexual and transgender", "homosexual", "rainbow', "queer", "rainbow community", "lesbian", "bisexual" and "Fa'afafine". The language and terminology around mental health was used, again using the Boolean operator OR, and resulted in 470,912 articles. The searched terms relating to mental health were: "mental health", "Psychiatry", "mental wellness", "mental disorders", "substance abuse", "substance dependence" and "drug abuse". Lastly the experiences were searched with results of 152,431 using the Boolean operator OR with search terms that include "lived experience", "perception" and "perceived". Combining all three search phases together using the Boolean AND resulted in 70 articles that met search criteria within the parameters.

For PsychINFO search terminology included: "male homosexuality", "bisexuality", "lesbianism", "transgender", "homosexuality", "LGBT", "GLBT", "gay", "lesbian", "bisexual", "transexual", "queer", "lesbian gay bisexual", "gay lesbian bisexual", "gay lesbian bisexual transgender", "lesbian gay bisexual transgender", "LGBTQ", "lesbian gay bisexual transgender and queer", "gay lesbian bisexual transgender and queer", "rainbow community" and "rainbow family". Searching the LGBT community on PsychINFO using the assigned and appropriate terminology for the database resulted in 42,235 articles when using the database Boolean OR. Following this, mental health was searched, and terminology adjusted to the database resulted in 333,467 articles, again the Boolean OR was used to combine the terms used "mental health", "mental illness", "psychiatric patients", "substance abuse", "drug abuse", "drug dependence", "substance dependence" and "illicit substances". Lastly the experiences were searched, using the

Boolean OR resulted in 437,194. "life experiences", "phenomenology", "lived experience", "perception/or self-perception/or social perception", "perception" and "perceive". Combining all three phases together using the Boolean AND resulted in 511 articles. Search parameters were adjusted and reduced to the number of articles to 70.

2.3.1 Selection of studies

A total of 141 articles met the criteria for review of title. A duplicate was removed from the total number of article titles, leaving 140. All article titles were screened, with the abstracts being reviewed for any articles that were of any relevance to meeting the objectives of the integrative review. Of the 140 articles, 24 met the criteria for full text reading. A manual search of articles references lists added an additional five studies that adjusted the total to 29 articles. Of those 29 articles, 15 were excluded for a variety of reasons, such as research design and participants who experienced a learning disability or family members with dementia. This left a total of 14 articles for quality appraisal, 13 were qualitative, and one was mixed methods were only qualitative data was used. The PRISMA 2009 flow diagram represents the process of article selection. Appendix 1 lists the articles that were excluded following quality appraisal.
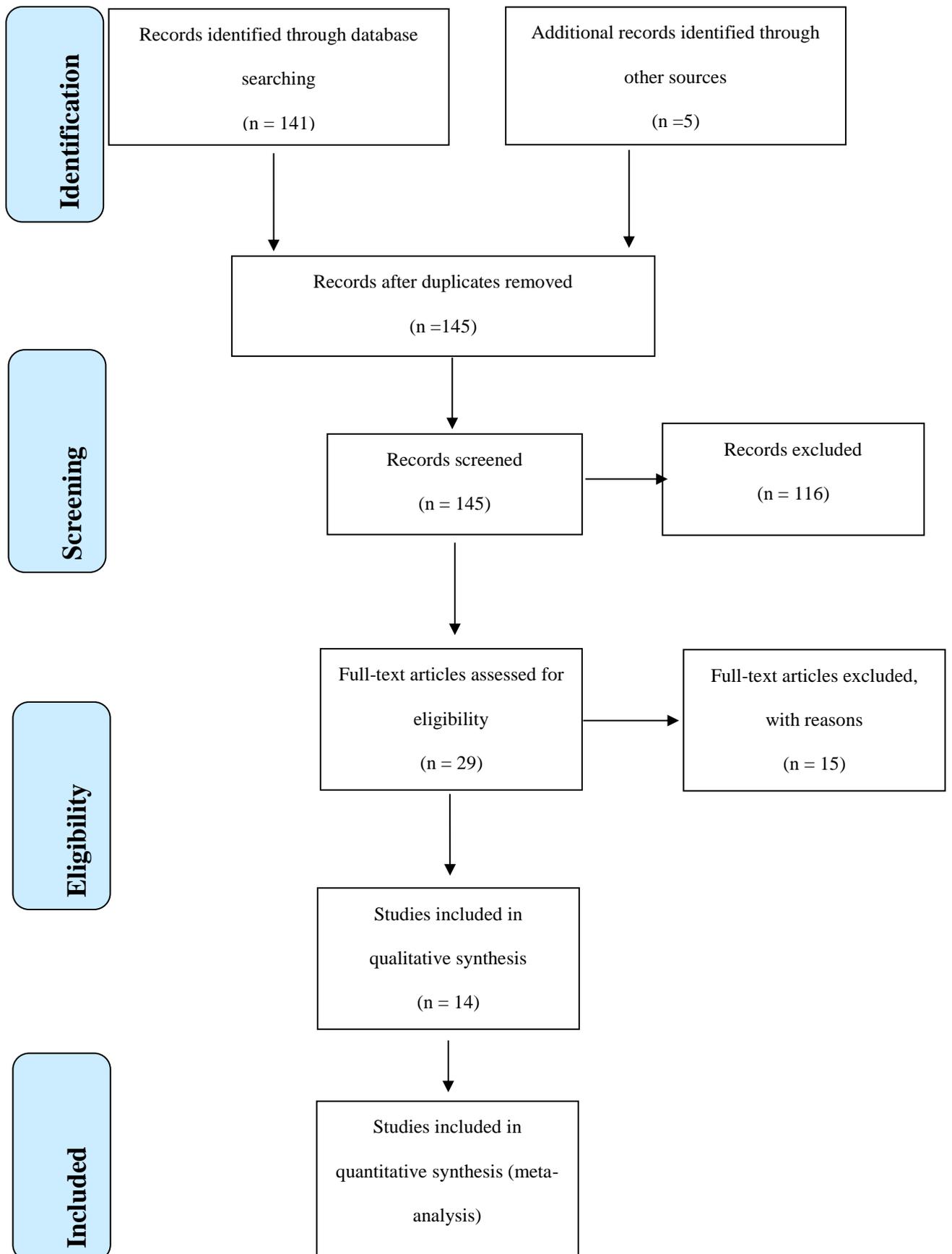
Figure 1: PRISMA Flow diagram of search process

2.3.2 Quality appraisal

All forms of literature review are subjected to the process of appraisal, or critique, of research evidence (Joanna Briggs Institute [JBI], 2017). The purpose of the appraisal process is to assess the methodological quality of the approved studies to address possible bias in the design, analysis and conduct of the research (JBI, 2017). The research is subjected to appraisal by two appraisers for rigorous analysis of the methodology (JBI, 2017). The JBI critical appraisal checklist for qualitative research approved by the University of Otago, is used to assess the quality of the research selected for appraisal. The appraisal tool was used by the author and one of his supervisor's through the University of Otago. Articles were included or excluded from the integrative literature review following appraisal using the JBI tool (Appendix 2)

2.4 Ethics

Ethical approval was not required for this integrative review as literature used was already published. The research was conducted in a manner that reflected the authenticity of the published work, remaining truthful to the authors' findings and discussion throughout the literature review.

2.5   Data analysis stages

2.5.1   Data reduction

Data reduction was completed in two primary steps following the integrative review methodology (Whittemore & Knafl, 2005). The first step in data reduction is organising the primary data into a logical system that would enhance and facilitate the data analysis. The primary sources were organised in a logical manner, ordered by date of publication. All of the primary data, apart from one that was mixed methodology, were qualitative research. The extraction of data from the mixed methodology focused only on the qualitative data obtained.

2.5.2   Data display

The second step of the data reduction process is to use techniques that simplify the primary data sources into a manageable framework using a matrix or spreadsheet to examine the data extracted from the primary data source. Primary data was extracted onto a table format (Appendix 3), with a logical and systematic approach to examining the data on one page. Headings on the table for logical organisation of the data included: author, country, sample size, sample gender and sexual orientation, method, aim, mental health needs identified, experiences of seeking help, conclusion. Examining the primary sources through a table allowed a succinct and organised approach to systematically comparing the primary data sources on the sample characteristics, specific issues, and variables throughout the studies. The data is displayed on a table (Appendix 3) that allowed a visualisation and starting point of

interpretation of the data. The data is displayed in a way that identified patterns and

relationships of the primary data sources to be used in the data analysis process. The

display of the data is used in the interpretation of the research question or problem

identified throughout the data analysis stage of the integrative review process

(Whittemore & Knafl, 2005).

2.5.3 Data comparison

The data is examined through the data display (Appendix 3) to identify emerging

themes, patterns or relationships between the primary sources. This allows the

comparison of the theoretical and/or empirical evidence of the interpretation of the data

earlier in the integrative process. It remains essential to be critical of, and creative with,

the data display throughout the analysis process to identify and compare the accuracy

of the key patterns and themes identified throughout the primary research (Whittemore

& Knafl, 2005).

Chapter Three   Findings

3.1   Introduction

This chapter will summarise the articles that were included in the literature review. The summaries are followed by the synthesis of data from the integrative review extraction process. Lastly, the chapter then details the key themes and subthemes identified.

3.2   Overview of selected studies

A total of fourteen articles met the eligibility criteria for the integrative review process. The PRISMA flow diagram (Figure 2.1) represents the inclusion and exclusion process of this review. Articles used in the integrative review ranged in dates of publication from 1998 – 2016. The countries in which the research was undertaken were New Zealand, Netherlands, United States of America (USA), Canada and the United Kingdom (UK), including Ireland and Scotland as individual countries. The number of participants ranged from four to 889. Participants involved in the studies identified as one or more of the follow: gay, lesbian, bisexual, transgender or intersex, and also identified as either male, female, transmale, transfemale or non-binary gender.

3.3   Study Summaries

Robertson (1998) completed a qualitative explorative study of gay men's experiences and views of health care in the Lothian area of Scotland. Twenty participants initially engaged in focus groups which assisted the research team to

develop themes. These themes were the focus for interviews with a further 17 participants. All the sample group (*n*=37) were individuals who identified as active within the gay scene, as well as educated and of higher socio-economic status. Robertson (1998) identified the importance of self-identifying as homosexual as this was the sample population recruited for the research. As the research aim focused on health, people who had a diagnosis of HIV positive were also included in the sampling. The aim of the research was to explore the experiences of gay men and the view they have of health and health care use.

Robertson (1998) identified that depression and suicide were significant health factors for the cohort who participated in the research, finding that 25 percent of the participants had accessed health care because of their suicidality or anxiety. Problematic alcohol use was noted as a coping mechanism for some participants when dealing with their homosexual identity, but the percentage was not given. Participants reported that they were unlikely to disclose their homosexuality to health professionals out of fear that their identity would be the primary focus of the health professional, rather than addressing the underlying mood or anxiety problem. One of the participants reported inpatient psychiatric admission for aversion therapy for treatment of his homosexuality. The participants clearly articulated that health professionals often used heterosexist language, effectively forcing gay men to lie or to make explicit statements in regards to their sexual orientation. The participants expressed a deep distrust of professionals working in health services (Robertson, 1998).

Matthews, Lorah and Fenton (2005) used grounded theory methodology to examine in-depth factors that contributed to 20 lesbian women's recovery from

addiction to alcohol and or drugs. Participants lived in the West Coast, Midwest, Mid-Atlantic and Northeast regions of the USA. Women who participated self-identified their ethnicity as Caucasian, White, European American, African American, or Jewish. Participants were recruited through purposeful sampling to meet the criteria of the qualitative research. The sample selection were individuals 18 years and older, who identified as lesbian and in recovery from alcohol and/or other drugs for a minimum of one year.

Matthew et al. (2005) found the major theme that emerged from their research was self-acceptance as a lesbian woman while also recovering from alcohol or other substance use. The majority of participants reported positive experiences with lesbian based Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) services. Matthew et al.'s (2005) participants believed the essential aspect of having talking therapy with a non-judgemental person was the essence of recovery, and found working alongside therapists who were non-judgemental to be beneficial towards their abstinence from alcohol or other substances.

Pettinato (2008) completed a grounded theory methodology study of lesbian women's experiences of alcohol misuse. A total of 13 women were interviewed after being sober for over 24 hours. Twelve of the 13 participants identified as lesbian, and one identified as bisexual. They latter was included because of her committed monogamous lesbian relationship at the time of the interview. All participants were from the Northwest of the USA, and all at various stages of their recovery from alcohol misuse. The majority of the participants identified as Caucasian, with two describing their heritage as mixed Native American, and others identifying as mixed ethnicity

including Japanese. Participants had all completed at least high school qualifications, some had completed college courses, and one woman had completed two PhDs. Twelve of the participants had experienced sexual abuse by a family member or relative before or during adolescence. Ten of the woman identified that members of their immediate family were currently or had been addicted to alcohol.

Pettinato (2008) identified a key theme of the use of alcohol as a means of the participants disconnecting with their lesbian identity. Pettinato (2008) found that the participants' disconnectedness with their own identity stemmed from childhood adversity and sexual trauma; only one participant denied any adversity. Participants explained the challenges they faced with acceptance of their self-identity, including previous suicide attempts and suicidality. However, participants experienced homophobia from their family and community, and often delayed accessing health care due to the fear of discrimination and heterosexist bias. Participants reported positive experiences through therapy that focused on past trauma and recovery from alcohol dependence.

Daley (2010) explored the relationship between self-disclosure of sexuality, and the wellbeing and recovery of lesbian/queer (LQ) women who have or are currently engaged in mental health services. Daley (2010) used a grounded theory approach to explore this phenomenon through face to face interviews with 32 women living in Canada. Twenty-two of the participants were mental health service users; 21 identified as female and one identified as transgender female. Their self-identified ethnicity included Caucasian, Jewish, Native, Israeli, Chinese and Human. The 10 service providers ranged in ethnicity and included European, Filipino and South Asian. Three

of the service providers identified as lesbian, one identified as bisexual, two as queer and four as heterosexual.

Seven of the service providers worked in community based setting, two were employed in a hospital inpatient unit, and one in an outpatient unit. The focus of their work varied widely: women specific programmes; a LGBTIQ specific counselling service; an ethno-specific mental health agency; a consumer/survivor advocacy setting; and a case management role. The service providers had a range of professional designations including social worker, community mental health worker, nurse, counsellor and survivor advocate.

The key themes that emerged from Daley's(2010) research were articulated as the dismissal of LQ sexuality as an identity, compartmentalisation of concerns by LQ women, and understanding the potential stress or supports for LQ women. These three themes were what participants identified as their experience when self-disclosing their sexual identity in relation to their well-being and recovery from mental illness. The importance of sexual identity was explained as a significant factor that contributes to the foundations of recovery. Heteronormative barriers were often seen as a requirement that the LQ women are required to adhere to, and therefore their own sexual identity was dismissed or neglected. LQ women were often labelled as "difficult" or given an Axis II diagnosis that indicates a personality disorder, had an impact on them of non-recognition, non-affirmation, non-acceptance and perceived homophobia. Participants described often not disclosing their mental health concerns through counselling services or mental health clinicians, therefore increasing their distress and risk of self-harming or suicide (Daley, 2010).

McAndrew and Warne (2010) completed qualitative research of gay men from the UK to capture the lived experiences of suicidality. A total of four participants were involved in the research, sharing their lived experiences of mental health problems. Individuals were interviewed face to face in a safe environment, given the sensitivity of the topic. The researchers used a bricolage approach within the methodology to explore the participants' multifaceted life experience. Purposeful sampling was used for recruiting the four participants. All participants had experienced suicidality during their adolescence and had come to terms with identifying as gay. McAndrew and Warne (2010) explain that recruitment for this research was difficult, probably because of the sensitive nature of the research aim. McAndrew and Warne (2010) identified limitations with the research methodology, particularly data collection. They concluded that a means of data collection, such as digital storytelling was less intrusive and confronting than face-to-face interviews could have been used to engage more participants in the research.

McAndrew and Warne (2010) found themes based on internalised homophobia that led to mental health problems. The participants explained a sense of self-loathing of their sexuality that led to self-harming behaviours, anxiety, depression and suicidality. McAndrew and Warne (2010) explained that suicide was prevalent amongst gay men, and many who were seeking help often experienced heterosexism and homophobia by health professionals and institutions. Gay men were more likely to benefit from health providers who were targeted at the population group; however, this distinction continues to marginalise and segregate the community from mainstream health care, reinforcing the need to be hidden from society. McAndrew and Warren (2010) found psychotherapeutic relationships were considered the essence of

34

responding to patients when coming to terms with their sexual orientation and suicidality. The researchers suggested clinicians should practise in a non-judgemental way to provide holistic care, but are often faced with organisational challenges that create barriers to provide such treatment (McAndrew & Warne, 2010).

Ross, Dobinson and Eady (2010) completed a qualitative research using grounded theory to examine the factors that bisexual people perceive as significant in association with to their mental health. A total of n=55 participants met the eligibility requirements of the study as being over the age of 16 and self-identifying as bisexual, or attracted to or sexually active with both women and men. Six focus groups were conducted in Toronto, Canada where the study was based, and two met in Ottawa, Canada's capital city. The focus groups ranged in size from three to nine participants. Two of the focus groups were with women, three with men, and one with transgender and transsexual people. There were an additional nine interviews with participants who lived remotely or could not be involved in the focus groups for other reasons. Seven of the interviews were conducted by telephone and two were completed at a location requested by the participant.

Ross et al. (2010) analysed their key focuses using a framework of the macrolevel, focused on social structure; mesolevel, focused on the interpersonal level; and lastly microlevel, specific to the individual level. Factors at all three levels were identified as determinants of health that the participants described as potential protective and risk factors for mental health problems.

The macrolevel aspect of the framework was explained as the dismissal or disapproval of bisexuality along with biphobia and monosexism when experiencing mental health care. Participants often felt that they would have to explain or justify their sexual orientation. This concern created barriers for transgender and transexual people when accessing gender identity services, as it was seen as the individual being confused with their sexual orientation and not their gender identity. Ross et al.'s (2010) participants described a sense of invisibility because of their bisexuality, and articulated their frustrations with society's assumption of their homosexuality, or heterosexuality, being tied to the gender of their partner. Bisexual individuals reported stigmatisation around their sexual orientation, and often being portrayed as disease carriers by the heterosexual population because of their perceived sexual promiscuity. One participant had experienced homophobic violence due to her sexual orientation. All the participants had experienced beliefs and attitudes around bisexuality through forms of monosexism, biphobia and homophobia, and this effected their emotional well-being (Ross et al., 2010).

Mesolevel factors focus on the social belief that bisexuality does not exist and that bisexual individuals are ether gay, lesbian or heterosexual. Bisexual people often experience ongoing social stigma that is based on their relationships being polyamorous and not monogamist. The participants reported this stigma to be experienced within their family and community, although supportive relationships with likeminded bisexual individuals were expressed as being a positive influence on an individual's mental health. However, within the wider gender and sexual minority community, bisexual individuals reported biphobia associated with gay and lesbian events, and are often faced with more complex relationships as a whole community.

Ross et al.'s (2010) found microlevel factors are focused on the individual's acceptance and understanding of their bisexuality, often leading participants to internalise social beliefs and attitudes towards bisexuality. During this period participants described an association with poorer mental health as their sexual identity caused anxiety. Some participants engaged with a supportive therapist and counselling to assist this process, but overall the participants explained that self-acceptance of their sexuality was a process that took time.

Eady, Dobinson and Ross (2011) used a qualitative research design to understand the experiences of bisexual individuals who have sought mental health care, their understanding of whether their needs were met, and their perception of health providers' attitudes towards bisexuality. Of the 55 participants recruited from the province of Ontario, Canada. Using a broad inclusion criteria, 74.5% of the participants identified as bisexual. Research data was obtained through individual interviews or focus groups. A total of eight focus groups were conducted that ranged between three and nine participants in each group. The focus groups were separated by gender, where participant numbers allowed, to capture the different factors that bisexual women and men experience regarding their mental health and emotional wellbeing when accessing mental health services. Two of the focus groups were with bisexual women, three with bisexual men and one with female to male transgender participants, and met in the Toronto area. The researchers discussed the limited availability of research around the transgender population who identified as bisexual, and felt it was therefore important to include their experiences in the study as they identified as bisexual. Two other mixed gender focus groups met in Ottawa and Guelph, Ontario to capture the experiences of bisexuals in a range of geographical locations.

Individual interviews were conducted with a total of nine participants who either lived in rural settings or could not be included in the focus groups for other reasons. Seven of the nine interviews were conducted by phone. Both individual interviews and the focus groups were conducted by an experienced and qualified researcher who identifies as bisexual. The researchers used semi-structured questions for both the interviews and the focus groups to explore the research question.

Eady et al. (2011) found two overarching themes that focused on negative and positive experiences when engaging with mental health services. The participants found negative experiences with mental health services were based on judgemental practice, pathologising their bisexuality or being dismissive of their identified sexual orientation. Dismissal of the participants' sexual orientation was articulated as unhelpful for the provider's practice. Providers were seen as defining bisexuality as a transition phase or a non-valid sexual orientation. This approach would often result in the individual no longer engaging with the therapist even though they continued to have mental health needs that remained unaddressed. Participants expressed frustration with mental health providers, as they felt that the primary focus the clinicians was on their bisexuality which was unrelated to their individual mental health needs, or the clinicians directly associated their mental health problems with their bisexuality. Overall, participants found that their bisexuality was pathologised and highlighted as the issue when seeking mental health care for a range of additional issues. Eady et al.'s (2011) participants found, when developing therapeutic relationships with mental health professionals, excessive or intrusive questioning about their bisexuality was not relevant, or helpful, when focusing on their mental health needs. This view was underpinned by the feeling that participants were undertaking therapy to educate the health practitioner on bisexual

health needs, which often created a sense of being taken advantage of. Participants articulated a sense of frustration around this, as there were limited public mental health services to engage with, and therefore participants were often obligated to financially support their own therapy through private health providers.

Although Eady et al.'s (2011) participants described negative experiences, they also felt there were positive experiences when engaging with mental health service providers. Many participants found positive experiences were attributed to the mental health providers practice of being "open-minded". Participants found that providers who independently educated themselves on bisexuality and the mental health issues associated were more likely to offer positive outcomes for participants who in tern, spent less time educating the practitioner. Participants reported that disclosing their bisexual identity to providers through open-ended questions was the most respectful way of enquiring about their sexual orientation. Although some of the participants had negative experiences of this, they decided to withhold disclosing their sexual identity unless the information was relevant to the care, because of past experiences that resulted in feelings of alienation. However, participants explained disclosure can create a judgement free and open place to discuss issues that may relevant to their bisexuality. Many participants expressed a sense of anxiety because of past negative experiences, and felt that health providers would make judgements directly associated to their bisexuality. It remained essential that health providers were positive or neutral in their reactions to the disclosure of the individual's sexual orientation, as this enhanced the therapeutic relationship.

Eady et al. (2011) found that the use of appropriate language was also essential in developing a therapeutic relationship. Participants were often exposed to a heterosexist, monosexist bias towards bisexual people by mental health providers. Transgender and transexual bisexual individuals were often exposed to stigmatisation and marginalisation in their mental health service experiences. Eady et al. (2011) described a limitation to their research was the participants' greater ability to recall negative experiences with mental health service providers, as such as biphobia, homophobia or other judgemental attitudes, than positive experiences.

Rounds, McGrath and Walsh (2013) completed a qualitative research design to explore individuals' experiences when accessing healthcare, with a particular focus on the behaviours experienced by the participants. The researchers used focus groups as a way to capture experiences by exploring individuals' perspectives and descriptions when accessing health care services. Participants included in the study lived in the Pacific Northwest region of the USA. Participants were individuals over the age of 18, who self-identified as lesbian, gay, bisexual, transgender and queer (LGBTQ), had seen a health care provider within the last five years and had disclosed their sexual orientation to the health provider. Participants completed a questionnaire around basic demographics that included whether they had health insurance, and the types of health care providers they had seen in the last five years. A total of 11 participants responded and were involved in the focus groups. There was no clear description as to how the focus groups were arranged. The participants involved within the focus groups were asked to discuss behaviours by health care providers that made them for good or bad when engaging with health care providers, and also a specific interaction with a health care provider that was felt good to have one and one bad aspect that would continue or

hinder engagement with care. Further questions focused on obtaining an understanding as to why LGBTQ people experience a different degree of quality care, and what is specific and special to the LGBTQ patients and their needs of care. Lastly, the groups discussed what advice LGBTQ people would give to health providers.

Round et al. (2013) found overarching themes that were based on the behaviours of health care providers. These were found as to be either supportive in engagement or barriers to engaging health care. Knowledge was identified as a key theme within Round et al.'s (2013) research, as participants found a foundational understanding of the health needs for the LGBTQ community were important in order for providers to offer appropriate health care. They found that understanding the basic health care issues of the LGBTQ community, along with the use of appropriate terminology by health care providers, often led to a more therapeutic engagement.

Findings from the focus groups identified the privilege and power difference when LGBTQ people access health care and are often in a vulnerable position, as heterosexuals are the majority population and culture when accessing health care. Due to health care provider's focus on majority populations, internalised heterosexist bias and homophobic acts are barriers to LGBTQ individuals speaking up and advocating for themselves and their health needs. Within the knowledge theme Round et al. (2013) discussed the importance of the health professionals' understanding of insurance policies. This was focused towards individuals seeking transition services and the lack of awareness and knowledge to the process and costing around accessing health care.

Round et al. (2013) found communication and interpersonal skills to be one of the primary themes highlighted in their research. Many of the issues experienced by the LGBTQ community were discussed, and it was found that many health practitioners' professional practice directly related to the standard of care provided and received by LGBTQ individuals. Developing and building trust in a respectful therapeutic manner was essential for the participants, but they described incidents when engaging with health professionals led to them feeling negatively judged. The health professionals were belittling of the patients' needs; made generalised assumptions and stereotypical comments directed at the patient; argued with the patients; and at times generally refused to discuss the patients' health concerns.

Round et al. (2013) found that language was one of the key issues for LGBTQ people when engaging with health services. Participants found that the limited education that health professionals have around the LGBTQ health needs had an impact on the terminology and language used, especially for people who identify on the gender continuum. The participants felt that some questions were focused on the health professional's understanding of the LGBTQ issues rather the individual patient's needs.

Round et al. (2013) identified that participants would engage with health professionals who identified as LGBTQ friendly and who are competent at engaging with these patients. Participants felt undermined and dismissed when engaging with health professionals who advised that they were experienced working with the LGBTQ community, but later find out during procedures there was cultural insensitivity towards the individual's gender or sexuality. Transgender participants felt that when receiving health care for their sexual health needs, they were often left exposed and vulnerable

during physical procedures, with the health professional using the wrong pronouns and not protecting their privacy.

The LGBTQ community is a unique group of individuals with specific health needs. The participants in Round et al. (2013) study explain that although they come from different socio-economic backgrounds and have individual cultural differences, the one thing the community shares as a whole is stigma and invisibility within health care. Due to the specific health needs of this population the need for LGBTQ competent practitioners was identified by the study as a key contributing factor in reducing the health disparities of this population. Many of the focus groups attributed poor health to stigmatisation, homophobia and transphobia, all leading to substandard health care.

Participants found that although homosexuality is no longer a mental disorder within the APA, they continued to feel pathologised for their sexual identity. Transgender individuals transitioning continue to be pathologised with gender identity disorder in order to access medical insurances and providers to allow their physical transitioning. The LGBTQ participants found the way current medicine is practised reflects the systemic discrimination that is still experienced by the community. As LGBTQ individuals are often exposed to negative experiences by health providers, their ability to form trusting relationships with health professionals is mitigated by a sense of caution because of the harm they have experienced in the past. Round et al.'s (2013) participants found that the use of blank forms and templates that allowed individuals to complete them without feeling classified allowed a sense of control over self-disclosure.

Adams, Dickinson and Asia (2013) completed a qualitative research design using three methods for data collection. The initial stage of data collection was an email survey to gather information on mental health promotion and specific services focused on the Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) population in New Zealand. The email survey was sent to senior staff members who are responsible for mental health in all 21 District Health Boards. The survey was also sent to all providers of services to the GLBTI health, and social services and support organisations were identified as key informants. After the survey was completed, 17 key informants were interviewed primarily by telephone or face to face. Written responses to the interview questions were completed by two informants. Informants were people typically working in mental health or having an interest in the mental health of the GLBTI community. Some of the informants identified as GLBTI themselves. Following the interviews, an online qualitative survey was used to capture issues and gaps within the current mental health services and health promotion. A total of 124 participants completed the online submission, and the survey identified basic demographics that included sexual and gender identity, age, ethnicity, mental health service users and geographical location.

Adams et al. (2013) found themes that focused on current mental health promotion and mental health service provision, and the associated gaps and key issues. Adams et al. found that health policy and strategy documents used to guide mental health care lacked any reference to specific mental health needs for the GLBTI community. One finding was that several district health boards viewed their mental health care as affordable to access, and accessible to all and did not identify any need for GLBTI specific services. GLBTI participants found a lack of publically funded

44

services and supports through the New Zealand mental health service for those with mild to moderate mental health needs through the public health service.

Adams et al.'s (2013) participants articulated the need for mental health services to be provided in a culturally safe and appropriate way. Although mental health care has changed vastly over recent years for the GLBTI community, there remains ongoing stigma, homophobia, transphobia and prejudice towards gender and sexual minorities in mental health care. Participants identified a clear need for dedicated GLBTI services and health promotion that focused on the community's mental health needs.

Benson (2013) completed a qualitative research design using a feminist-informed phenomenological approach to research transgender people's experiences of therapy in the USA, in North Dakota. A purposeful and snowball sample method was used to recruit seven transgender participants. One participant identified as Latino and six as European Americans. Three of the participants are biologically female and identified as female-to-male, one biological male identified as a male-to-female cross dresser, and the remaining three biological female participants identified as female-to-male. Six of the participants were in a partnered relationship, three being legally married and one divorced. The participants varied in age, socioeconomic status and were graduates. Interviews were conducted at convenient locations for the participants and recorded. The interviewers used semi-structured open questions.

Benson (2013) identified four key themes and two subthemes in her research. The initial theme identified was based upon the reason for accessing mental health services. Benson found that when transgender people engage with mental health services for

therapy, their gender identity is seen as the focus of their mental health problems and perceived as problematic. However, this focus is challenged by the participants who experience an additional layer of stigma, prejudice and transphobia associated with their mental health needs. The participants were often engaging with mental health services for therapy not only for their gender identity disorder, but for emotional health, well-being, and relationship satisfaction. Participants in the study used therapy as a way to address relationships with loved ones or family members, but also for their struggles with mental health diagnoses such as depression and anxiety. Although the primary focus of the therapy was for other mental health problems, participants retrospectively recognised a precursor to developing those issues their acceptance of the underlying gender identity disorder.

An additional theme that came from Benson's (2013) research was gender identity. Participants often engaged mental health services in order to complete the legal and medical process of transitioning gender, which required support from a medical or mental health professional to complete the necessary documentation for the medical treatment or intervention to need. Although one of the participants acknowledged a positive experience, other participants explained a sense of frustration with having to engage with mental health professionals in order to commence treatment for transitioning.

Benson's (2013) study identified that there is a problem in the clinical practice of mental health clinicians. As therapists were not well informed of the issues directly related to transgender people. The participants discussed the need for therapists to be informed about transgender health issues, rather than the therapist relying on the

individual to teach them. Participants felt they are financially taken advantage of by therapists in having to educate them during paid therapy sessions. It was well articulated by participants that mental health professionals receive inadequate training on the mental health needs of the transgender population, and often confused gender and sexual orientation issues. Participants found an additional barrier to treatment was their individual finances. Some of the participants were enrolled in college, and found many health insurance policies do not cover the treatment that is associated with gender transition. All of the research participants were engaged with transgender advocacy groups, and these provided a forum to identify transgender friendly health professionals.

The last identified theme from Benson's (2013) research was therapy that was provided in a transgender affirmative way. Participants found that therapists who have experience or received training around transgender people's needs were sought out by the community. Clinicians who are aware of the mental health needs of the LGBT community were identified as safe practitioners whom transgender participants felt they were able to engage in the sensitive nature of their mental health therapy.

Aggarwal and Gerrets (2014) completed qualitative research in the Netherlands as part of a graduate training programme that was exploring Dutch homosexual men's culture and the paradox of the lived experience, using an ethnographic method. Initially, participants were observed for a total of 410 hours. The observations included participants on social media, at gay night life venues including clubs and bars, and within their homes. Following the observational aspect of the research, life history interviews were conducted in an unstructured narrative way with a total of 12

participants. The sample group was obtained through snowball sampling, with self-identifying gay men recruited through social and academic networks and the internet. Participants were not purposely selected because of their mental health experience, although the subject was raised in the interview if the participant had not articulated any mental health information. Participants were seen on multiple occasions, which the researchers reported to have deepened the trust and understanding between the participant and researcher. Participants were all Dutch speaking, white and self-identified as gay.

Following the life history interviews, a total of 10 expert researchers in the field were interviewed. One of the researchers with a clinical background reported that four of the men likely suffered, or were currently suffering, a mood or anxiety disorder, with one participant disclosing suicide attempts. The data obtained from the observation, life histories and semi-structured interviews were presented to epidemiological researchers in the field of gay mental health for the Dutch population: that included social scientists specialising in gay issues, Amsterdam's public health office, and representatives from national gay health, mental health and gay rights organisations. The results were presented to these stakeholders, along with health professionals and a number of gay men who verified the study findings and contributed to the analysis. The researchers reported 30-50 attendees were present throughout the two stakeholder feedback sessions.

Aggarwal and Gerrets (2014) found themes associated with the participants' adolescence and growing up in Dutch society. The participants identified experiencing depression and anxiety while growing up and coming to terms with their sexual

orientation. They explained that their own behaviours changed in the way they acted, dressed and even spoke to conform to masculine norms. Participants identified a sense of dread and angst with the coming out process. One participant disclosed that he had attempted suicide on three occasions throughout his lifetime.

The participants identified the need for a meaningful intimate relationship as an important factor that contributes to the mental health of Dutch gay men. The researchers found that this need is a determinant of developing mental illness that creates a sense of loneliness, sadness, lower self-esteem, and often fuels feelings of inadequacy amongst the community. The additional theme linked with meaningful relationships is the subcultures within the homosexual community. The participants identified that physical appearance enhances the individual within the subcultures that the individual belongs to. Not only does being attractive give access to sex, but also to meaningful friendships and social success. As a result, the participants identified body image as being a contributing factor to an individual's mental health problems, as it has an effect on all aspects of the individual's engagement with the gay community. Throughout the study the participants acknowledge the stigma associated with identifying as homosexual. They found stigma not only from society generally, but also within the gay community.

Ellis, Baily and McNeil's (2015) findings originated from the UK Trans Mental Health Study completed by McNeil, Bailey, Ellis, Morton, and Regan (2012). Ellis et al.'s (2015) study focuses on transgender people's experiences of the Gender Identity Clinics (GICs) and mental health services to gain a greater understanding of their experiences as a whole, and also to evaluate the services from transgender clients

perspectives. The primary research used a mixed-methods design survey comprising standardised tests, quantitative scales, fixed response questions and qualitative open response questions. To formulate the survey, the researchers engaged key stakeholders, professionals working with trans people and an advisory group of trans community representatives. The survey also drew on past national reports on the trans through published and nonpublished literature. The study had a direct electronic link to the survey and was circulated by email to over 70 organisations in the UK that are targeted specifically towards the trans community, although additional organisations were included that focused on the wider LGBT community.

A total of 899 participants responded, although throughout the analysis the response rate was lower depending on the topic and question asked. For the mental health service questions, a total of 621 participants identified they had previously or were currently engaged in mental health services. Of these, 202 participants answered their engagement with GICs. Within the sample group there was a wide range of gender identities that included male, female, nonbinary gender identity, and no gender identity, along with various stages of transitioning. McNeil et al. (2012) identified throughout their research that sampling for the trans population remains a complex issue when undertaking research, because of the defined terms used and due to trans individuals keeping their identity or history private. The majority of the participants self-identified as white British, Scottish, Welsh, English or Northern Irish, but the demographics of the survey were not always completed. The majority of the participants lived in England (84%), with the remainder living in Scotland (11%), Northern Ireland (less than 1%), and Wales (4%). The purpose of Ellis et al.'s (2015) research was to explore

the qualitative responses to the survey questions completed in McNeil et al's. (2012)
research.

The two themes Ellis et al. (2015) found were the participants' experiences with
the mental health services and with GICs. A total of 621 participants (66%) had
engaged or were engaged with mental health services through public or private
organisations for reasons other than medical transitioning purposes. The researchers
suggest that trans people present as higher mental health service users than the general
population. Although this finding could be a bias in the study as the sample was
directed at trans people accessing services, it may be an overrepresentation of the
population group. There was a variation to how the participants felt when engaging
with mental health services particularly based on disclosing their trans identity or
history as transgender. The participants identified frequently throughout the survey that
the public health system mental health practitioners had inadequate experience or
limited knowledge about trans issues, a common issue throughout other academic
research on trans people's mental health experiences. The participants felt that their
gender identity was not acknowledged and considered as genuine by the health
professional, but instead was considered a symptom of their mental ill-health.
Participants explained that due to clinicians' lack of knowledge on trans mental health
issues and lack of experience working with trans patients, the participants' mental
health problems were confabulated as being trans.

The second theme identified by Ellis et al. (2015) was the experiences trans
people had with GICs. Participants felt it was difficult to obtain the assistance and
treatment needed for their medical transition. There were multiple reasons for

dissatisfaction with GICs, notably the extensive wait times, but some of the dissatisfaction was more complex. One participant experienced being "misgendered, misnamed and mispronounced" (p.11) and was asked a range of questions felt to be unnecessary and invasive. Participants felt they were unable to be truthful throughout their encounters at GICs with health professionals, particularly around their mental health. They felt that if they disclosed information about their mental health problems, particularly depression and anxiety, that surgery or medical interventions would be withheld. A heteronormative view of gender and sexuality was a common experience felt by participants. One participant explained that they lied about their sexual orientation, and self-identified as heterosexual, although they truly identified as bisexual, as they felt that otherwise health professionals would question their gender identity.

A proportion of the participants felt they were often pressured into doing things in order to prove their gender to the professionals in the GICs. These included legally changing their name, and dressing in highly gender appropriate ways to fit conventional norms. Over half of the participants felt emotional distress or concern about their mental health while attending GICs, and continued to feel they were unable to talk about this with the health professionals out of fear their transition would not be taken seriously.

Ellis et al. (2015) identified that health care services are in a position to assist trans people in validating their gender, and that they need to reflect and meet the needs of the community. The study found that health professionals are ill-informed of the issues surrounding transgender people's health needs, and Ellis et al. expressed concern

about mental health services having a gate keeper role for transgender people to obtain any gender confirmation treatment. This situation means that when the trans community engages with mental health services for therapeutic intervention, they are fearful of the power imbalance.

McCann's (2015) study focuses on the qualitative data obtained from a mixed method study that aimed to examine the mental health experiences of lesbian, gay, bisexual and transgender (LGBT) people in Ireland. The mixed method design involved surveys of 125 LGBT people and 20 semi-structured interviews. The study focuses on the interview findings of four self-identifying transgender people. The whole research involved promotion of the study through LGBT and mental health organisations throughout the Republic of Ireland. An online survey was conducted, with participants given the option of an additional interview. Participants needed to be over the age of 18, self-identify as LGBT and have used mental health services in Ireland in the last five years. The sample group used in McCann's (2015) research are four identifying male to female transgender individuals from Ireland.

McCann (2015) found all of the participants had experienced mental health problems, primarily anxiety and depression, and three of the participants spoke about ending their own life. Participants explored the need to have paperwork signed off by a psychiatrist to access funding for their gender transition. Not only was it considered an arduous process, people were often left frustrated and disappointed by the length of time it took in order to get gender affirming surgery, often participants felt they would go abroad for surgery, but would have to consider the financial implications. Participants described tension between themselves and clinicians' preparedness to

support the transition, often driven by the participants frustration. Participants who engaged with mental health practitioners for emotional support felt they were left with low self-esteem following engagement, due to clinician's negative views of transgender individuals. Accessing informative and appropriate resources was identified as challenging, as there was limited public information available. A participant described engaging an accepting support group for lesbian and gay people, which reduced her loneliness during the transition process.

McCann (2015) found participants, when engaging their mental health needs with practitioners, were able to identify positive experiences. Participants explained that "looking around" for the right therapist who fitted their individual needs was important; others described finding a therapist who possessed qualities and values similar to their own. Although some clinicians had limited experience of transgender issues, it was practising in a sensitive manner that was deemed therapeutic. All participants of McCann's (2015) study positively identified help they received from organisations and LGBT groups in accessing emotional support.

Participants of the study were asked to identify and discuss the challenges for improving the current mental health services, with a specific focus on people who identified as transgender. One of the participants identified the importance of accessing practitioners who are competent and have the skills, knowledge and attitude to work with transgender people. Another participant identified the increased level of marginalisation and loneliness experienced by transgender people, along with stigma and a negative societal attitude. Additional to this was transgender people living in rural areas needing an equal opportunity to access appropriate and inclusive support.

Ross et al. (2016) completed a mixed methods study in Toronto, Canada to enhance understanding of the relationships between bisexuality, poverty, and mental health. For the purpose of this integrative literature review, the focus on Ross et al.'s findings will be on the qualitative data. Ross et al. used a respondent-driven sampling methodology and recruited 302 participants who completed a survey to obtain the data; the findings analysed were used for the qualitative research method. Survey participants were asked if they would attend a follow up interview. A total of 41 participants were purposively selected for interviews based on a range of variables that included gender, socio-economic status and geographic location among other variables. The gender of the sample selected was about equally of male, female and non-binary. The majority of the participants identified as white, one-fifth identified as aboriginal/First Nations along with participants self-identifying as Black Caribbean, South Asian and Latin American. A total of 64% of the selected participants were identified as being in a lower individual income bracket, earning less than $29,000 per year. Semi-structured interviews were conducted in person by one of the authors.

Ross et al. (2016) found pathways that were used to describe the analysis of the data obtained. The first pathway is related to early life experiences that relate to later life, bisexuality and poverty. Some of the participants described their experiences, particularly when engaging with mental health services. Participants were aware of the impact that social class has on their ability to obtain adequate and timely mental health care.

The second pathway was the impact that employment has on a bisexual individuals' mental health. Participants identified that their bisexuality affected their

employment choices and opportunities, directly influencing their socio-economic status.

The third pathway found in Ross et al.'s (2016) study was the connectedness of poverty, mental health issues, and individuals' bisexuality. Participants described poverty leading to discrimination, lack of social support and limited engagement with the community. Participants also articulated experiences of discrimination from the LGBT community, seeing the majority as middle class with two incomes and no children.

The final pathway identified focused on the limited access to mental health services because of participant's poverty and bisexuality. Participants articulated a barrier in accessing appropriate mental health care based on affordability, particularly counselling. They found there is limited public health funding for mental health care, including medication; however, participants found medication was not a solution to their mental health needs. Limited publicly funded counselling services were seen to provide poor quality care and further inaccessibility due to lengthy wait lists.

Ross et al. (2016) further found that publicly funded practitioners who are mandated to provide care to multiple stigmatised identities was difficult due to the limited access and availability because of extensive wait times, which usually left participants needing to financially support their own treatment. The majority of the participants felt engaging in privately funded mental health care was virtually inaccessible due to financial constraints. However, some participants were fortunate

enough to be able to access some mental health care their employment insurance policy.

Ross et al. (2016) found that early life events have a significant impact on the individual's ability to obtain financial stability in later adulthood, and the combination of poverty and bisexuality is strongly associated with poorer mental health including symptoms of post-traumatic stress disorder and depression. The research further found that obtaining employment because of an individual's bisexuality is based on the stigma associated with their identity, and impacts on the ability to afford or access appropriate housing and health care, that in turn has a direct impact on their mental health.

3.4 Data synthesis

The relationships and reoccurrence of the identified themes are well established throughout the primary research and are clearly presented within the data display (Appendix 3) throughout the data extraction process. Two key themes and five subthemes were identified from the data analysis (Figure 2).
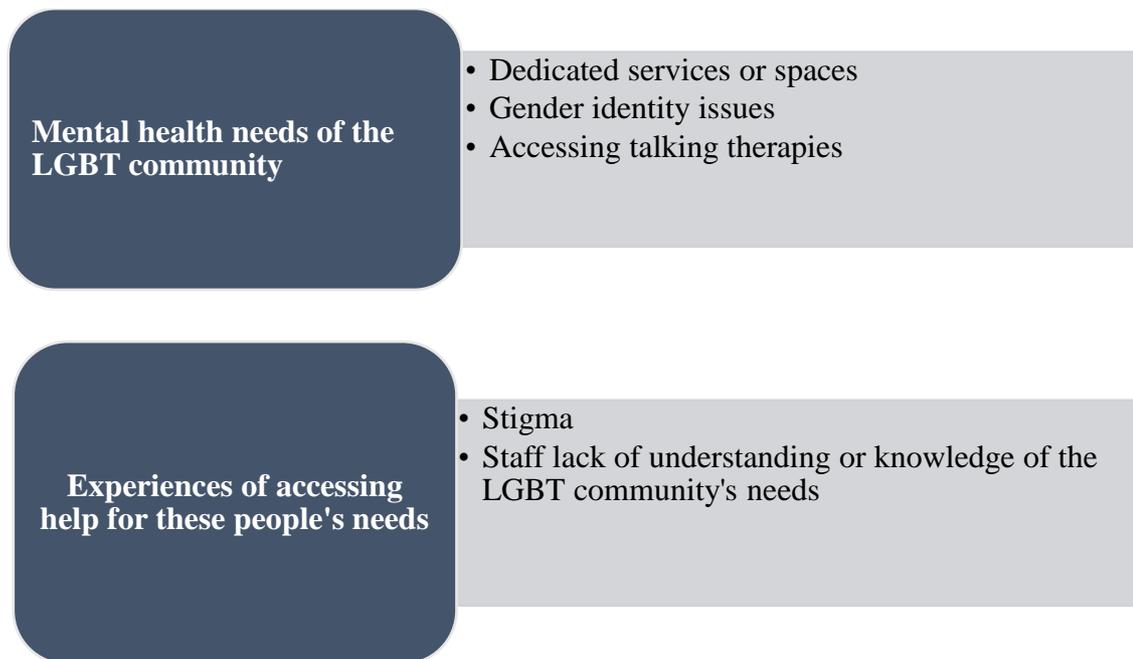
Mental health needs of the LGBT community	• Dedicated services or spaces • Gender identity issues • Accessing talking therapies
Experiences of accessing help for these people's needs	• Stigma • Staff lack of understanding or knowledge of the LGBT community's needs

Figure 2: Synthesis of findings

The first key theme identified is the mental health needs of the LGBT community, which all of the studies used in the integrative review explored. This overarching theme is used to capture the needs of the sexual and gender minority community that have been explored within the primary research of needs identified when accessing mental health care. The key theme has been categorised into three subthemes: dedicated services or spaces, gender identity issues and accessing talking therapies.

The first subtheme identified was the dedicated services or spaces for the LGBT community. It was identified by seven of the primary researchers that the LGBT community felt a specific mental health need for their community was to have LGBT friendly services or spaces that acknowledge the different mental health care that is required for this community. The researchers identified participant's need for specific

mental health services that are dedicated to providing care to gender and sexual minorities, as often this population has not been acknowledged in the current health system. Part of this subtheme is focused on the transgender community who require mental health services to agree with any gender confirmation process.

The second subtheme is focused on the transgender community and is related to gender identity issues. Five of the studies included in the integrative review explored the mental health needs of the transgender community who are a complex cohort of patients who need appropriate mental health care. The participants identified that the current health services do not address the needs of the transgender population and accommodate appropriate resources to address their gender identity issues. Specific mental health care includes the need for a psychiatric diagnosis of gender identity disorder to access the appropriate medical and surgical intervention for gender confirmation, that for some is a health insurance policy requirement to access insurance and funding.

The third subtheme identified was accessing talking therapies; this was a reoccurring theme identified throughout the data analysis process. Eleven of the articles identified a mental health need of the LGBT community as access to talking therapy in an affordable and timely manner. The participants reported having some positive and negative experiences with therapists when engaging in talking therapy, and this was often determined by the therapist's knowledge of LGBT mental health issues. The participants emphasised the importance of accessing culturally sensitive and LGBT friendly therapist's, but had a common experience of therapists addressing their mental health needs based on their sexual orientation or gender identity and not the mental

health problems that the participant wanted to address. Robertson's (1998) participant identified that he had experienced treatment through a therapist for his homosexuality, and not for the underlying mental health problems he was wanting to address. Roberston's (1998) study is the oldest used in the integrative review, and this practice of treating homosexuality as the mental health problem itself is now uncommon, it has been identified in contemporary research finds that a focus on sexual orientation is the primary experience that individuals from the LGBT community when engaging in talking therapy and not the primary issues that LGBT people are accessing therapy for.

The second key theme identified throughout this integrative review has been captured as the experiences of accessing help for the needs identified above. All of the primary research studies identified the experiences of LGBT people when accessing mental health care for their needs. This theme has been categorised into two subthemes: stigma and staff's lack of understanding or knowledge of the LGBT community's needs.

The first subtheme is stigma, eleven of the research studies identified key elements of stigma and discrimination experienced by members of the LGBT community when accessing mental health care. Homophobia, biphobia and transphobia, along with monosexim and heterosexist bias, was often experienced by LGBT individuals when engaging with mental health services. The researchers explored in depth the experiences of the LGBT community when engaging in mental health care and these participants, were often confronted with the barriers of not only having a mental health problem, but identifying as a member of a minority population. Often participants were ignored or mistreated for their sexual orientation or gender identity,

leaving them silenced out of fear when utilising mental health services because of the additional stigmatisation they experienced.

The second subtheme identified throughout the data extraction process is health care staff's lack of knowledge or understanding of the LGBT community's needs. Seven of the primary research studies used in the integrative review found that participants were frequently exposed to uneducated health professionals when addressing the LGBT community's mental health needs. Participants often felt they were pathologised for their sexuality or gender identity and were left undertreated for the primary mental health problem they were initially seeking help for. The staff's lack of knowledged, often left participants feeling vulnerable and hopeless as their sexual orientation or gender identity was not acknowledged, leading to culturally insensitive practice. Participants found that mental health clinicians were often over intrusive when asking questions that were not primarily related to the mental health intervention, and participants were left feeling they were providing education to the staff during these interactions. Although some of the participants identified such experiences as negative, others saw staff's attitudes to self-learning and development around the LGBT mental health issues as innovative, and a positive outcome when engaging with these clinical staff. The participants identified that there remains a lack of understanding and knowledge of the health issues of the LGBT community, and that more time and resources are required to improve the care that is provided to this minority population.

3.5 Conclusion

Chapter three methodically examined the individual primary research sources used in the integrative review to identify and develop themes. The two main themes identified have been the mental health needs of the LGBT community and the experiences of LGBT people when accessing mental health care for their needs. The first theme has been subcategorised into three subthemes that are dedicated services or spaces, gender identity issues and talking therapies. The second theme was subcategorised into two subthemes, stigma and staff's lack of knowledge or understanding of the LGBT community's needs. Both themes and subthemes will be further discussed in Chapter Four.

Chapter Four   Discussion

4.1   Introduction

The mental health needs and experiences of the LGBT community have been often overlooked in health research when accessing mental health care. Chapter Four examines in detail the findings from the integrative literature review. The initial theme found was the mental health needs of the LGBT community. This was then subcategorised into three subthemes, identified as: dedicated services or spaces, gender identity issues, and talking therapy. The second theme was the LGBT community's experiences of accessing health care, subcategorised into two subthemes that have been identified as stigma and staff's lack of understanding or knowledge. This discussion will then be followed by recommendations based on the findings of the integrative review, which reflect the clinical implications for practice that would best address the disparities experienced by the sexual and gender minority community. Lastly, the chapter discusses limitations and strengths of the integrative review, and the implications this research may have for further studies in this area.

4.2   Discussion of literature

This section will discuss the findings of the integrative literature review. It will further discuss the integration of the literature using supportive or unsupportive literature throughout the discussion.

4.3 The mental health needs of the LGBT community

The mental health needs of the LGBT community have often been dismissed or ignored by the current health system, in particularly the mental health services. The LGBT community is composed of a range of ethnicity, gender, sexual orientation, religion, age and socioeconomic status which presents with its own challenges. However, there are needs that the LGBT community have identified to achieve emotional and mental well-being when accessing mental health care that have been often over looked through health policy and service delivery for this community. Heterosexisim, transphobia, homophobia and biphobia all present as challenges for the community in achieving social inclusion and health equality (McCann & Sharek, 2014).

4.3.1 Dedicated services or spaces

Throughout the integrative literature review it has been identified that a specific need of the LGBT community when engaging with mental health services is to have dedicated services or spaces that focus primarily on LGBT mental health issues. The lack of dedicated services or spaces means many LGBT people across the life span find it difficult to engage and access appropriate and quality health care (Keurohlian, Ard & Makadon, 2017). Health and social systems and services have been often viewed as unwelcoming for the LGBT community, and this has a negative impact on the way services are received (McCann & Sharek, 2014). Daley and MacDonnell (2011) discuss the significance of health inequality experienced by the LGBT community within health that leads to increased risk of mental health concerns and chronic diseases.

Despite universal access to health care, LGBT people do not receive health care from providers compared with that received by the non-LGBT community. The embedded heterosexisim, homophobia, biphobia and transphobia throughout all social institutions continues to reflect the social exclusion experienced by the LGBT community and reinforce that their needs are invisible (Daley & MacDonnell, 2011). This creates a lack of confidence in the health system and raises concerns that LGBT people will not be treated with respect and dignity when engaging with health services (Morales, King, Hiler, Coopwood & Wayland, 2014). LGBT people will only be willing to engage with health care providers effectively if they can be comfortable and true to themselves (Keuroghlian et al., 2017). However, Bostwick and Hequembourg (2014) found that bisexual people are less likely to experience discrimination within healthcare, social services or employment settings, which is a unique experience compared to the majority of sexual and gender minorities.

The mental health system has seen a significant transformation worldwide following deinstitutionalisation and more enlightened ways to empower mental health consumers through user-led policy development and initiatives (McCann & Sharek, 2014). Although significant changes have occurred within the mainstream mental health service, LGBT individuals often spoke about a sense of hiding their sexuality and gender identity because of the mistrust experienced within mainstream mental health care.

Access to mainstream mental health services for specific and specialist care was identified as extremely limited for members of the LGBT community, and in particular the transgender community (McCann & Sharek, 2014). Pelletier and Tschurtz (2012)

65

explain that there is no single approach that works best when addressing the health needs of the LGBT community, and discuss the need for the health care environment to become more inclusive, more welcoming and safe to improve the health equality of the LGBT community and their families. Pelletier and Tschurtz (2012) identify several key areas that should be implemented through health strategy and policy. These include the need for leadership that focuses primarily on the factors the patient experiences and interacts with in the health care environment. These factors include; provision of care, treatment and services targeted as appropriate health interventions that would be harm reductive, such as counselling and screening; and lastly, a workforce of competent, well trained and informed health professionals who offer and provide inclusive and welcoming care to the LGBT community and their families (Pelletier & Tschurtz, 2012).

The LGBT community identified the need to see existing service providers and provision for these services to be reviewed and changed in order to become responsive towards the needs of the LGBT community. Such changes would include increasing the access to mental health care, being provided with health practitioners knowledgeable in LGBT health issues, and allowing a range of therapeutic talking interventions or therapies that are easily accessible and affordable (McCann & Sharek, 2014). There is overwhelming evidence within the literature that there remains a lack of mental health providers and services that are responsive and sensitive to the LGBT community's needs internationally (Rutherford, McIntyer, Daley & Ross, 2012).

Within a NZ context, gender and sexual minority mental health care provisions have not been identified within mainstream health care nationwide (Adams, Dickinson

66

& Asiasiga, 2012). The independent district health boards are key stake holders in providing resources, but there is a lack of mainstream mental health initiatives focusing on the sexual and gender minority populations. Participants in Adam et al's (2012) study articulated clearly that publicly funded and accessible mental health care is inaccessible to those with mild-moderate mental health problems, and this was significantly more for the transgender population, who are often obligated to engage in privately funded services to address their needs.

4.3.2 Gender identity issues

The transgender community continues to be one of the most neglected cohorts of the sexual and gender minorities within health care, as they encounter barriers that deprive them of opportunities, dignity and respect that haves a damaging effect on their mental wellbeing (Winter et al., 2016). The transgender community are often marginalised by a socio-legal environment that is driven by politics, religious views and an economy that excludes the community from mainstream society, which enhances the community's risk taking behaviours (Wylie et al., 2016).

The transgender community have specific health needs when accessing mental health care, but these experiences are often reported as negative when engaging with mental health services (Riggs & Bartholomaeus, 2016b). Members of the transgender community access mental health care in primarily relation to their gender dysphoria. The recent change in diagnostic criteria in the DSM-V from gender identity disorder (GID) to gender dysphoria was considered to be less stigmatising and it focused on the

feeling-state experienced by the individual, rather than the view that there was a need to repair the identity back to the individual's birth gender (Applegarth & Nuttall, 2016).

Transgender people accessing mental health care are conceptualised as having a mental disorder because of their individual experiences and presenting complaints (Winter et al., 2016). Gender dysphoria is a psychiatric diagnosis that is required by the transgender community to begin any gender conformation medical interventions (Riggs et al., 2015); however, the transgender community still experience barriers in mental health services to obtaining this diagnosis (Adams et al., 2012). GID is often pathologised by mental health professionals as the primary issue when transgender people access mental health care. However, some gender issues experienced by the transgender community are often ignored or dismissed as being a symptom of a mental health condition (Bess & Stabb, 2016).

Gender and sexual minorities within the western medical model are pathologised and often viewed as deviant individuals who require legal and medical attention (Wylie et al., 2016). The view that transgender people are mentally disordered has been criticised by clinicians, researchers and the transgender community, who argue that mental health diagnoses continue to psychopathologise their diversity (Winter et al., 2016). Crowe (2006) explored the concept of mental health diagnosis in mental health nursing as distinguishing and understanding the abnormal behaviours experienced by mental health consumers, although, abnormality is constructed by the DSM that on the basis of "what society can expect as normal behaviour" (Crowe, 2006, p. 126). It is often the role of a psychiatrist to diagnose mental disorders, following their clinical training and experience. However, psychiatrists often focus on a particular diagnosis

and fail to observe other behaviours that could potentially cloud the clinical picture (Crowe, 2006). One of the key roles that mental health clinicians have with the transgender community is determining the appropriateness for medical interventions in order to transition gender, as the clinicians effectively remain as gate keepers (Bess & Stabb, 2009).

Mental health services that are specific to the transgender community are seen as limited, and are inaccessible for many transgender people, which often results in having to access privately funded health care for the appropriate interventions required (McCann & Sharek, 2014). Transgender individuals who had undergone gender confirmation surgery were reported as having better mental health than those who had not yet undergone any medical interventions (Riggs, Ansara & Treharne, 2015). Transgender people still remain at increased risk of death, including suicide, even after transitioning (Winter et al., 2016).

4.3.3 Accessing talking therapies

There is current evidence that the LGBT community experience poor mental health outcomes because of social stress, experience of discrimination, and living in a heterosexist or homophobic environment (Rutherford et al., 2012). Therefore it is expected, given the higher rates of mental illness within the LGBT community, that they are more likely to seek mental health care compared to their heterosexual counterparts (Rutherford et al., 2012). Access to appropriate and affordable talking therapies has been identified throughout the literature as a specific need that the LGBT community has identified (McCann & Sharek, 2014).

When engaging with talking therapy, the LGBT community face a range of challenges throughout their therapeutic engagements. Some individuals reported feeling invalidated, mistreated and pathologised throughout therapy (Applegarth & Nuttall, 2016). The transgender community are often cautious with psychologists who are the gatekeepers to eligibility for medicalised interventions for transition (Vitelli & Riccardi, 2010). There is the potential that talking therapy will facilitate a positive identity and personal growth (Applegarth & Nuttall, 2016). Most clinical therapists have never had informative training when working with the LGBT community, but therapists who provide appropriate forms of therapy, regardless of their sexual orientation, can be effective. However, there is evidence that matching the therapist and individual based on sexual orientation can be beneficial (Jeffery & Tweed, 2015). LGBT-affirmative services that engaged in talking therapy were identified as having benefits, as therapeutic relationships were established more easily with the LGBT individual being less vigilant about their identity (Lucksted, 2004).

Mental health therapists working in an affirmative way promote a strength based approach, identified as a culturally sensitive model that is appropriate when working with members of the LGBT community (Adams et al., 2012). Therapeutic interventions have a role in reducing minority stress, using sexual and gender minorities affirmative cognitive behaviour therapy models to address sources of stress such as the workplace, schools, religious institutions and families. Psychological interventions capable of reducing affective, interpersonal and cognitive pathways that are linked with minority stress could enlist existing personal strengths of the individual (Pachankis, 2014).

4.4 The experiences of the LGBT community accessing mental health care

The LGBT community experience unique barriers when accessing mental health care. A reoccurring theme throughout international research, as well as in Aotearoa/New Zealand research, is the health adversity experienced by the LGBT community because of the systematic discrimination within health care (Treharne & Adams, 2017). At times this discrimination occurs unintentionally by health professionals because of the foundational heterosexist/monosexist view within healthcare (Neville & Henrickson, 2008). This view causes LGBT individuals to choose not to disclose their sexual orientation or gender identity when engaging with health services because of their previous experiences of homophobia, transphobia and biphobia (McCann & Sharek, 2014).

4.4.1 Stigma

There are many reasons people do not engage or access mental health services which are well documented within the literature; however, stigma has been identified as the key factor and barrier for individuals neglecting their mental health needs and being reluctant to obtain treatment (Shannon, Goldberg, Flett & Hewitt, 2018). Stigma is experienced by people living with a mental illness, and is a major concern (Ungar, Knaak & Szeto, 2016). Stigmatisation of people who are affected by mental illness has negative consequences for the individual and family members, as well as psychiatry as a professional body (Babic, 2010). Stigma is associated with negative attitudes and prejudice towards people who experience mental illness, but is often a combination of fear or ignorance (Babic, 2010). Those who are stigmatised experience a range of

repercussions such as psychological, economic and social loss, which results in isolation and often homelessness (Babic, 2010).

The labelling of psychiatric conditions as mental illness can have beneficial or harmful effects on both the individual and the public's attitude. A positive view of a psychiatric label is that it can be seen as increasing interprofessional communication between mental health facilities and mental health professionals. On the other hand, a negative consequence of a mental health label is the public's attitude, creating greater perception of the dangerousness of the individual that therefore results in social distancing within the community (Rüsch, Evans-Lacko, & Thornicroft, 2012). This perception creates tension for those needing to seek mental health treatment, but are hesitant to engage with services because of the self-stigma associated with a mental health label (Rüsch et al., 2012).

Self-stigma is considered the internalised belief and ideas that individuals are less valued in society because of their psychiatric diagnosis (Corrigan & Watson, 2002). Self-stigma can be projected in ways such as lowered self-esteem or righteous anger. The sense of anger is fuelled and energised by individuals who have a perception of the injustice of the social stigma (Corrigan & Watson, 2002). Stigma does not just affect the individual with a mental health label, but is inclusive of the individual's family members also. Hinshaw and Cicchetti (2000) explain that families also experience a combination of reactions because of a family member with a mental disturbance, such as shame, guilt, fear, secrecy, withdrawal and concealment, and become frustrated with the lack of health service provision.

Stigma has been primarily associated with mental illness; however, sexual and gender minorities are victims of such stereotypes within health care generally, and the wider society. Individuals who are exposed to discrimination of a personal nature are often at greater risk of developing depression, experiencing psychological distress or even committing suicide (McGarrity, Huebner, & McKinnon, 2013). Minority stress theory is used to formulate an understanding of the sexual and gender minority community. Minority stress is a three-way process that includes: internalised homophobia, actual prejudice events, and perceived stigma. When focusing on the perceived stigma experienced by the sexual and gender minority community, it is often referred to as expectations they will encounter of discrimination and rejection because of a negative perception of a group in society (McGarrity et al., 2000).

LGBT individuals who experience mental health problems are uniquely affected by a double form of stigma because of their LGBT identity and experiencing a mental illness, which poses a significant barrier in the process of acceptance and recovery (Mizock, Harrison & Russinova, 2014). Clinical bias was seen as a contributing factor that was associated with LGBT individuals when engaging with mental health services. LGBT mental health consumers frequently reported a sense of being desexualised and dehumanised within treatment, and often their mental health issues were overlooked (Lucksted, 2004). The LGBT community are exposed to homophobia and transphobia by mental health clinicians, and often felt unwelcomed by mental health services, as they are viewed as "heterosexual institutions" (Mizock et al., 2014).

Health care providers have a contributing role in anti-stigma interventions. However, health care professionals are also seen as stigmatising and marginalising

people who experience mental illness in ways such as discriminatory behaviours or practices, being given less time or less adequate treatment, and diagnostic overshadowing. It is argued that these practices are accounted for by the significant proportion of premature mortality in people with a mental illness (Ungar et al., 2016). Mental health professionals who are well aware and trained in stigma and its implications, but still continue to subscribe to stereotypes surround mental illness (Corrigan & Watson, 2002). The traditional medical model still perpetuates the professionals' attitude of "us versus them" (Hinshaw & Cicchettie, 2000, p. 572), that conflicts with contemporary mental health practice and only further disempowers the individual receiving treatment (Hinshaw & Cicchettie, 2000).

4.4.2 Staff 's lack of understanding or knowledge

It has been repeatedly identified throughout the literature on sexual and gender minorities' health needs that a key component that remains neglected is the lack of informed education of health providers surrounding the health issues of the LGBT community. In regards to education, there remains a demand for development of competencies that empower the critical knowledge, attitudes and skills that are needed to provide appropriate and affirmative care to the LGBT community (Keuroghlian et al., 2017). Past research has indicated that formalised teaching on LGBT issues is either not occurring or is not being achieved in undergraduate or postgraduate medical training (Rutherford et al., 2012). Dorsen and Van Devanter (2016) suggest the more recent generation of nurses are considered to be more comfortable discussing issues around sexual orientation and gender identity, compared to more experienced nurses

who were trained in a conservative era and are generally less comfortable discussing these issues because of their more contemporary training.

Specifically when working with transgender people, health professionals often lack the knowledge and understanding around the current barriers to accessing mental health care by this cohort, and are often unaware of the sensitivity of transgender people's issues (Riggs & Bartholomaeus, 2016a). This is because health professionals are more aware of issues surrounding gay, lesbian and bisexual people, but less informed about transgender issues (Riggs & Bartholomaeus, 2016b). With further education and training, informed clinicians are more likely to feel more comfortable and competent when working alongside transgender people. Riggs and Bartholmaeus' (2016b) study found that psychiatrists are the least likely group of health professionals to have any clinical knowledge of transgender issues, which is alarming given that psychiatrists and mental health nurses are the most likely cohort of mental health professionals to work with this community. As psychiatrists are involved in the gatekeeping process for transgender people to access the appropriate medicalised gender reassignment transition, indicates a degree of concern if they lack the socio-political knowledge and contemporary issues for the transgender community (Riggs & Bartholmaeus, 2016b). Making LGBT health a priority in medical training was identified throughout Rutherford et al.'s (2012) research, which prompted the need to improve the mental health care system of LGBT people by introducing a training programme targeted at all mental health clinicians. The implications of this mandatory training on LGBT issues would allow a minimum exposure to the key issues, terminology and important considerations when proving quality care with LGBT individuals (Rutherford et al., 2012).

4.5 Recommendations and implications for practice

The findings from this integrative review illustrate the need for health professionals, including mental health professionals, to be aware of the implications and impact of interactions they have with the LGBT community, and the systemic effect on this community's health outcomes. There is a need for health policy development and implementation to acknowledge gender and sexual minorities, with clear health objectives of reducing the disparities that are experienced by this community. Not only will this change in confronting the heterosexism within the health care setting, but will further address the importance of culturally safe practice. Organisations providing health care need to recognise the heterosexist approach that commonly reviles and make suitable changes, using gender appropriate forms and inquiring when engaging with the LGBT community. Education continues to present as a primary driver to improve the knowledge of health professionals about the LGBT to prevent unintended stigma and discrimination. Education on the LGBT community would empower health professionals, when working alongside members of the community, to establish therapeutic relationships and understand this community's the specific needs.

Additional findings from this research indicated the need for identified designated spaces or services for the LGBT community. The review found this view to be an area of contention, as mainstream health care has the ability to address these needs, but designated services could only further sigmatise sexual and gender minorities. In countries with a larger population than NZ, this may be a way of addressing and reducing the specific health disparities of this community. The

transgender community in particular require specialist care throughout their psychological and physiological transition. Therefore, specialist gender identity clinics may be required to provide the appropriate resources for their health needs. In NZ, the population of gender and sexual minority is limited, and therefore the development of such services would need to be undertaken within mainstream care.

As the LGBT community has specific health needs, the role of advanced health professionals such as nurse practitioners could be seen as a resource that may well reduce the health disparities of this community. Over recent years there has been a significant shift in the number of registered nurses advancing to becoming nurse practitioners, who are identified as experts in their area of practice (Fisher, 2005). This nursing role could enhance the transparency between general health services and mental health, particularly focusing on the transgender community when accessing medical interventions for their gender conformation procedures.

4.6 Limitations of research

There remain limitations throughout any type of research. This integrative review identified key limitations of primary resources that have used terminology and language that it consider out of date. The terminology used in the search of primary sources therefore focused on only four cohorts within the gender and sexual minority community, and excluded others such as intersex, asexual, queer and pansexual as these terms are not yet commonly found in the research literature. It has been well explained throughout the research that the LGBT community are often considered to be

particularly private, and accessing quality data that is relevant to the research question can be difficult.

4.7 Implications for future research

This integrative review highlights the need for contemporary health research to be undertaken on the individual cohorts within gender and sexual minorities because of those needs being specific to gender and sexual orientation and practices. Although health research has been conducted on specific cohorts including gay men, or men who have sex with men and HIV/AIDS, there remains very limited research that looks at their mental health needs, or indeed, those of any member of the gender and sexual minority community. This lack of research is then problematic when international bodies of health indicate the need for additional research to identify and address the health needs of the LGBT community.

Heterosexist views within health research have been identified as a barrier to the development and undertaking of research. There remains a need for further funding and specialist researchers, due to the cultural sensitivity of the community, to further explore the health needs of the transgender community, in particular indigenous communities, as they are at higher risk of facing discrimination and multiple barriers when accessing health care.

4.8 Conclusion

The LGBT community are a unique community who are identified with a range of ages, socio-economic status, ethnicity, religion and culture within the sub cohorts.

The LGBT community are exposed to specific stressors and one theory commonly used in the literature discussed in this research to be accountable for these stressors is the minority stress theory. This theory underpins the primary issues experienced by the LGBT community in many ways, from a macro social level to a micro social level. The community experiences a range of disparities not only in their health, but employment and social opportunities because of their sexual orientation or gender identity. As a result, this often leaves individuals poorly treated by health professionals and social service providers, and therefore increases the individuals' risk of developing mental health problems, and potentially risk-taking behaviours. Although the community endures a range of negative experiences, it also embraces resilience by empowering individuals to be truthful to themselves.

There is a need for health professionals, in particular mental health clinicians, to be aware of the impact their interactions have on the LGBT community, and the implications this can have on whether individuals access further care. The discrimination and stigma experienced throughout health care systems needs to be challenged to change its current heterosexist view. Health policy at a national and international level needs to meet the LGBT community specific by transforming the delivery of health care services to this significant minority group.

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Appendix two – Critical appraisal checklist

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JBI Critical Appraisal Checklist for Qualitative Research

Reviewer_____Date_____

Author _____Year_____Record Number_____

	Yes	No	Unclear	Not applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: Include ☐   Exclude ☐   Seek further info ☐

Comments (Including reason for exclusion)

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Critical Appraisal Checklist for Qualitative Research | 3

Appendix Three – Summary table of extracted data

Author	Country	Sample size and Sexual and gender orientation	Method	Aim	Mental Health needs identified	Experiences of seeking help	Conclusion
Adams, Dickinson and Asiasiga (2013)	New Zealand	(*n*=124) GLBTI	Email Survey Interviews Online qualitative survey	To identify the current mental health promotion initiatives focused on the GLBTI population, as well as mental health service specifically for the GLBTI people	• Dedicated LGBTI-focused mental health services • Public health services for mild to moderate mental health needs	• Impact of Stigma, Homophobia and Transphobia.	Increased inclusion in policy Limited services for GLBTI people

Aggarwal and Gerrets (2014)	Netherlands	(*n*=12) Gay men	Ethnographic method: Observation, Interviews	How can one understand this Dutch paradox of high rates of mental health problems among gay men in a country with marked sociocultural, economic and legal equality?	• Depression • Anxiety • Self-esteem • Suicide • Body imagine	• Stigma	Absence of symbolic equality. Heteronormative behaviours
Benson (2013)	United States of America	(*n*=7) Transgender	Phenomenological: Feminist-informed	The study aim is to give voice to self-identified transgender people and provide therapist an opportunity to learn from the experiences of this marginalized population	• Seeking therapy • Gender identity issues • Well-being, relationship satisfaction • Emotional health • Depression • Anxiety • Process of gender identity – changing name and	• Transphobia • Prejudice • Stigma • Lack of educated and informed therapist on transgender health needs • Financial barriers	Diagnosis of Gender identity disorder Affirmative practice and training

					documents requiring mental health professional		
						•	•	
Daley (2010)	Canada	(*n*=32) 21 women 1 Transgender woman who were mental health services users 10 service providers	Constructive grounded theory methodology	Is to provide data to support mental health service providers and consumers/survivors in addressing sexuality related issues during their interactions, and to serve as a basis for further development of knowledge and practice skills required to work with sexually diverse women	• Accessing counselling services • Recovery AOD • Axis II diagnosis • Risk of suicide/ self-harm • Eating disorders	•Homophobia •Dismissal of sexuality and lack of opportunities to explore • LQ women would not disclose sexual orientation during therapeutic engagements out of stigma and silence.	Self-disclosure Therapeutic relationships Sexuality is a quality of life issue and critical aspect of overall health and wellbeing

| Eady, Dobinson and Ross (2011) | Canada | (*n*=55)

Bisexual people | Qualitative community based study | Is to understand the experiences of bisexual people who have sought mental health service, their perception of providers' attitudes towards bisexuality, and whether they felt their overall needs were met by the mental health care system | • Negative and positive experiences with counselling or therapy.
• Limited services provided by public health sector
• Anxiety | • Dismissal of sexuality
• Pathologizing sexuality as mental illness
• Non-judgemental Therapeutic relationships
• Lack of education
• Competency in practitioners who are open to gender and sexuality
• Stigma
• Marginalization
• Homophobia
• Biphobia | Not making issue of sexual orientation

Negative experience results in terminating relationships with therapist leaving unmet health needs.

Improvement to MH organisations to meet the needs of bisexual group.

Improve education on health needs of LGBT community |

| Ellis, Bailey and McNeil (2015) | United Kingdom | (*n*=889) Trans people | Mixed-method design, quantitative scales and fixed response questions, as well as open response qualitative questions | The purpose of this study was to gain a better understanding of the experiences of trans people as a whole and to evaluate the above services in relation to trans clients. | • Gender reassignment medical assistance
• Anxiety
• Depression
• Assess to timely services for assessing assistance with GID | • Primary focus on trans issues not mental health problems
• Trying to prove they are worth treatment (hormones/surgical interventions)
• Developing therapeutic relationships or alliances out of fear
• Barriers of protocols in accessing transitioning treatment
• Ill-informed clinicians on Trans health issue | Adopting a flexible patient-centred approach, policy and practice changes to improve the health outcomes of the specific group. |

Matthews, Lorah and Fenton (2005)	United States of America	(*n*=20) Lesbian women	Qualitative – grounded theory	The purpose of this study is to examine, in an in-depth and narrative fashion, the factors that woman who self-identify as lesbian and in recovery from addiction have found helpful in their recovery from addiction.	• Recovering alcoholic • Recovery from other drugs • Talking therapy as a positive experience	• Addressing both Substance use and internalized homophobia through a lesbian based Alcohol Anonymous or Narcotic Anonymous lead to a greater self-acceptance	Recovery was gender, sexual orientation, ethnicity and addiction. Lesbians in recovery must overcome stigma and discrimination, which is vital that the complexities are incorporated in treatment.
McAndrew and Warne (2010)	United Kingdom	(*n*=4) Gay men	Qualitative psychoanalytically informed methodology	To facilitate the exploration of the early biographical experiences of adult gay men who have engaged in suicidality	• Anxiety • Depression • Suicidality • Self-harming behaviours • Therapy benefits when engaging with non-judgement clinicians	• Homophobia • Heterosexism • Often seek services specifically targeted to population • Sexual orientation is ignored by MH care providers • Psychotherapeutic relationships that benefit gay men	While accessing specific services for their sexual identity continues to challenge the idea of continuing to keep their identity hidden from

							mainstream health care
							MH nurses to challenge socio-political acceptance of homosexuality
McCann (2015)	Ireland	(*n*=4) Transgender people	Mixed Methods for the larger study. This paper focus on the qualitative method	To examine the mental health experiences of lesbian, gay, bisexual and transgender (LGBT) people in Ireland. This study will focus on the Transgender people interviewed.	•Depression •Anxiety •Suicidality •Necessary paperwork and sign off for accessing gender conformation •Emotional and psychological support	• Frustrated and disappointed by process • Accessing appropriate services and supports while transitioning • LGBT group providing emotional support • Stigma • Competency of practitioners in the area	Identifying services that are appropriate and accessible with limited cost Lack of support for family members Policy and practice area developments

							Pathologizing of trans health issues
Pettinato (2008)	United States of America	(*n*= 13) 12 Lesbian woman 1 bisexual woman who was in a relationship with another woman at the time of the interviews	Qualitative – Grounded theory	The experiences of midlife and older lesbians who misuse alcohol	•Alcohol misuse •Past sexual abuse •Childhood adversity •Suicide attempts •Positive experiences with therapy •Recovery from alcohol use	•Discrimination •Homophobia •Heterosexism	Multiple issues when addressing alcohol misuse in lesbian Lack of lesbian focused health education

Robertson (1998)	United Kingdom - Scotland	(*n*=37) Gay men	Qualitative – grounded theory Focus groups (*n*=20) then individual interviews (*n*=17)	The aim of the study is to explore gay men's experiences and views of health and health care	•Depression •Anxiety •Suicide •Problematic alcohol use •Treatment for homosexuality	•Reluctant to discuss sexuality •Treatment for being gay verses underlying MH issue •Deep distrust of mental health services	Social stigma Gay men have multiple mental health needs Health organisations neglecting health issues
Ross, Dobinson and Eady (2010)	Canada	(*n*=55) Bisexual people	Qualitative – Grounded theory	To describe the perceived determinants of mental health for bisexual people	•Supportive counsellors and therapist •Anxiety • Public health to be more supportive and active promotion of bisexuality	•Transgender cannot be bisexual •Bisexuality is dismissed or disallowed by health services •Biphobia •Homophobia •Homophobic violence •Monosexism •stigmatised for sexual promiscuity	Discrimination of bisexuality Further research is required in this area

Ross et al., (2016)	Canada	(*n*=41) Bisexual people	Mixed methodology Qualitative data was obtained using Charmaz's grounded theory approach	To enhance understanding of the relationship between bisexuality, poverty and mental health	• Substance missus • Depression • PTSD • Life adversity • Limited public funded counselling services • Affordable services with a LGBT mandate	• Inaccessible due to wait times and financial barriers	A significant proportion of the bisexual population live in poverty that effects their mental health. Early life events effect financial stability Poverty impacts mental health
Rounds, McGrath & Walsh (2013)	United States of America	(*n*=11) LGBTQ	Qualitative – Focus groups	To obtain this information via focus groups with LGBTQ people regarding behaviours of health	• To be familiar with insurance companies policy for Trans people	• Homophobia • Stigma • Negatively judged • Systematic discrimination • Transphobia	Lack of competency when working

| | | people | | care providers that improve or impede quality of care and then to summarize those behaviours | • Development of therapeutic relationships
• Clarity around questioning
• LGBTQ friendly spaces when accessing services
• Need health care that is culturally sensitive with LGBTQ issues
• The need of Diagnosis in order to access medical interventions for Trans people | • Substandard level of care
• Difficulty of providers understanding the lived experience and the implications this has on the community accessing health
• Accessing health care not for sexuality issues but illness or health care
• Treating homosexuality as a illness
• Forms not indicating gender or gender non specifies. | with this population

Health care providers need educating

Need for empowering LGBTQ people to access appropriate health care |