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Research Article

Practices for LGBT+ Individuals

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Abstract – This study examines the challenges faced by LGBT+ individuals in accessing mental health and healthcare services. Historically, LGBT+ individuals have been associated with psychiatric disorders for many years, particularly with the classification of homosexuality as a disease in the DSM (Diagnostic and Statistical Manual of Mental Disorders). Its removal from the DSM in 1973 marked a significant turning point in approaches to LGBT+ mental health. Today, LGBT+ individuals remain at high risk for mental health issues, particularly depression, anxiety, suicidal ideation, and substance use. The main contributing factors include discrimination, social exclusion, peer bullying, and internalized stigma. Especially young LGBT+ individuals may experience serious mental health problems when they do not receive adequate social support in school settings and within their families. In nursing, culturally sensitive and inclusive approaches can facilitate LGBT+ individuals' access to healthcare services. Madeleine Leininger's transcultural nursing model suggests that cultural differences should be considered when providing care to this population. Nurses play a critical role in promoting healthcare equity by offering services that align with the lifestyles, values, and beliefs of LGBT+ individuals. In conclusion, to reduce mental health issues among LGBT+ individuals and enhance their access to healthcare services, it is essential to strengthen social support mechanisms and implement inclusive policies in schools and healthcare systems.

Keywords – LGBT+ Inviduals, Mental Health, Health Disparities, Health Equity, Nursing Care.

I. INTRODUCTION

Richard von Krafft-Ebing was one of the most influential figures to pathologize homosexuality. His Psychopathia Sexalis examined unconventional sexual behavior through the lens of 19th-century Darwinian theory. Freud disagreed with Krafft-Ebing's view of homosexuality as a "degenerative condition", arguing that it could also occur in people with high intellectual qualities. Instead, Freud argued that everyone is born bisexual and that childish homosexual feelings can develop into homosexual behavior in adulthood. Throughout his life, Freud adhered to the theory of psychosexual development, defining homosexuality as "not shame or disease, but a variation resulting from a certain pause in sexual development".

In contrast, most psychiatric psychoanalysts of the generation after Freud considered homosexuality pathological [1]. In the mid-20th century, Rado, a Hungarian immigrant who was influential in psychiatry and psychoanalysis, argued, contrary to Freud, that there is no congenital bisexuality and normal homosexuality. Rado saw heterosexuality as the only biological norm and defined homosexuality as a phobic avoidance resulting from inadequate parenting. Guided by these views, in 1952 the APA classified

homosexuality as a 'personality disorder' and 'sexual deviation' in the DSM-I and included it with transvestism, pedophilia, fetishism, and sexual sadism [2].

Homosexuality was used to refer to sexual orientation in earlier editions of the DSM and has been a controversial topic in the mental health community. The removal of homosexuality from the DSM in 1973 reduced the debate over whether primary attraction to the same sex was a psychiatric disorder. Before DSM-II, therapists generally viewed homosexuality as undesirable or pathological and advocated for change. The APA's exclusion of homosexuality from the category of disorder was the first instance in modern medicine that divided the organization and "declared that a disease does not exist" [3]. For some, the removal of homosexuality from the DSM was a statement that behaviors that do not conform to social norms should not be considered pathological. It was argued that homosexual preferences were not "morbid" but culturally condemned. At the time of its publication, many mental health professionals and activists questioned whether the definitions in DSM-III continued to pathologize homosexual behavior. This was associated with the continued belief that "deviations from traditional gender roles are a symptom of illness". With the addition of GIDC to DSM-III, some clinicians continued to treat children with opposite gender identity (APA). Although GIDC was renamed gender identity disorder (GID) in 1994, some clinicians continued to support Bem's view that the diagnosis was "an attempt to prevent adult homosexuality through psychiatric intervention with children". However, research has shown that most children diagnosed with gender identity disorder (SID) grow up to be lesbian, gay, or bisexual (LGB), with two-thirds of boys in particular growing up gay. Yet not all children who experience gender issues identify as LGB in adulthood [1].

The biggest challenge in pathologizing gender atypicality is the lack of consensus on gender conformity. According to the DSM-IV-TR, Gender Identity Disorder is defined by the extent and prevalence of cross-gender desires, interests, and activities. However, although the DSM-IV-TR states that "this disorder does not imply that a child does not conform to stereotypical gender role behaviors", the subjectivity of the criteria can lead to children being diagnosed when they exhibit gender atypical behaviors without showing obvious distress or impairment. Thus, many LGB adults are misdiagnosed with SIDS as children because they more openly display their sexual orientation than their gender identity [3].

In a real situation, clinical judgment is important in determining whether Sam should be diagnosed with GIDC. If the patient shows symptoms of a disorder and no other condition can explain these symptoms, clinicians may have to make a diagnosis. In the case of CID, however, this may not always be helpful, as a diagnosis can lead to severe stigmatization and distress for the individual and their family. Transgender people may fear ostracization and the diagnosis may cause them to withdraw from their support network, as well as increase adjustment responses related to depression, anxiety, and rejection stress. For this reason, many clinicians prefer not to diagnose for the sake of the patient [3].

The fact that the DSM-IV-TR has different criteria for the diagnosis of BPD in boys and girls emphasizes gender differences. The most prominent difference is that boys should only "imitate women's clothing", while girls should "insist on wearing masculine clothing". According to the DSM-IV-TR, a boy's wearing women's clothing is sufficient to meet the criteria for mental illness, whereas girls must choose to wear boys' clothing to be diagnosed. This disparity suggests that masculinity should be rewarded, but female behaviors are acceptable for girls but not for boys (APA).

The differences between past treatment methods and the current clinical consensus for individuals diagnosed with BPD reflect societal influences. Traditionally, a girl diagnosed with BPD would receive behavior modification and/or psychotherapy and more feminine behaviors would be encouraged. Adults, such as in one case study, would receive forty-five-minute sessions of behavior modification and psychotherapy, as well as ECT sessions over 6 months. However, there is currently no recommended or empirically supported treatment for GID. There is an interdisciplinary consensus that psychotherapy is not intended to treat gender identity disorder. Furthermore, surgical sex reassignment is recognized as the only effective treatment for this disorder. The shift in psychotherapeutic treatments reflects a change in societal acceptance, emphasizing societal influences on the understanding of mental disorders and treatment criteria [3].

II. LGBT BASIC CONCEPTS

Sexual Orientation refers to a person's ongoing emotional, romantic, and/or sexual attraction to persons of a particular gender. Individuals can declare this orientation or they may not be able to do so due to fear of pressure and violence. Sexual orientation cannot be understood through external observations or prejudices. Heterosexuality and LGBTI+ identities are among sexual orientations.

Gender Identity refers to the gender to which people feel they belong and with which they identify [4]. This identity cannot be understood through external observations or physical characteristics. Gender identity is a process that covers psychological and social aspects beyond being related to the body. The right to self-determination includes the right to freely decide on their bodies and to participate in social life equally and freely.

Sexual Identity refers to how a person identifies themselves with those to whom they feel emotional, romantic, and sexual attraction. Furthermore, sexual identity is a term used when people identify or do not identify with a sexual orientation or find it appropriate not to identify with any sexual orientation [3]. Queer Generally refers to people who reject heteronormativity and are not heterosexual. However, from time to time, it is also embraced by heterosexual transgender people. Queer is essentially a political concept, it rejects the heterosexual narratives imposed on society and the "acceptable LGBTI+" politics that reinforces them. Although queer is sometimes used as an umbrella term for "non-heterosexual" instead of LGBTI+, this usage is opposed by many queer individuals and some heterosexual trans people. In some sources, it is spelled "kuir" in Turkish, but it is also spelled "queer".

LGBT is an acronym for lesbian, gay, bisexual and transgender people. Other acronyms such as LGBTIAQ (lesbian, gay, bisexual, transgender, intersex, asexual, aromantic and queer people) or LGBT+ are used to include other groups. However, the most commonly used term worldwide is LGBT. Lesbian refers to women who only feel emotionally and sexually attracted to other women; gay refers to men who only feel emotionally and sexually attracted to other men; bisexual refers to people who feel emotionally and sexually attracted to the same or different genders. A transgender person (often abbreviated as trans) is someone who has a gender identity that is different from the sex assigned to them at birth. Trans women are assigned "male" at birth but identify as female; trans men are assigned "female" at birth but identify as male. Non-binary (NB) is a term used to describe people whose gender identity does not fit the male/female binary [5].

Cis-heteronormativity refers to the assumption that everyone is heterosexual and cisgender, and the belief that these two identities are superior to all other sexual orientations and gender identities. This view is internalized by everyone living in a cis-heteronormative society [5].

III. MENTAL STATUS IN LGBT INDIVIDUALS

Individuals with minority sexual orientations are exposed to stressors such as discrimination, exclusion and internalized stigma. Sexual minority members may face everyday discrimination, internalized homophobia, hiding their identity and other forms of stigmatization. Epidemiological evidence shows that sexual and gender minorities (SGM) are among the highest risk groups for mental health problems such as major depression, anxiety disorders, substance use, suicidal ideation and sexual health. Sexual stigma is a cultural belief system that denigrates and socially invalidates non-heterosexual individuals. These experiences can have negative effects on mental health [6]. Lesbian, gay and bisexual (LGB) people have been found to have a 1.5-5 times higher risk of mental disorders, suicidality and deliberate self-harm than heterosexual people. In recent years, major mental health disparities have emerged between youth and adults in sexual minority groups. Western countries have experienced legal, political and social improvements for LGB people. Many countries have included sexual orientation in their anti-discrimination laws. By 2021, marriage equality is legally recognized in 29 countries and civil unions have increased. In the West, some progress has prevented the stigmatization of people with minority sexual orientations [7].

The study shows that factors such as minority stress, discrimination, bullying, aggression, violence and internalized sexual stigma can trigger the development of mental disorders. Furthermore, people with minority sexual orientations are less likely to disclose their sexual orientation in healthcare settings. They

may hesitate to seek treatment for mental health problems due to fear of discrimination and may tend to discontinue treatment after actual experiences of discrimination [8].

Lesbian, gay and bisexual (LGB) youth report higher rates of mental health problems such as suicidality, depression and substance use compared to their heterosexual peers. According to recent estimates, approximately 4% of US adults identify as LGB [9], while approximately 15% of adolescents identify as LGB or questioning [10]. These proportions may be underestimated given that sexual minority youth use other labels such as "pansexual" or "mostly heterosexual"; in addition, some youth who identify as "heterosexual" report the same sexual attraction and/or behavior [11].

While the mental health of transgender adolescents (adolescents who identify with a gender identity other than their sex assigned at birth) has been less well studied, existing evidence suggests that these youth experience high rates of suicidality and symptoms of depression [12, 13]. Prevalence rates for transgender youth can be difficult to estimate, as the number of adolescents seeking treatment in gender health clinics has increased in recent years [14].

A. Suicide Attempt/Risk-Depression

Suicide is the second leading cause of death among adolescents [15] and LGB adolescents are at risk. Compared to heterosexual adolescents, LGB adolescents are twice as likely to have suicidal ideation. National data from the 2015 Youth Risk Behavior Surveillance System (YRBSS) show that 43% of LGB adolescents in the US have seriously considered suicide in the past year, 38% have made suicide plans, 29% have attempted suicide, and 9% have made an attempt that required medical intervention [16]. The same survey found particularly high suicide rates among bisexual girls, with 35% of this group having attempted suicide and 12% requiring medical intervention [17].

Minority stress has been associated with increased levels of suicide among LGB adolescents, with peer bullying being the most frequently examined stressor. Peer bullying refers to being subjected to verbal or physical attacks. LGB adolescents who experience more peer bullying report higher rates of suicide, including suicidal ideation, attempts, and non-suicidal self-harm [18]. While 61% of transgender adolescents reported having suicidal thoughts throughout their lives, 31% attempted suicide [19]. One study found that suicide levels in transgender adolescents were higher than in cisgender heterosexual and cisgender sexual minority peers [20].

15% of LGBT individuals meet the diagnostic criteria for Major Depressive Disorder. High levels of depressive symptoms in adolescence can negatively affect the long-term mental health of LGB individuals. A systematic review found that the main risk factors for depression in LGB youth are intrinsic factors such as internalized sexual orientation-related oppression, identity concealment, parental rejection, and bullying [21]. Furthermore, sexual minority-related bullying was found to mediate the relationship between depressive symptoms and suicide.

B. Substance Use

LGB adolescents show higher rates of substance use than their heterosexual peers, almost three times the rate of heterosexual adolescents. A study based on data from California found that substance use among transgender youth was 2.5-4 times higher than among their cisgender peers. Furthermore, LGB youth exhibit higher rates of cigarette, alcohol, marijuana, cocaine, and injection drug use than their heterosexual peers, and recent data suggest that LGB adolescents have higher rates of vape use [22].

C. Coping with Stress

Social support plays an important role in helping LGBT people cope with stress and protecting them from mental disorders. A study in Wisconsin showed that LGBT youth in schools with Gay-Straight Alliances (GSAs) exhibited lower levels of truancy, substance use, suicide attempts and risky sexual behaviors compared to youth in schools without GSAs [23]. In qualitative interviews, it was found that sexual minority adolescents emphasized the support of LGBT centers and organizations and that parental and peer support was important in coping with substance use, depression and psychological distress [21] [24].

IV. LGBT INDIVIDUALS AND MENTAL HEALTH NURSING

Various social determinants (such as social class, gender, race/ethnicity, sexual orientation and gender identity) contribute to inequalities and marginalization. This exclusion has complex impacts on people's health and well-being. The LGBT population presents worse outcomes in terms of both physical and mental health compared to the cis-heterosexual population. LGBT people have higher rates of depression, anxiety, substance abuse and suicide. Lesbian and bisexual women have a higher prevalence of osteoporosis and some types of cancer, and a higher rate of being overweight or obese [25]. Gay and bisexual men have higher rates of HIV, viral hepatitis and sexually transmitted infections; anal, prostate, testicular and colon cancers are also common. In transgender individuals, body modification processes and high rates of self-harm and suicide have been reported [26] [27].

Transgender people experience discrimination and high rates of interpersonal violence, and a large proportion of this population does not have health insurance. Trans men and NB (Non-Binary) people, especially those who are capable of pregnancy, are often excluded from services such as breast cancer screenings and gynecological/obstetric care because medical staff make incorrect biological assumptions [27]. Trans women are driven into prostitution due to exclusion from the workforce and poverty, which puts them at risk of incarceration, violence, STIs and drug addiction. Lesbian and bisexual women have been found to be at higher risk of accessing cancer screening services [25]. The specific problems of bisexual people are often overlooked in the “gay” category, making them invisible. According to available data, bisexual women and men are at disproportionate risk of issues such as intimate partner violence.

The health and social needs of the LGBT community vary at different stages of their lives. During adolescence and youth, there are higher risks of bullying, risky sexual behaviors, suicide and family rejection. In adulthood, LGBT people are more likely to use tobacco, alcohol and drugs. They are also less likely to have children, increasing the risk of loneliness, social isolation and lack of access to health services in old age. Many LGBT people feel discomfort and insecurity due to discriminatory attitudes in health systems. The standard acceptance of cis-heterosexuality, stereotypes and prejudices create barriers to individualized care for this population [25-27].

The intercultural nursing perspective developed by Madeleine Leininger is useful for analyzing how nurses influence the care they provide to groups with different cultures. This theoretical framework, while treating care as a cultural practice, directs transcultural nursing towards a comparative study to understand the similarities and differences between cultures and sees these differences as a source of enrichment. The aim of transcultural nursing is to provide care that is compatible with each individual's lifestyle, values, beliefs and meaning system [28]. Race/ethnicity and religion, as well as gender identity and sexual orientation, can be considered components of an individual's culture. Therefore, this theoretical framework helps to avoid prejudiced and discriminatory attitudes during care and to understand the specific health needs of the LGBT community [29].

The LGBT community faces health inequalities related to the discrimination they experience because of their sexual orientation or gender identity. Both health workers and the health system can contribute to this discrimination or help reduce these inequalities by advocating for human rights. Therefore, addressing health inequalities in the LGBT community should be addressed at both the individual and structural level to achieve health equity [5].

Nurses establish close relationships with patients by being at the forefront of health services and providing care to populations living in different social contexts. The role of nursing an important component is advocacy for excluded populations. For this reason, nurses are key to reducing health inequalities among LGBT people can play a role [26].

LGBT in school settings inclusive sexuality education to improve the mental health of young people, sexual and programs such as gender diversity, bullying and suicide prevention are recommended. Providing accurate information to families, and enabling them to share their stories to allow them to understand the negative effects of parental rejection on health is important. In addition, health professionals should be provided with training should be provided and specialized health services should be provided for this population. Focussed strategies should be implemented. Presentations as educational tools, simulations, small group discussions and short films can be used [30] [31].

Nurses, and LGBT to reduce health inequalities in the community, including the health inequalities faced by this population. Can intervene by understanding health risks. Mental health, substance abuse and screening for adverse childhood experiences, gender-affirming language to create a culturally sensitive health environment and to support LGBT education. In addition, the inclusion of LGBT health in the nursing school curriculum advocates for the inclusion of the training of health care providers to support and monitor compliance with non-discriminatory policies [32].

V. RESULTS

In conclusion, to reduce mental health issues among LGBT+ individuals and enhance their access to healthcare services, it is essential to strengthen social support mechanisms and implement inclusive policies in schools and healthcare systems.

Conclusion LGBT+ individuals continue to face significant mental health challenges due to systemic discrimination, social exclusion, and lack of culturally sensitive healthcare. To address these issues, healthcare professionals, particularly nurses, must adopt inclusive and empathetic approaches that respect individual identities and experiences. Implementing culturally competent nursing practices, promoting social support systems, and integrating inclusive education in healthcare settings are crucial steps in reducing health disparities and supporting the mental well-being of LGBT+ individuals. Additionally, structural changes at policy and institutional levels are needed to ensure equity in healthcare access and to foster safe and supportive environments. Ultimately, promoting inclusivity and acceptance within both healthcare and societal contexts will contribute to the holistic well-being of LGBT+ individuals.

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