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MENTAL DISTRESS IN PERSONS FROM SEXUAL ORIENTATION AND GENDER IDENTITY MINORITY COMMUNITY

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ABSTRACT

People of diverse sexual orientation and gender identity (SOGI) community are a minority in the society all over the world including Nepal. They face stigma, prejudice, discrimination, and lack of opportunities in society, and hence are expected to have more mental distress than other persons of binary categories (i.e., male and female), as predicted by minority stress theory. This study aimed to assess the prevalence of depression, anxiety, and stress (common name: psychological distress) among LGBTQI+ persons of Nepal. A survey was conducted among 244 participants (M_{age}=25.8 years, SD=7.94) using sociodemographic questions and the DASS-21. Depression, anxiety, and stress were seen in 75.4%, 85.7%, and 60.2% of SOGI diverse people. Depression, anxiety, and stress correlated significantly with each other but not with age or number of close friends. Having income and coming out affected depression. Having the family's unconditional support affected stress. Family's knowing about participants' SOGI status affected depression and anxiety. The conclusion is that SOGI diverse people have more depression, anxiety, and stress than people from binary categories. Some social factors like having income, getting family support, and opening up about SOGI status are responsible for the mental distress of SOGI minority people. Psychosocial interventions are urgently needed to help the SOGI minority people lessen their mental distress and promote their mental health.

Keywords: depression, anxiety, stress, LGBTQI+, SOGI, Nepal, the LGBT community

INTRODUCTION

Lesbian, gay, bisexual, transgender, queer plus others like intersex and asexual (LGBTQ+) individuals have a higher rate of mental health problems like anxiety, depression, stress, substance abuse, and other psychopathologies (Garaigordobil & Larrain, 2020; Meyer, 2003; Semlyen *et al.*, 2016; Yarns *et al.*, 2016) than other persons from binary categories (i.e., male and female). People from diverse sexual orientation and gender identity (SOGI) are a minority and have to consistently face discrimination, stigma, prejudice and lack of or ban from opportunities in society. Hence, they are prone to mental distress. This topic has not been studied enough in Nepal. Its inquiry can lead to better knowledge about SOGI people's mental health problems and the required interventions to enhance their mental health.

The prevalence of depression and anxiety in bisexual persons is higher than in gays and lesbians (Ross *et al.*, 2018). Among gay and bisexual men, one in four have depression and one in six have anxiety (Prestage *et al.*, 2018). They also use illicit drugs infrequently. Gay men are three times more likely to be depressed than general adults (Lee *et al.*, 2017). Non-suicidal self-injury, suicide, substance disorder, and mood disorder are higher among sexual and gender minority people (American Psychiatric Association, 2018; Liu *et al.*, 2019). The poor mental health of LGBTQ+ persons may lead to dire consequences. For example, elevated levels of depression and drug abuse may lead to suicidal ideation and attempts (Hatchel *et al.*, 2019). So, understanding the mental health of LGBTQ+ is important and necessary.

Mental Distress of Nepali LGBTQ+ People

In Asian societies, LGBTQ+ individuals, known by the words *Hijada, Fulu fulu, Singaru, Maugiya, Meti,* and *Kothi* among others in Nepal (Chhetri, 2017), hardly disclose their sexual orientation. homonegative attitude of society, seen in homophobia and transphobia, is to blame. Internalized homophobia and experiences of sexual violence may be other related factors (Breen *et al.*, 2020). When LGBTQ+ individuals come out, their families may be unsupportive contrary to the expectation of being a source of support and resilience, and the family of origin may estrange (Baskaran & Hauser, 2022; Milton & Knutson, 2021). Support from the family of origin predicts depression in them. The individuals also face abuse, violence, and discrimination (Rana, 2020; M. Storm *et al.*,

2020). So, their mental health is affected negatively. In times of difficulty like the pandemic, they may face more discrimination and those who experience it are more prone to mental health problems (Kneale & Bécares, 2020). Consequently, they even refrain from taking basic services like seeking health care because the institutions may have practices favoring heterosexuals (heteronormativity) or cisgenders and are biased towards sexual and gender minority (SGM; Aryal & Atreya, 2021). The healthcare service providers may pathologize the identities and distress may increase (Wandrekar & Nigudkar, 2020).

Legally, persons from SOGI diverse community cannot be discriminated (International Commission of Jurists, n.d.; Regmi & van Teijlingen, 2015), especially after a Supreme Court ruling in December 2007. Some rights have also been ensured for LGBTQ+ people. An indicator is the option of having "third gender" in the citizenship card (Pokhrel *et al.*, 2014) and "other" in the gender category of the passport (Cousins, 2018). Nepal is ahead in Asia in providing rights to them, but socially they face overwhelming prejudice and stigma (Greene, 2015). Transgender women and men who have sex with men (MSM) had different levels of depression and suicidality but being cheated and threatened, and forceful marriage made them vulnerable to suicidal ideation or attempt (S. Storm *et al.*, 2021).

Predictors of Mental Health of LGBTQ+ People

Some risk factors play a role in the emergence of mental health problems. Some protective factors play a role in placating mental health problems or even prevent them from occurring. LGBTQ+ persons are coming out at younger age now (Russell & Fish, 2016) but peer victimization is the greatest at this age. A negative family climate during pandemic was associated with depression and anxiety in LGBTQ+ persons (Gato *et al.*, 2020). At other times also, a family that nags for being homosexual, transexual or bisexual is a significant stressor. Non-heterosexuals face more bullying and cyberbullying (Garaigordobil & Larrain, 2020). Almost three-fourths of LGBT+ students have faced lifetime bully (Hinduja & Patchin, 2020). Abuse of LGBTQ+ people can range from verbal abuse and blackmail to 'corrective rape' and coerced conversion orientation (Shidlo & Ahola, 2013). Cyberbullying is a cause of mental health problems like depression, self-harm and suicidal ideation (see Abreu & Kenny, 2018 for a review) and non-heterosexuals face more aggressive bullying (Garaigordobil & Larrain, 2020). Concealment of sexual/gender identity, internalized homophobia/

homonegativity, intimate partner violence, perceived stigma, victimization, and discrimination are the risk factors for mental health (Lee *et al.*, 2017; A. Miltz *et al.*, 2019; Oginni *et al.*, 2018). Daily tobacco use was associated with mental health problems among gay and bisexual men (Prestage *et al.*, 2018). Social isolation and marginalization also increased mental health problems (Prestage *et al.*, 2018). Intimate partner violence was associated with depression (A. R. Miltz *et al.*, 2019). The universal stress factors like conflict with parents, substance use/abuse, and history of physical/physical abuse/harassment also lead to mental health problems in LGBTQ+ persons (Russell & Fish, 2016). LGBTQ+ persons' rejection sensitivity also predicted mental health problems (Mahon *et al.*, 2021; Slimowicz *et al.*, 2020). The presence of one mental health problem may cause the emergence of another one also. Unsupportive or discriminatory policies may exacerbate the mental health. For example, minority stress was found to increase among LGBTQ+ people following the win of Donald Trump in 2016 who failed to show support for them (Gonzaleza *et al.*, 2018).

There are various risk factors for mental health for LGBTQ+ people. For example, loneliness, stigma, and substance abuse are the risk factors for older LGBTQ+ people (McCann & Brown, 2019). Internal stressors and chronic physical health conditions also may cause some mental health issues. Depression and anxiety were more common for LGBTQ+ with unemployment, younger age, and emotional sensitivity during the pandemic (Gato *et al.*, 2021; Town *et al.*, 2021). LGBTQ+ individuals from other groups of marginalization (like *Dalit,* poor, and disabled) may have to withstand the complexity of multiple marginalization (intersectionality). LGBTQ+ patients want "palliation of social and structural pain" besides physical, emotional, and spiritual care (Baskaran & Hauser, 2022). They fear growing into old age alone. They do not have many career options or job opportunities (Boyce & Coyle, 2013) and many of them, especially poorer ones, may be pushed to sex work. The lack of social acceptance is another bad thing that gives them a sense of exclusion. Some of them get involved in sex work because of this lack of acceptance (Wilson *et al.*, 2021). They may be obligated to maintain double identities (Panthee, 2019) as they cannot come out. They may be coercively prepared for relationships like marriage (Pathak *et al.*, 2010). LGBTQ+ people fear humiliation, gossip, and ridicule (Cousins, 2018) when they visit institutions to take services like healthcare. Perceived discrimination predicts suicidality

(Kohlbrenner *et al.*, 2016). The majority of them have been harassed at the workplace, school, or elsewhere (Ghimire *et al.*, 2019). Even if some LGBTQ+ individuals' families are supportive, they may face bullying in society (Nori, 2012). Financial autonomy could give them a chance for a life of content (Bista, 2012).

Minority stress theory, which is the theoretical framework for this study, says that sexual and gender minorities experience distinct chronic stressors like victimization, prejudice, and discrimination related to their stigmatized identities (Meyer, 2003). They experience more stress than people from majority groups. The stressors come in the form of objective external stressors (like institutionalized discrimination), an expectation of discrimination, and an internalization of homonegativity (Russell & Fish, 2016). Because they face much negative attitudes from family and society, they may be ashamed of their sexual orientation and gender identity (SOGI). Minority stressors (like internalized homophobia and stigma) all correlate with anxiety among SGM (Griffin *et al.*, 2018).

Perceived social connectedness and support were found useful for the mental health of LGBTQ+ persons during the pandemic (Lee *et al.*, 2017; Tuzun *et al.*, 2022). Policies to ensure their civil rights can also be helpful. Anti-bullying policies and persons in charge (like teachers) with positive attitudes towards LGBTQ+ (Kolbert *et al.*, 2015) can prevent mental health problems. Perceived online social support was not linked to the well-being of LGBTQ+ people (Han *et al.*, 2019). Despite many perils of cyberspace (like harassment, isolation, and exclusion), the queers may find it a good source for social belonging and connection (Robards *et al.*, 2018). Sense of coherence and connectedness to the LGBTQ+ community are resilient factors against anxiety (Griffin *et al.*, 2018; Mahon *et al.*, 2021).

This study aimed to determine the prevalence of mental distress, operationally defined as depression, anxiety, and stress for this study. Moreover, it also sought to identify its sociodemographic correlates/ associates.

METHODS

Participants

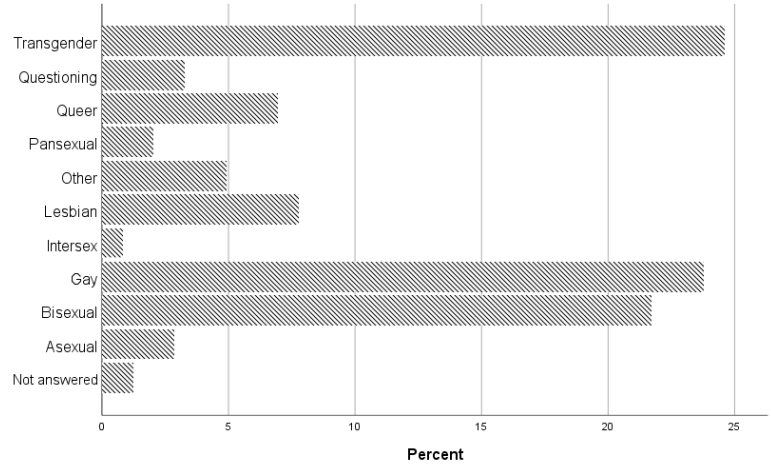
The sample, made by snowballing technique, consisted of 244 participants from the whole country. The mean age of participants was 25.8 years (SD=7.94). Participants ranged from 14 to 62 years. There were 61.1%

of participants from the hilly region, 7.3% from the mountainous region, and 31.6% from the plain region (or Tarai) of the country. Only 38.6% of participants said that they had at least a source of income. Among those who had a source of income, some belonged to the business world whereas some were employees. Some were sex workers while some were laborers. Some were artists while others were designers. The sample included SOGI diverse people from many occupations.

Among all, 72.6% of participants were Hindu, 14.9% were Buddhist, 3.7% were Muslim, 2.5% were Kirat, 2.9% were Christian, 1.7% were atheist, and the rest said they belonged to other religions. The 56.3% of participants said that they lived with the families they were born in, and 27.7% said they lived with a family/partner they chose later. SOGI diverse people with 95 surnames participated.

Figure 1

Different SOGI representations in the sample



Measures

The Nepali version of DASS-21 (Thapa *et al.*, 2021) was used with minor modifications in translation. For example, the response options (4-point Likert) were changed to past tense (as in the original scale) in place of the present tense in Thapa's *et al.* translation. DASS-21 has 21 items with 7 items to measure each depression, anxiety, and stress. The response options included "Did not apply to me at all" scored as 0, "Applied to me to some degree, or some of the time" scored as 1, "Applied to me to a considerable degree or a good part of time" scored as 2, and "Applied to

me very much or most of the time" scored as 3. More scores meant more distress for each construct. Additionally, a sociodemographic questionnaire was used. It asked participants of their age, if they had close friends, no. of close friends, if their families knew/accepted their SOGI status and similar questions.

Procedures

Informed consent was acquired from participants. They had been informed about the voluntary nature of the survey and the right to withdraw. Among all, 8% of data were collected online (using Google Forms) and the remaining data were collected in person by using a questionnaire that consisted of a sociodemographic questionnaire and the depression, anxiety, and stress scale or DASS-21 (shorter version of DASS-42). Six data were deleted listwise for the participants had left all fields in DASS items empty or there was an issue with the response set.

Research assistants contacted some persons from the LGBT community and requested them to give contacts of other persons from the SOGI diverse community. They met them in person to get the questionnaire filled out. Assistants were ready with online forms alternatively. They also collected data from the picnic program of SOGI diverse community.

Data Analysis

Data from 250 participants were collected with the help of research assistants. Six data were discarded for no response in DASS fields; 244 data were analyzed and included in the report. The descriptives, frequency distribution, t-test, and correlation coefficient have been used to process data.

RESULTS

Among all participants, more than one-third (38.5%) said that their families supported them unconditionally (i.e., without the condition of forsaking their SOGI), nearly one-third (34.3%) said their families accepted their SOGI, 62.1% participants said that they came out, 43.3% of them said that they have told their families, and 87.2% of them said that they had close friends. Table 1 shows the summary of the major three factors of distress.

Table 1

Descriptives of factors of mental distress

	Depression	Anxiety	Stress
M	18.1	18.8	18.8
SD	10.6	10.3	10.1
Mdn	18	18	18

Table 2 shows that 75.4% of SOGI diverse people had depression, 85.7% of them had anxiety and 60.2% of them had stress based on Lovibond and Lovibond (1995).

Table 2

Levels of distress among LGBTQ+ persons

Distress Factor	Depression		Anxiety		Stress	
Level	f	%	f	%	f	%
Mild	26	10.7	9	3.7	38	15.6
Moderate	56	23	57	23.4	40	16.4
No	60	24.6	35	14.3	97	39.8
Severe	55	22.5	31	12.7	41	16.8
Very severe	47	19.3	112	45.9	28	11.5

Table 3 shows the correlations between three factors of mental distress and two sociodemographic variables.

Table 3

Correlations coefficients between quantitative variables of the study

		Age	**No. of close friends**	**Stress**	**Anxiety**	**Depression**
Age	Pearson's r	—				
	df	—				
	p-value	—				
No of close friends	Pearson's r	0.121	—			
	df	189	—			
	p-value	0.095	—			
Stress	Pearson's r	0.028	-0.03	—		
	df	231	200	—		
	p-value	0.673	0.672	—		
Anxiety	Pearson's r	0.036	-0.012	0.801	—	
	df	231	200	242	—	
	p-value	0.584	0.862	<.001	—	
Depression	Pearson's r	0.024	-0.039	0.762	0.765	—
	df	231	200	242	242	—
	p-value	0.717	0.578	<.001	<.001	—

Using the t-test for independent means, having or not having income significantly affected depression, t (239)= 1.94, p=.05. Not having income caused more depression. Living with family or a chosen partner did not affect any factor of mental distress. Neither did having close friends or getting family acceptance of SOGI status. Family's knowledge about participants being SOGI community members significantly affected depression, t (229)= 2.35, p=.02 and anxiety, t (229)=2.23, p=.03. If family did not know it, they had more depression and anxiety. Coming out significantly affected depression, t (225)= 2.14, p=.03. Not turning up caused more depression. Having or not having unconditional support from family significantly affected stress, t (224)=2.19, p=.03. Not having it caused more stress.

DISCUSSION

Interpretation of Results

The levels of mental distress (i.e., stress, depression, and anxiety) are very high in the persons from SOGI diverse community. Severe or very severe levels alone of depression, anxiety and stress among them are 41.8%, 58.6%, and 28.3% respectively. The lack of association of mental distress with some sociodemographic factors like age, family acceptance of SOGI, living arrangement, having close friends and friendship circle size is interesting. However, the fact that other variables like having income source, family's knowledge about SOGI, and their unconditional support significantly associated with mental distress means that social factors are responsible for it.

Comparison With Past Studies

The older adults are the age groups found to be highest in depression. This study showed that SOGI diverse people have much higher depression than them (P. Adhikari & McLaren, 2023). The study by P. Adhikari and McLaren had shown 44.3% older adults as having depression. 19.2 and 16.4% of construction workers were found to have anxiety and stress (B. Adhikari *et al.*, 2023). The LGBT community was found to have far more anxiety and stress than them who are supposed have an arduous life. Social factors such as social isolation and connectedness (Garcia *et al.*, 2020) have been established as determinants of the mental health of the LGBT community. This study also showed that family's knowledge and their unconditional support significantly relate to mental distress.

Implications

As posited by minority stress theory, the claim that minority people face more distress is supported in this study. The presence of a high level of mental distress indicates that there is an urgent need for interventions to lessen it and promote mental health among SOGI diverse people. This research has also supported that social connectedness is helpful for their mental health as has been established (Garcia *et al.*, 2020). So, the interventions aimed at reducing the mental distress among them should address social isolation and enhance connectedness.

Future Studies

Future studies can focus on identifying the determinants of mental distress. They should focus on social, psychological, and biological factors as suggested by the biopsychosocial model. Moreover, the factors indicated by minority stress theory also should be tested if they cause distress. In addition, the protective factors need to be identified to promote mental health among the LGBT community.

CONCLUSION

SOGI minority community has more mental distress (say depression, anxiety, and stress) than people in binary categories (i.e., male and female). Some socioeconomic factors have been identified as determinants of mental stress among LGBTQI+ persons. They have income sources, get unconditional support from family, and their knowledge about participants' SOGI. The findings of the study added support for minority stress theory. Interventions to promote mental health in the SOGI minority community are urgent. In the future, predictors of mental distress should be identified.

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