The history of mental health treatment of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) populations is an uneasy one. In the 1950s and 60s, many psychiatrists believed that homosexuality (as well as bisexuality) was a mental disorder. Lesbians and gay men were often subjected to treatment against their will, including forced hospitalizations, aversion therapy, and electroshock therapy.

Fortunately, there have been great strides made since the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders, or the DSM, in 1973. Despite this, there are still disparities and LGBTQ+ people continue to experience unequal treatment when seeking care.

Mental Health Treatment and LGBTQ+ Populations
Since 1973, the attitudes of mental health professionals have shown a positive change toward LGBTQ+ populations. For example, a 2005 study found that 58% of psychologists supported a gay-affirmative stance in therapy, compared to only 5% in 1991.

Despite these positive changes in attitudes, however, many mental health professionals still report a lack of focus on LGBTQ+ issues in their training. For example, a survey of therapists-to-be found that even though they had positive attitudes about LGBTQ+ populations, they generally felt unprepared to counsel LGBTQ+ clients, and many programs lacked coursework or training modules on LGBTQ+ issues.

Nevertheless, studies suggest that LGBTQ+ populations are actually more likely to report using therapy or counseling than cisgender, heterosexual groups. Upon reflection, this is not so surprising given the stressors that LGBTQ+ people confront, such as biphobia, transphobia, homophobia, societal discrimination, coming out, and negotiating family relationships.

There are still disparities, though, in both mental health research and services when it comes to certain LGBTQ+ populations, including: Transgender people, Bisexual people, LGBTQ+ people who are BIPOC, LGBTQ+ people living in rural areas, and LGBTQ+ people with serious mental illness.

Transgender people
The relationship between gender identity and the field of mental health is complicated and cannot be done justice in a few paragraphs. However, too often it is the case that people whose gender does not match their assigned sex at birth, face the most severe discrimination and maltreatment in most settings, including healthcare settings.

As transgender people become more visible, it is important for providers to understand that gender identity and expression is not the same as sexual orientation (transgender people often identify as straight). In addition, identifying as transgender does not automatically mean that someone has a mental illness.

Bisexual people
Bisexual people continue to be overlooked in mental health research and may often confront stereotypes when seeking therapy or other mental health services. They may also face rejection from the larger heterosexual community as well as from gay and lesbian communities.

When working with bisexual clients, it is important for mental health professionals to recognize that for many, a bisexual identity is a legitimate identity and does not represent confusion or lack of a commitment to a gay (or
straight) identity. Mental health providers should not assume that bisexuality is the presenting issue. Rather, they should take their cues from the client and proceed accordingly.

**LGBTQ+ people who are BIPOC**

To date, most research on LGBTQ+ populations has been done with predominantly white samples. The mental health issues and needs of LGBTQ+ people of color, therefore, are still largely unknown and vastly understudied.

What we do know, however, is that LGBTQ+ African American, Latinx, Native American, Asian Pacific Islander, and people of other non-white racial identities share at least one thing in common: they must confront racism as well as homophobia, biphobia, and/or transphobia. These multiple levels of oppression and the experience of being part of a historically marginalized community within a historically marginalized community may contribute to an increased vulnerability to mental illness, particularly depression and anxiety.

In addition to these issues, there is the reality that people of color are underrepresented in mental health professions. For example, while African Americans comprise about 12% of the population, only 2% of psychologists and 4% of social workers are African American. This lack of representation in the field of mental health providers may contribute to an underutilization of mental health services among members of BIPOC communities in general and may also mean that for LGBTQ+ people of color seeking mental health treatment, there are even fewer culturally competent resources available.

**LGBTQ+ people living in rural areas**

Not all LGBTQ+ people live in big cities. For LGBTQ+ people living in rural areas, there may be a number of barriers to finding LGBTQ+ -friendly mental health providers, programs, and services. In a study of mental health providers serving two rural communities, participants reported widespread anti-LGBTQ+ bias and an overall lack of resources for LGBTQ+ people. Unfortunately, fears of harassment — or worse — prevented LGBTQ+ providers from working with LGBTQ+ consumers to create networks and resources.

**LGBTQ+ people with serious mental illness**

To date, most information we have about LGBTQ+ people and mental health is related to counseling or psychotherapy. There is little to no information about LGBTQ+ people with serious mental illnesses or those who require services other than therapy. What little we do know, however, suggests that LGBTQ+ people with serious mental illnesses are often subjected to poor treatment, particularly in the public mental health system. They often feel compelled to hide their sexual orientation or gender identity in an effort to protect themselves from ridicule or maltreatment from counselors, peers, and staff.

Furthermore, those agencies specifically serving LGBTQ+ populations are often uneducated or unprepared to address the needs of those who have a serious mental illness.

Those in in-patient settings have also reported that attempting to negotiate unfriendly or blatantly homophobic or transphobic settings can be quite taxing. Efforts to conceal a fundamental part of themselves — their sexual orientation or gender identity — can interfere with successful treatment, as LGBTQ+ people are not able to bring the entirety of who they are into treatment.

**Addressing Disparities**

One key way to address these disparities is through LGBTQ+ cultural competency trainings for all people working in mental health professions. Cultural competence involves the *individual* and their attitudes, behaviors, and beliefs as well as the *institution* and its behaviors and policies. Individual cultural competence means that one can communicate effectively with people who have different identities from themselves. At the institutional level, it means that an agency is consciously set up to meet the needs of people from different cultures and who hold identities different from their own. It is only through education that we can begin to dismantle the barriers to care that many LGBTQ+ people still confront.

*NAMI March 2016; Updated December 2021*