

Exploring lived experiences of the LGBTQ+ community: A qualitative study on mental health care and collective well being.

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ABSTRACT

This study aims to conduct a comprehensive study of the mental health concerns and psychological needs of LGBTQ+ (Lesbian, Gay, Bisexual, and Queer) community in India. As societal awareness and acceptance of diverse sexual orientations continue to grow globally, it becomes imperative for psychology students to study more and more about psychological and counselling needs of LGBTQ+ community. This research aims to interpret the specific mental health concerns and psychological needs within the LGBTQ+ community by conducting a thematic analysis of eighteen in-depth interviews with self-identified LGBTQ+ individuals. The study explores participants' lived experiences across a spectrum of sexual orientations, focusing on their perceptions of mental health, barriers to care, and sources of resilience. The main objective of this research is to identify the prevalent mental health issues within the LGBTQ+ population as well as to understand the specific psychological needs in response to these challenges. This study highlights the pressing need for holistic, inclusive and accessible mental health services focused on the specific needs of LGBTQ+ community. To foster psychological well-being and equity within the LGBTQ+ community, the insights were derived from thematic analysis, providing an evidence base for healthcare providers. This research will try to bridge the gap between mental health needs and ensure all individuals have access to respectful, empathetic, and effective psychological care..

Keywords: LGBTQ+ community, Psychological Challenges, Mental Health Concerns, Psychological Needs, Struggle.

INTRODUCTION:

LGBTQ+:

LGBTQ+ is the very common short form used to denote sexual orientations of the people who identify themselves as Lesbian, Gay, Bisexual, Queer and other orientation. (*LGBTQ+ Definitions, Terms and Concepts - The Annie E. Casey Foundation*, n.d.)

A woman sexually, emotionally and romantically attracted to other women, identifies self as a "Lesbian" (L). On the other side men sexually, romantically and emotionally attracted to other men, identifies as a "Gay" (G). Sometimes women also prefer to call themselves as a gay women. A person on any gender or sexual orientation is sexually, emotionally and romantically attracted to more than one gender, identifies as "Bisexuals" (B). "Queer" (Q) is an umbrella term used for the people who do not identify themselves as heterosexual. These people consider themselves as gender-fluid, non-binary, or non-confirming identity. The Plus (+) sign is used for all other sexual orientations and gender identities which are part of this community (*Defining LGBTQ+ - The Center*, n.d.).

Traces of LGBTQ+ community has deeply rooted in Indian Mythology and history. Homosexuality has been mentioned in ancient scriptures and architecture. Kamasutra which means "Aphorism on Love" a book

written by Vatsyayana in Sanskrit gives some references of homosexual behaviours. It is difficult to estimate the exact time of its inscription, but is considered to be written between 1st and 6th century AD. In the ninth chapter of the book named "Auparishtaka" which means oral sex, it mentions that, Auparishtaka is done by women to a woman and men to men (Tiware, 2012). Another chapter "Purushayita" in Kamasutra, mentions about self-independent women who are engaged in sex with females known as, Swarini. There are few references too about men who are having sex with men. (Mehrotra Deepanshi, 2021) This book has mentioned about three types of genders – "Pums Prakriti" means man, "Stree Prakriti" means women and "Tritiya Prakriti" that is third gender. Here third gender refers to people with different homosexual activities. (Tiware, 2012)

While such instances in our mythology shows social acceptance to LGBTQ+ community, this community is facing discrimination since British colonial era. In 1861 section 377 was introduced, according to which consensual same sex relationships were criminalized. After independence in 1947, the law remained same for LGBTQ+ community. The organizations such as, Humsafar Trust, NAZ Foundation founded in 1980's and 1990's played an important role in working for rights of LGBTQ+ community, supporting LGBTQ+ community as well as increasing awareness about this community. In 2009 Hon'ble Delhi High Court effectively

decriminalized consensual same sex relationships, as section 377 violated the fundamental rights of individuals. In 2013, Hon'ble Supreme Court had reversed the High Court's decision. Later, the case of Navtej Singh Johar vs State in 2018, had marked a significant decision for the LGBQ+ community wherein the Hon'ble Supreme Court of India decriminalized consensual homosexual acts between adults under Section 377. Hon'ble Supreme Court recognized transgender people as "Third gender", as well as the Transgender Persons (Protection of Rights) act was later introduced in 2019.

Mental Health:

"A state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" is the mental health definition provided by World Health Organization (*Mental Health*, n.d.). Mental health may have a great impact on an individual's daily life. It also has some effects on personal relationships and physical health. People's thoughts, feelings, and behaviours are all part of their mental health (Felman Adam, 2024).

Recently World Health Organization has given new guidelines to strengthen mental health policies and systems. The World Health Organization estimates that up to 90% of people have serious mental health issues but are still untreated (*New WHO Guidance Calls for Urgent Transformation of Mental Health Policies*, n.d.). Research breakthroughs have started to change the way mental health services are provided. While new methods are being created to measure outcomes and customize interventions based on individual profiles, extensive research is advancing our understanding of the genetic and neurological foundations of disorders (like bipolar disorder). (*Developing Tools for Measuring Mental Health Outcomes - National Institute of Mental Health (NIMH)*, n.d.).

The human rights aspect of mental health is still very important even after enormous advancements in medical knowledge and the introduction of novel treatments. Recently, the World Health Organization has launched new guidelines for governments to transform mental health policies and system with an emphasis on leadership and governance, service organization, workforce development, person-centred interventions as well as addressing social and structural determinants of mental health along with suggestion of involving the people with lived experiences in shaping the policies. (*New WHO Guidance Calls for Urgent Transformation of Mental Health Policies*, n.d.).

LGBQ+ community is at a high-risk of mental health problems than heterosexual and straight people. People from this community commonly face depression, anxiety, stress and other mental health issues (Vashisht et al., 2024).

Rationale of the Study:

The rationale for this qualitative study stemmed from the growing disproportionate risk for mental health issues of LGBQ+ people due to socio-cultural circumstances leading to discrimination, stigma and consequent obstacle to affirming care (*LGBTIQ+ People: Statistics | Mental*

Health Foundation, n.d.). Past researches suggests that LGBQ+ people are put at greater risk of mental health conditions such as depression, anxiety, substance abuse disorders, and suicide thoughts due to minority stress, internalized homophobia, and social isolation (Meyer, 2003). Disparities in mental health within this demographic are not only an exclusive result of innate vulnerabilities, but are rather disproportionately influenced by social factors including homophobia, transphobia, and institutional discrimination (Gaur et al., 2023).

Despite the decriminalization of homosexuality in India (Section 377, IPC, 2018), the prevailing societal issues of cultural conservatism, a lack of inclusive education, and a lack of affirmative psychological assistance lead the people of LGBQ+ community to mental health issues (Soohinda et al., 2025). As such, a qualitative, thematic study founded on in-depth interviews provides a valuable method to discover these individual stories, record nuances in emotional and psychological experiences, and investigate the relationship between identity, support networks, and institutional frameworks. This study also intends to shed light on how mental health training programs and psychology curriculum might be modified to incorporate inclusive and affirming material about gender diversity and sexual orientation (McCann & Brown, 2017).

In summary, mental health is foundational to human flourishing and societal progress, but vast unmet needs persist due to structural, social, and resource barriers. As evidence-based interventions, technological advances, and rights-based policy frameworks continue to evolve, the imperative remains to build accessible, inclusive, and effective mental health systems for all.

Research Question:

1. What are the mental health challenges faced by LGBQ+ community?
2. What are the lived experiences of LGBQ+ individuals in seeking and receiving psychological support?

Objective of the research:

1. To study the mental health challenges faced by LGBQ+ community.
2. To explore the lived experiences of LGBQ+ individuals in seeking and receiving psychological support?

Methodology:

Research Design:

A qualitative research method has been used for this research. This exploratory approach, seeks to understand in-depth experiences of LGBQ+ individuals faced while interacting with mental health professionals. To understand the real life complexities, emotions and deep perceptions qualitative approach is very effective. This study's main goal is to understand the various viewpoints and lived realities of the LGBQ+ community, focusing on the unique challenges they face in mental health care setting.

The semi structured interview process is very flexible, allowed participants to share their life stories in their own

words. In addition to identifying recurring themes, this method permits the emergence of novel topics and experiences that organized questionnaires might overlook.

Data Collection:

Eighteen in-depth semi-structured interviews were conducted, in person and using secure online platforms. Informed consent was obtained from all participants, and were assured confidentiality and anonymity. Participants were given option to withdraw at any point during research.

Sampling:

Purposive sampling technique was used to ensure it will include wide representations of sexual orientations within LGBQ+ spectrum. A snowball sampling was also used, where initial participant’s referred other potential participants from the community.

Sample Size:

Eighteen Individuals from LGBQ+ community were interviewed for achieving data saturation in qualitative research.

Inclusion criteria:

Age: Above 18 years.

Self-declared individuals from LGBQ+ community.

LGBQ+ individuals who have been to therapy for mental health problems due to their sexual orientation.

Exclusion Criteria:

Age: Below 18

Individuals from LGBQ+ community who are not publically open about their sexual orientation.

Individuals from LGBQ+ community who never undergone with any mental health services.

Coding / Theme:

In depth analysis of the lived experiences interviews have generated few themes. Nvivo 15 software has been used for qualitative thematic coding. The themes and sub-themes are arranged hierarchically. In total four themes were generated. Each theme has its sub-themes according to the experiences shared by the interviewee.

Result and Thematic Analysis:

Presented below table represents themes and subthemes from the thematic analysis.

Theme	Subthemes
The psychosocial burden of Minority Stress	1. External adversity and stigma 2. Internalized psychological Impact
The duality of therapeutic encounter	1. Iatrogenic harm 2. Facilitators of healing
Systematic inequities and structural barriers	1, The accessibility void 2. The affirmative care gap
The imperative for educational reform and future directions	1. Deficits in professional competency 2. Pedagogical requirements 3. Envisioning systematic change

Presented below are the tables based on themes containing subthemes, codes and data extracts.

Theme 1: The psychosocial burden of Minority Stress

Subtheme	Codes	Data Extract
1.1 External adversity and stigma	1.1.1 Experiences of Homophobia / Biphobia	“Even though I live in a metropolitan city, there’s a lot of unspoken homophobia. People joke about gay individuals without realizing the harm it causes.” (P3) “The biphobia I faced often subtle has had a lasting impact on my self-esteem.” (P7) “It’s the subtle exclusion homophobic jokes at the office or the relentless questions at weddings about why a 'settled' man like me isn't married” (P4)
	1.1.2 Internal Fears	“There is a constant fear of being "found out." (P2)

		<p>“There’s still a fear of being judged, excluded, or even passed over for promotions if my identity becomes public.” (P3)</p> <p>“Anxiety is the biggest one, especially fear of exposure and fear of rejection.” (P6)</p> <p>“There’s this constant fear of rejection or being misunderstood.” (P7)</p>
	1.1.3 Navigating daily struggle	<p>“I struggled with the feeling that I was trapping my husband in a marriage with someone who wasn't fully his.” (P2)</p> <p>“My struggle was living in constant monitoring mode. I kept checking how I spoke, how I dressed, and what I shared, especially around family.” (P11)</p>
1.2. Internalized psychological Impact	1.2.1 Emotional dysregulation	<p>“I acted like a different person at home and work, and I was myself only in small private spaces. I felt guilty for lying, but honesty felt dangerous.” (P6)</p> <p>“I kept switching between explaining myself and staying silent. At home, the pressure to marry a man made me feel trapped. I also felt guilty for hiding parts of my life. That emotional push and pull made me tired, anxious, and sometimes angry at myself.” (P 13)</p>
	1.2.2 Psychological distress	<p>“I lived with constant anxiety and stress” (P1)</p> <p>“Depression and suppression. I have learned to bury my true self so deep that sometimes I forget who I am. Anxiety has been my constant companion.” (P2)</p> <p>“Profound loneliness. I have a constant stress and I feel anxious all the time. I am always fearful throughout my life while doing any activity.” (P16)</p> <p>“I had constant suicidal thoughts in my mind. I even had been from sexual abuse as I was very suppressive person.” (P17)</p>

Theme 2: The duality of therapeutic encounter

Subtheme	Codes	Data Extract
2.1 Iatrogenic Harm	2.1.1 Providers bias and discrimination	<p>“When I told her I was gay, she immediately shifted the tone of the session.” “Her entire approach treated my orientation like a problem that needed to be fixed.” (P3)</p> <p>I mentioned being bisexual and she immediately said, “Are you sure it’s not just experimentation?” (P7)</p>
	2.1.2 Pathologizing identity	<p>“She told me I just hadn't met the 'right girl' yet and that marriage would fix my hormonal imbalances.” (P4)</p> <p>“The therapist asked if I had been abused as a child, and kept looking for a reason behind my orientation.” (P6)</p> <p>“His full attention was to make me feel more about girls and females. He even asked me to watch porn movies to fix this.” (P18)</p>
	2.1.3 Invalidation of Lived experiences	<p>“I also encountered professionals who avoided discussing my identity altogether, as if it were irrelevant to my mental health struggles.” (P1)</p> <p>“He ignored by saying that it is just a phase and I am cooking the stories because I don’t want to get marry.” (P2)</p> <p>“She kept asking whether I was confused or trying to rebel.” (P13)</p>

2.2. Facilitators of healing	2.2.1 Affirmative Practice	<p>“LGBQ+ affirmative therapy, where my identity was acknowledged as a natural part of who I am rather than a problem to fix.” (P1)</p> <p>“My current therapist doesn’t pathologize my experience and has helped me build communication with my partner.” (P9)</p>
	2.2.2 Therapeutic alliance	<p>“She didn't gasp or judge when I told her. She validated that I can love my husband and still be bisexual.” (P2)</p> <p>“My current therapist doesn’t just tolerate my identity—she validates it.” (P3)</p> <p>“Affirmative therapy helped me most, especially when the therapist validated my identity and focused on coping with stigma, not changing me.” (P13)</p>
	2.2.3 Identity specific coping skills	<p>“Just having a space where I didn't have to explain or justify my existence was healing. She focuses on coping mechanisms for family pressure and boundary setting, rather than trying to 'change' who I am.” (P4)</p> <p>“Affirmative therapy helped the most, especially when the therapist validated my identity and focused on coping skills.” (P6)</p> <p>“The psychologist helped me in self-acceptance and psycho-educated me about my feelings and thoughts.” (P17)</p>

Theme 3: Systematic inequities and structural barriers

Subtheme	Codes	Data Extract
3.1 The accessibility void	3.1.1 Geographic disparities	<p>“Many services are concentrated in big cities, leaving people in smaller towns with very few options.” (P3)</p> <p>“The biggest gap is access to clearly affirmative therapists, especially outside large metros. Therapy is expensive, and many cannot continue long enough to benefit.” (P6)</p> <p>“Affordable queer-affirmative services are limited, making access difficult for many. In smaller cities, there is little to no clear visibility of LGBTQ+-friendly professionals, which increases fear and uncertainty while seeking help.” (P9)</p> <p>“Affirmative therapists are usually expensive and based in metros. For someone in a smaller city, options are limited.” (P14)</p>
	3.1.2 Provider scarcity	<p>“There is a lack of accessible and affordable LGBTQ+ affirmative therapists, which makes it difficult to find safe and understanding professional support.” (P5)</p> <p>“There is also limited support in local languages, and few community-based safe spaces.” (P6)</p> <p>“In smaller towns, there is little public education or training for general counsellors on LGBTQ+ issues, limiting access to affirmative care.” (P10)</p> <p>“The biggest gap is access to clearly affirmative therapists, especially outside a few known networks. Therapy is expensive and not everyone can continue.” (P13)</p>
3.2. The affirmative care gap	3.2.1 Absence of specialized services	<p>“I found it difficult to access LGBQ+ affirmative therapists, as many mental health professionals were not adequately trained to understand experiences such as coming out, discrimination, and minority stress.” (P1)</p>

		<p>“First, there’s a lack of openly queer-affirming therapists.” (P3)</p> <p>“Western textbooks don't cover the guilt of disappointing Indian parents or the specific trauma of forced marriages.” (P6)</p> <p>“There is also an absence of reliable LGBTQ+-friendly therapy directories, making it difficult for individuals to find safe and affirming therapists.” (P7)</p> <p>“I got referred from psychologist to psychologist to find the best one for me. I faced problem of confidentiality too with my first counsellor.” (P18)</p>
	3.2.2 Institutional Barriers	<p>“Most LGBTQ+ support is geared toward the youth. Where does a 40-year-old mother go? We also need professionals who understand that we aren't always looking to leave our heterosexual marriages” (P2)</p> <p>“Intake forms and therapy language often assume heterosexuality, so clients feel invisible from the start.” (P11)</p> <p>“There is also a gap in culturally sensitive counselling that understands Indian family pressure, marriage expectations, and confidentiality fears.” (P12)</p> <p>“Confidentiality fears are real, and culturally sensitive counselling that understands Indian family pressure is still limited.” (13)</p>

Theme 4: The imperative for educational reform and future directions

Subtheme	Codes	Data Extract
4.1 Deficits in professional competency	4.1.1 Knowledge Gaps	<p>“Many mental health services lacked cultural and religious sensitivity, failing to acknowledge how these factors deeply shape the experiences and struggles of LGBTQ+ individuals” (P1)</p> <p>“Mental health advice is still often influenced by moral judgments rather than affirming approaches, and many professionals lack sufficient training in cultural sensitivity and gender diversity, further limiting the quality of care provided.” (P9)</p>
	4.1.2 Blind spots in training	<p>“There is a lack of cultural nuance.” (P2)</p> <p>“Limited awareness of intersectionality, including the influence of gender, caste, and religion, further weakens mental health support.” (P7)</p> <p>“Many non-normative identities are still pathologized within mental health settings, which can be harmful and invalidating.” (P10)</p> <p>“Confidentiality fears are real, and culturally sensitive counselling that understands Indian family pressure is still limited.” (P13)</p>
4.2. Pedagogical requirements	4.2.1 Queer affirmative curriculums	<p>“The curriculum should include a comprehensive understanding of how discrimination and minority stress significantly affect the mental health of individuals with different sexual orientations.” (P1)</p> <p>“There should also be education on affirmative therapy practices and the importance of using inclusive language and forms.” (P3)</p>

		“It should also cover queer-affirmative counseling techniques to help future professionals provide inclusive and supportive care.” (P7)
	4.2.2 Sensitization training	“The curriculum must incorporate how factors such as gender identity, cultural background, religious beliefs, and socioeconomic status interact with sexual orientation to shape lived experiences and mental health outcomes.” (P1) “Training should also cover how caste, religion, and gender norms interact with sexuality in India, shaping distress.” (P8)
	4.2.3 Advocacy for queer education	“Including teachings on different sexual orientations in psychology programs would lead to better mental health outcomes for LGBTQ+ individuals by enabling therapists to provide more informed, sensitive, and affirmative care.” (P1) “Education can reduce bullying, reduce family panic, and improve how teachers and doctors respond. It also helps queer people recognise themselves earlier without shame.” (P6) “It will reduce unintentional harm in therapy, increase access to safe spaces, and eventually change public attitudes too.” (7)
4.3. Envisioning systematic change	4.3.1 Policy recommendation	“If schools and communities had even basic awareness programs, it would help so many people like me to feel less ashamed and more accepted.” (P5) “I’d like to see more inclusive campaigns, community-based counselling centers, free or subsidized queer therapy services, and government recognition of LGBTQ+ mental health needs.” (P7) “We need public awareness campaigns, queer-affirmative certification programs, and inclusion in national mental health policy.” (P9) “There should be government-backed training programs on sexual diversity.” (P10)
	4.3.2 Future Service Models	“I want a holistic approach where my sexuality is acknowledged as part of me, but not treated as a pathology that needs to be dissected in every session.” (P2) “I want mental health spaces to clearly signal inclusion, so clients do not have to take a risk just to be honest. Most importantly, mental health care should focus on dignity, autonomy, and reducing stigma-driven distress.” (P12) “I want the mental health field to move from "tolerating" us to actively advocating for our well-being and recognizing our resilience.” (P14)

DISCUSSION:

The present study explored the lived experiences of LGBTQ+ individuals regarding their psychological challenges and interactions with mental health services. The findings reveal a complex landscape characterized by significant psychosocial burden, systemic barriers to access, and a dichotomy of therapeutic experiences ranging from iatrogenic harm to affirmative healing. These themes collectively underscore the urgent need for structural and educational reform in mental healthcare.

The first major theme, The Psychosocial Burden of Minority Stress, highlights that the psychological challenges faced by participants including homophobia,

life struggles, and emotional distress are not intrinsic pathologies but rather direct responses to a hostile social environment. The findings suggest that the external pressure of societal rejection and ongoing discrimination deeply impacts the individual, manifesting as internalized emotional struggles and heightened vigilance. The data indicates that for many participants, "mental health issues" are inextricably linked to the trauma of holding a marginalized identity. Consequently, this suggests that effective therapy cannot simply treat symptoms (e.g., anxiety) in isolation; it must also address the root cause: the continuous navigation of a heteronormative and often homophobic society. The Psychological Mediation Framework posits that stigma-related stress creates mental

health disparities by disrupting general psychological processes such as emotion regulation, social support, and cognitive schemas which then serve as the primary mediators leading to psychopathology (Hatzenbuehler, 2009)

A critical finding of this study is the polarized nature of mental health services, captured in the theme The Duality of the Therapeutic Encounter, which contrasts the potential for iatrogenic harm against the healing power of affirmation. The data reveals concerning reports of professional discrimination and bias, where therapists pathologize queer identities or invalidate lived experiences, thereby committing microaggressions that breach the therapeutic alliance and risk re-traumatizing vulnerable clients. Conversely, participants identified affirmative care as a vital protective factor, demonstrating that "helpful" therapy extends beyond mere neutrality to active validation of the queer experience. This dichotomy underscores the conclusion that clinical neutrality is insufficient; rather, competent care must be explicitly affirmative to effectively counteract the pervasive impact of societal stigma and encourage continued help-seeking behaviours. The study done by Pachankis and others says that the clinical neutrality is insufficient for LGBTQ+ clients, as it often masks iatrogenic harm, and argues that therapy must be explicitly affirmative to bridge the systemic gap in care. (Pachankis et al., 2023).

The theme Systemic Inequities & Structural Barriers moves the discussion beyond individual provider competence to broader systemic failures. The findings reveal a "geographic hierarchy" of care, where affirmative services are concentrated in urban centers, leaving those in smaller or non-urban cities in a "referral desert." Structural barriers and binary-coded medical infrastructures create a state of "functional inaccessibility" that systematically deters LGBTQ+ individuals from seeking care. This exclusion is compounded by a geographic hierarchy, relegating non-urban populations to "referral deserts" where inclusive services are financially and physically out of reach (Bhattacharjee, 2023). This lack of access exacerbates the isolation felt by rural LGBQ+ individuals. Furthermore, even where services exist, the Gap in Mental Health Services suggests a distinction between availability and acceptability. A clinic may be open, but if it lacks LGBQ+ affirmative protocols, it remains functionally inaccessible to this population.

Finally, the theme regarding The Imperative for Educational Reform identifies the root cause of many service gaps: a deficiency in professional training. Participants perceive a lack of knowledge among professionals, suggesting that current psychology and psychiatry curricula fail to adequately cover queer-affirmative topics. The results argue that cultural competence training cannot be elective or peripheral. To bridge the gap between "Expected Changes" and current realities, training programs must integrate specific modules on sexual orientation, gender identity, and the specific mental health needs of the queer community. Without this foundational pedagogical shift, the "blind spots" in treatment identified by participants will persist. To bridge the gap between expected care and current reality, psychology and psychiatry curricula must move

beyond elective training to integrate queer-affirmative modules as a foundational requirement. Addressing these professional "blind spots" through mandatory, specific education on sexual orientation and gender identity is the only way to eliminate systemic service gaps and ensure true clinical competence (Keuroghlian et al., 2017).

CONCLUSION:

This study illuminates the profound impact of societal marginalization on the mental health of LGBQ+ individuals, revealing that psychological distress in this population is frequently a direct response to external hostility rather than intrinsic pathology. The findings expose a critical dichotomy in mental healthcare: while affirmative therapy acts as a vital protective factor, facilitating healing and self-acceptance, the prevalence of iatrogenic harm through provider bias and invalidation remains a significant barrier. This polarization underscores that clinical neutrality is insufficient; effective care requires explicit affirmation of queer identities.

Furthermore, the research highlights deep systemic inequities, particularly a "geographic hierarchy" that leaves non-urban individuals in a referral desert, exacerbating isolation. Ultimately, the study identifies a pervasive deficit in professional training as a root cause of these disparities. To bridge the gap between current realities and equitable care, the mental health field must prioritize structural and pedagogical reform. This includes mandatory, comprehensive training on LGBQ+ issues and the decentralization of affirmative services. Only by dismantling these structural and educational barriers can the mental health system transform from a source of potential harm into a truly safe, inclusive, and healing space for all.

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