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Article

Challenges in Psychotherapy With the Clients rom LGBTQAI+ Community: Psychotherapy and Interference of Sociocultural Factors

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Abstract

A prominent gap between addressing mental health needs and mental illness and help-seeking behavior in the context of gender and sexual orientation is nationally and globally observed. There are evident risks of mental health issues associated with discrimination, socio-cultural factors, and inadequate or stigmatized services available based on their identity, resulting in challenges to seek help. However the therapists also face unique sociocultural challenges in the treatment process with community members. The objective is to illustrate the 2 case presentations of the clients having either sexual orientation or gender identity related issues along with psychiatric diagnoses as reported. The research aims to understand the qualitative impacts of sociocultural factors and psychopathological morbidity on psychotherapeutic process. The case series present sample of 2 cases who are ranging from 20-30 years, assigned sex at birth male, reported gender fluidity and homosexuality, respectively along with socio-cultural-psychopathological factors. The intervention was eclectic psychotherapeutic interventions such as a combination of psycho education, Cognitive Behavior Therapy, relaxation and Mindfulness techniques distress tolerance skills, and Client-centered approach. With the help of these two case presentations, authors try to highlight the interaction of sociocultural factors and psychopathology acting as a challenge during the psychotherapy process in the context with specific challenges faced by the clients and therapists.

Introduction

LGBTQAI is a short abbreviation of Lesbian, Gay, Bisexual, Trans, Queer, Asexual, Intersex and other non-binary identity and orientation. To understand LGBTQAI+ and their challenges better it's important to understand the difference between gender identity, gender expression, and orientation to sex assigned at birth. Sex is assigned at birth, is an anatomical and biological construct that determines sexual orientation as male or female at birth. Gender is explained to have socio-cultural psychological dimensions denoting particular patterns, behaviors, expressions, and experiences (Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). Gender identity can be understood by a person's sense of identity which can be congruent or incongruent to his assigned sex at birth. A person may express having gender identity as gender-queer, bi-gender, transgender, pan-gender, or non-binary (Roselli, 2018).

Gender role expression is a constellation of a person's appearance, expressions, and behaviors which are culturally defined as masculine-feminine. Similarly, gender role conformity means the congruence or adherence of a person's gender role expression to culturally defined norms based on sexual orientation. Transgender is a diverse group including trans-sexualism where individuals desire or go through Hormonal Replacement therapy or surgical treatment for changing physiological sex characteristics assigned at birth (Lippa, 2005, Bieschke, 2017).

Literature review

Literature focusing on the LGBTQIA+ community spotlights the prevalence of aggression, micro-aggressions, and discrimination experienced by these individuals, all of which significantly impact their mental well-being. Moreover, such discrimination encompasses not only their sexual orientation and identity but also takes into account factors such as race, color, disabilities, age, religious beliefs, and social status (Nadal, 2023).

A prominent gap between addressing mental health needs and severe mental illness and helpseeking behavior in the context of gender and sexual orientation is nationally and globally observed. There are evident risks of mental health issues associated with discrimination, socio-cultural factors, and inadequate or stigmatized services available based on their identity, resulting in challenges to seek help. Worldwide, the changes and acceptance in understanding homosexuality and other variants and distinguishing them from crime or psychopathology is occurring near to 20th century (Drescher & Byne, 2009).

The American psychiatric association and WHO accepted homosexuality as a variant status and some countries gave recognition and decriminalized same-sex relations or marriages (Sadock, 2009).

According to a research it was reported that 70% of the LGBTQAI+ population reported the symptoms of stress anxiety or depression which were post-pandemic and had impact adverse impact on mental health (Dawson et al. 2021).

A study explained the pressure of socio-normative expectations where 73% of men and 43% of women opted for conversion therapy, different approaches to psychotherapy, and psychiatric medicines, electroconvulsive therapy just to adjust with normative alignment (Dehlin et al., 2015).

Even though in India there have been many movements towards LGBTQAI+ rights and their implementation right from 1999 to 2022. There is a lack of systematic implementation along with family members' denial, familial lack of support subjective fear of rejection and exclusion so show cultural religious and safety security issues etc. (Dagras & Mansi, 2021).

A research explain the role of adverse childhood such as neglect, abuse, maltreatment, familial conflict, and negative emotional expressions as harmful contributors to the development of chromatic negative impacts on the child and its development (Boullier & Blair, 2018).

It is explain that there can be a development of adverse negative feelings towards self, such as she didn't due to such adverse childhood experiences (Scheer & colleagues 2020).

Research in 2014 reported the role of advocating school atmosphere, bullying behavior faced by the victim linked to emotional distress somatic complaints development of anxiety and depressive features along with self-blame and self-doubt. Study shows that the LGBTQAI+ youth or population also face rejection when they come out of the closet and disclose their identity resulting in mental health issue such as anxiety depression feeling of abundant substance abuse suicidal tendency and many other comorbid psychopathology (Earnshaw & colleagues 2014).

In 2013, researchers delved into the utilization of affirmative therapeutic methods when working with the LGBTQ+ community, extracting valuable insights that were subsequently used to develop a module for gay affirmative counseling practices (Ranade and Chakravarty, 2013). Another study, led by SAAHAS, a group comprising queer mental health professionals, detailed a Queer affirmative Cognitive Behavioral Therapy (CBT)-based group therapy intervention designed for the LGBTQ+ community (Wandrekar & Nigudkar, 2019).

In 2014, the Indian Psychiatric Society (IPS) made a significant statement, affirming that homosexuality should not be considered a mental illness (Iyer, 2014), instead emphasizing its status as a normal developmental outcome (Power, 2018).

Regrettably, despite these positive developments, it remains troubling to observe that certain mental health professionals persist in employing conversion therapy practices, including methods such as electroconvulsive therapy, hypnosis, and the administration of drugs inducing nausea (Singh, 2016).

LGBTQAI+ youth also have a higher risk of developing internalizing symptoms and suicidal tendencies than the general population (Tyler, 2013). A study conducted in the USA explains self-reported conversion efforts, the role of self-harm, suicidal tendencies, and substance abuse higher in the LGBTQAI+ population as considered with the normative population (Green et al, 2018).

Socio-cultural factors such as religion, community, caste and faith also explain to have an adverse impact and as a source of emotional distress, fear of rejection, and difficulty faced to get accepted by their social circle in some youth. In India, there is a lack of studies and researchers providing multi-dimensional data about the challenges faced by the community (Drescher & Byne, 2009).

One study by reported a prevalence of 52.9% of psychiatric illnesses based on GHQ – general health questionnaire reporting to have somatic symptoms of anxiety, insomnia, social withdrawal, and depressive features in the MSM (Men who have sex with men)population (Patel et al. 2015,Prajapati, 2014). The mental well-being of MSM is influenced by a range of factors, including attributes of their partners, the presence of symptoms related to sexually transmitted infections, their marital status, and their living arrangements (Prajapati, 2014).

A study explains 6.2% of gave population from Manipur facing generalized anxiety disorder 3.1 % facing in panic disorder and 9.3 facing phobia related features (Niranjan, 2018).

A report suggests higher physical violence sexual assault and dramatic experiences faced by the LGBTQIA+ community working as sex workers or community-based organization (Thomson, 2019). A report suggested discrimination against the LGBTQAI community by psychiatrists and other mental health professionals based on traditional views and training about gender stereotypes traditional training and social stigma resulting in conversion therapy (Rao et al., 2016). Even though their no evidence of conversion therapy and its effectiveness, there are many mental health practitioners, spiritual and faith healers are involved into such practices (Forstein, 2004).

A research highlighted the need for a medical curriculum which is inclusive as well as nondiscriminative eliminating negative preconceptions regarding LGBTQAI+ which may create and maintain social stigma (Chatterjee & Ghosh, 2013).

A study reported a psychiatry book by West Bengal University mentioning terms like crossgender homosexuality, and ego-dystonic homosexuality leading to creating stigma and spreading misconceptions. National Medical Commission has issued an advisory to include LGBTQAI+ inclusive scientific information and eradicate offensive information from books such as homosexuality poses socio-psychological and moral problems in forensic medicine books (Meyer, 2003).

Methodology

Case Studies

Case A and B are the clients who were identified with motivation, adherence to treatment and consistency, resulting into between qualitative understanding of the involvement of sociocultural factors.

Client ‘A’ twenty-six-year-old client, assigned as a male by birth, from a sub-urban area of Maharashtra, reported severe distress post-coming out process, confusion related to sexuality,

persistent anxiety attacks, body image issues, and low mood. The client had sought a session after coming out to their parents and receiving rejection, irritation, and constant arguments with their parents. The client shared that, following their parents' discussion about marriage, they revealed their identity to their parents in a state of frustration and intense emotion. Sociocultural pressure, parents' disagreement, and denial were reported as contributory factors. The client reported having low functionality, fluctuating sleep, and appetite, and pervasive low mood. The client was diagnosed with Moderate depressive episode, without somatic syndrome (ICD-10) and was treated with Serlift (25mg), Clonotril (0.25mg), and Meloset 3mg. However, parents expressed their discomfort with psychiatric medicines. The client continued the medicines despite this, with the psychiatrist's advice.

Life and family history showed that the client lived with parents, grandparents, and younger sister. The client reported having cordial relations with their mother and sister, however, expressed distress with both parents after the coming out process. Educational history suggested that the client was an above-average student, less involved in extracurricular activities. Less confidence while expressing, fewer friends from childhood, preference for more solitary activities were reported. The client completed their Engineering and MBA and has been working in the private sector currently. The client specifically could recall and report several instances of feeling moderate discomfort while behaving as per 'normative masculine' expectations however, the client's parents expressed that never noticed the client's discomfort related to their assigned sex. The client was described as shy, obedient to authority, sensitive to criticism, indecisive, and critical of self. The client reported several experiences of bullying, discrimination, and exclusion from friends and peers, sometimes at the workplace.

Gradually, the client became socially withdrawn. Throughout the COVID pandemic, the client began working from home, leading to a decrease in their social interactions compared to their previous level of social engagement. The persistence of low mood and reduced interest in daily activities was reported during COVID. The client reported using social media to connect with more people from the community seeking social interactions to curb loneliness, but also faced a breach in confidentiality from a close friend from the community. This led to develop trust issues and despair. The client reported facing a physically abusive situation while meeting a stranger from a social media app leading to physical abuse and distress. The client when came was expressing gender dysphoria-like distress but after several sessions explained to identify as gender-fluid. Meanwhile, parental rejection was observed as client was taken to spiritual healer to oppose the client's Gender fluid identity. The therapy sessions were started based on deriving mutual therapy goals based on issues stated by the client along with family sessions and parental psycho-education.

Client 'B' twenty-four-year-old, assigned as a male by birth, belongs to an urban middleclass, traditional family, a native of central came with the dilemma of whether to come out to his parents. The precipitating factor was his brother getting acquainted with his chat messages with his friends related to his homosexuality. Persistent low mood, disturbed sleep quality, acute situational stress, and fear of confrontation were reported. In later sessions, when he came out to his parents and other family members, the symptoms were aggregated as

low functionality, difficulty with sleep quality, nightmares, reduced interest in daily functions, feelings of loneliness, and jitters when thinking about future life and partners were reported.

The client is temperamentally anxious, extremely sensitive, and has enmeshed attachment patterns with his family. He reported significant distress with crying spells after his parents expressed shock and rejection of his sexuality and with the thought that he is causing trouble to his parents & his family, the community will disown him. The client's childhood history is suggestive of misconduct and molestation due to his effeminate behaviors in school. In progressing later sessions he reported that his current partner is bisexual and disclosed about his marriage to him. He was diagnosed with Moderate depressive episode, without somatic syndrome with anxious dependent tendencies. The client reported impacts on his functionality, fleeting suicidal thoughts, and fatigue throughout the day. He was prescribed psychiatric medicines which he initially didn't take due to stigma and discomfort but later on, the client was again encouraged and he was given Serlift and Clonotril (0.25mg) to improve his symptoms. Psychoeducation and therapy sessions were started based on deriving mutual therapy goals based on issues stated by the client individually, however, the client's family denied being a part of the process. Client A reported to have better management of anxiety symptoms, a better understanding of triggers and fluctuations, and improved functionality in areas of life. The client continued to connect with interpersonal circles with healthy boundaries and avoiding impulsive emotional sharing to avoid problems in interpersonal relations.

Client B reported having fluctuations in the progress. The client was earlier prescribed psychiatric medicines, which he discontinued after 2-3 days. Due to some personal family emergency, the client discontinued therapy sessions for 2 months approximately. After coming back from his native place, his symptoms deteriorated hence he was again advised psychiatric medicines, and psychotherapy sessions were continued. Both clients are taking psychotherapy and psychiatric medicinal advice adhering to the treatment process.

Client A had in all 30 sessions and client B had 11 sessions. In the initial phase of therapy, the goal was to understand the detailed information of the nature of client's problem and to build therapeutic rapport and alliance, by providing a safe listening space to clients. In first session patient could describe his symptoms in detail, for which a detailed case history was taken. A detail history was taken about the past history because it had a significant impact on patient's personality. In the family history of both of these cases, parental figures were extremely religious and aligned to the communal faith. The family members showed significant distress and denial towards the client's identity and that were identified as a stressor. In the initial phase, Psycho-education carried out to develop a better understanding for the distress. Method of treatment, therapy process, role of confidentiality and other queries were addressed discussed.

In the initial and middle phase of the therapy, the supportive work was carried out emotional ventilation was encouraged. Simultaneous family sessions were proposed, however the resistance from family members and client was observed. After few sessions of supportive work, Cognitive behavior technique was initiated. Clients' emotions, thought

process were thoroughly discussed and then the clients were educated about rational-irrational thought process, cognitive errors and cognitive disputation. Socratic questioning, challenging anxious thoughts were found as helpful techniques. Along with CBT, mindfulness techniques such as deep breathing exercises, Jacobson's progressive muscular relaxation (JPMR), and 5 senses grounding techniques were demonstrated and encouraged as daily practice. Thought-feeling-coping diary, behavioral activation and regulation, monitoring mood, sleep, and appetite routines, radical acceptance of socio-cultural stressors, identifying impulses and triggers, was carried out. Identification of social support system, asking for help whenever over-whelming emotions were surfaced was encouraged to reduce risky behaviors.

Specific techniques from Dialectic Behavior therapy (DBT) such as distress understanding and labeling emotions and regulation are effectively carried out by clients during the sessions. Regular session follow-up is ongoing.

Result

It was seen that the clients (A & B) with consistent sessions, self-work, adherence to medicine, and sessions, showed good progress and improved management of their symptoms. The clients are now able to identify triggers and early signs of distress, to seek help whenever needed, connect to social supports, and reduce the likelihood of risky behaviors. They both are able to function adequately with ongoing sessions to learn management and prevention skills.

Challenges

In the initial phase, due to the impulsive decisions, emotion dysregulation, and the mood swings, it was difficult for the client's to identify the cause and manage the symptoms.

Due to the depressive features, it was difficult to follow through with the therapy exercises in the initial phase.

There were many factors interacting such as societal normative pressure, lack of family's support, anxiety symptoms manifested in psychological and physiological features, lack of social support in terms of friends and confidants were overlapping increasing the clients' complexities.

There is significant distress within family dynamics that have been identified, such as parents' rejection, denial; parent's expressed emotion, passive-aggressive communication styles within the family, religious values and spiritual faith, community's customs and traditional faith, etc. Family's social status, family member's personality, coping, and tendencies played a vital role in the process.

Due to the distressful dynamics of family members and enmeshed values, strong resistance from the clients and their family members for family therapy was observed and reported.

As the clients identified sexuality in the range of gender fluidity and homosexuality, respectively, all of them explained the lack of awareness and misconceptions about the LGBTQ community in the family, society and traditional community values made it more difficult for them to determine their 'being' in terms of appearance, expressions and behavior within the social situations even if they were willing.

Drop-out from psychotherapy sessions was seen due to socio-cultural-financial reasons, personality traits, or lack of consistency and motivation interpersonally.

Discussion

These four cases ranged between 20-30 years of age, assigned as male at birth however identifying themselves diversely as gender fluid, homosexual, transsexual, and non-binary identity. These clients came with significant distress and were seeking psychopharmacological help. Psychoeducation, supportive work, CBT techniques, DBT, mindfulness, and relaxation techniques were used along with pharmacological treatment for the clients adhering to the treatment.

During the course of therapy sessions, it was observed that family involvement and familial dynamics, parental denial, lack of support, and rejection played a vital role as challenges. The client's readiness for the treatment, receptivity, consistency, and adherence to the psychotherapy and pharmacological treatment line also contributed to the progress of the therapy.

The client's insight, willingness, and motivation to therapy, individual personality traits, situational distress, and social support systems also impacted their process of therapy.

Financial status and dependency, educational-occupational status, socio-cultural and value belief systems within clients and family-community structure were also had significant impacts on distress generation.

The process also observed therapist's distress during the preceding of the sessions. The clients' emergency calls, parent's interference or denial to be a part of the therapy process, fleeting suicidal thoughts of clients, socio-cultural resistant from society in general which was experienced by clients' and past overwhelming experiences were surfacing and impacting the process significantly.

Limitations

Family's non-conformity with the therapy process, parent's over-involvement or resistance, stigma and prejudices related to LGBTQAI+ community, socio-cultural-spiritual values acted as barriers in the process.

Involvement of spiritual or faith healers due to family member's interference and then conducting conversion techniques contributed to significant distress.

Lack of inclusion in workspace, discrimination in social settings, lack of social supports were identified as limitations.

As the distress and few situations were substantial, few therapy techniques were not apt.

Lack of empirical studies, lack of specific techniques curated for LGBTQAI+ community needs.

Further suggestions

Therapy techniques focusing upon the LGBTQAI+ community's needs notably will result into effective psychotherapy process.

There should me more research studies based on LGBTQAI+ community's mental health in Indian set-up.

More awareness generation, group therapy and support group modules has to be drafted for the LGBTQAI+ population.

Adaptation and generation of therapy modules for queer population can be curated with specific rationale making the process of therapy more effective.

References

American Psychological Association. https://doi.org/10.1037/11482-000 Chatterjee, S., and Ghosh, S. (2013). Void in the sphere of wisdom: A distorted picture of homosexuality in medical textbooks. (accessed January 10, 2023).

Beutler, L. E., Moleiro, C., & Talebi, H. (2002). Resistance in psychotherapy: What conclusions are supported by research. Journal of Clinical Psychology, 58(2), 207–217. doi:10.1002/jclp.1144.

Bieschke, K. J., Perez, R. M., & DeBord, K. A. (Eds.). (2007). Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients (2nd ed.).

Dawson, L., Kirzinger, A., & Kates, J. (2021). The Impact of the COVID-19 Pandemic on LGBT People. (accessed January 10, 2023). http://dx.doi.org/10.1037/sah0000361.

Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., Hyde, D. C., & Crowell, K. A. (2015). Sexual orientation change efforts among current or former LDS church members. Journal of Counseling Psychology, 62, 95–105.

Drescher J, Byne WM. Homosexuality, Gay and Lesbian Identities and Homosexual Behaviour. In: Sadock BJ, Sadock VA, Ruiz P, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009. pp. 2060–89

Earnshaw, V. A., Reisner, S. L., Juvonen, J., Hatzenbuehler, M. L., Perrotti, J., & Schuster, M. A. (2017). LGBTQ Bullying: Translating research to action in pediatrics. Pediatrics, 140, e20170432. doi:10.1542/peds.2017-0432.

Forstein M. The pseudoscience of sexual orientation change therapy. BMJ. 2004;328:E287–8.
Gaur, P. S., Saha, S., Goel, A., Ovseiko, P., Aggarwal, S., Agarwal, V., Haq, A. U., Danda, D., Hartle, A., Sandhu, N. K., & Gupta, L. (2023). Mental healthcare for young and adolescent LGBTQ+ individuals in the Indian subcontinent. Frontiers in Psychology, 14, 1060543. https://doi.org/10.3389/fpsyg.2023.1060543.

Green, A. E., Price-Feeney, M., Dorison, S. H., and Pick, C. J. (2020). Self-reported conversion efforts and suicidality among US LGBTQ youths and young adults, 2018. Am. J. Public Health 110, 1221–1227. doi: 10.2105/AJPH.2020.305701

Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: National Academies Press.

Iyer, M. (2014)., Homosexuality is not a disease. *The Times of India.* https://timesofindia.indiatimes.com/India/Homosexuality-is-not-a-diseasepsychiatristsay/articleshow/2996543

Juvonen, J., & Graham, S. (2014). Bullying in Schools: The power of bullies and the plight of victims. Annual Review of Psychology, 65, 159–185. doi:10.1146/annurev-psych010213-115030.

Lippa, R. A. (2005). Gender, nature, and nurture. Routledge.

Mental Health Commission of Canada. (2012). The mental health strategy for Canada. Mental Health Commission of Canada; Calgary, AB.

Meyer, I. H. (2003)., Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychol. Bull. 129, 674– 697.

Niranjan, H. (2018). A study on homosexuals and their psychiatric morbidities in a northeastern state of India, Manipur. Indian J. Soc. Psychiatry 34, 245–248.

Pandya, A., & Kumar, A. (2019). Policy Brief: Affirmative Counseling and Psychotherapy for Lesbian, Gay, Bisexual, and Transgender (LGBT) population: Priorities for Policy, Practice, and Research in India, 128-134.

Patel S. K., Prabhakar P., Saggurti N. (2015). Factors associated with mental depression among men who have sex with men in Southern India. Health 07:1114.

Power, S. (2018),. India's biggest psychiatric body declares homosexuality is not an illness. *Gay Star News.* https://www.gaystarnews.com/article/indias-biggest-psychiatricbody-declares-homosexuality-is-not-an-illness

Prajapati A. C., Parikh S., Bala D. V. (2014). A study of mental health status of men who have sex with men in Ahmedabad city. Indian J. Psychiatry 56:161. 10.4103/0019-5545.130498

Prajapati, A. C., Parikh, S., and Bala, D. V. (2014). A study of mental health status of men who have sex with men in Ahmedabad city. Indian J. Psychiatry 56:161. doi: 10.4103/0019-5545.130498.

Ranade, K., & Chakravarty, S. (2013). Conceptualizing gay affirmative counseling practice in India: Building on local experiences of counseling with sexual minority clients. *Indian Journal of Social Work, 74*(2), 335-352.

Rao T. S. S., Jacob K. S. (2012). Homosexuality and India. Indian J. Psychiatry 54 1– 3.

Rao, T. S., Sathyanarayana Rao, T. S., Prasad Rao, G., Raju, M. S. V. K., Saha, G., Jagiwala, M., et al. (2016). Gay rights, psychiatric fraternity, and India. Indian J. Psychiatry 58:241. doi: 10.4103/0019-5545.192006

Roselli C. E. (2018). Neurobiology of gender identity and sexual orientation. Journal of neuroendocrinology, 30(7), e12562. https://doi.org/10.1111/jne.12562

Sadock VA. Normal Human Sexuality and Sexual Dysfunctions. In: Sadock BJ, Sadock VA, Ruiz P, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009. pp. 2027–59.

Scheer, J. R., Harney, P., Esposito, J., & Woulfe, J. M. (2020). Self-reported mental and physical health symptoms and potentially traumatic events among lesbian, gay, bisexual, transgender, and queer individuals: The role of shame. Psychology of Violence, 10, 131–142.

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. Journal of Counseling Psychology, 63, 98–105. doi:10.1037/cou0000126.

Thompson, L. H., Dutta, S., Bhattacharjee, P., Leung, S., Bhowmik, A., Prakash, R., et al. (2019). Violence and mental health among gender-diverse individuals enrolled in a human immunodeficiency virus program in Karnataka. South India. Trans. Health 4, 316–325. doi: 10.1089/trgh.2018.0051

Tyler, K. A. (2013). Homeless Youths' HIV risk behaviors with strangers: Investigating the importance of social networks. Archives of Sexual Behavior, 42, 1583–1591. doi:10.1007/s10508-013-0091-3.

Wandrekar, J., & Nigudkar, A. (2019). Learnings from SAAHAS: A queer affirmative CBT-based group therapy intervention for LGBTQIA+ individuals in Mumbai, India. *Journal of Psychosexual Health, 1*(2), 1-10. doi: 10.1177/2631831819862414.

World Health Organization. (2013). Mental health action plan: 2013-2020. WHO Press; Geneva. World Health Organization. (2019). International statistical classification of diseases and related health problems (10th ed.)