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The Prevalence of Depression and Suicide Ideation among the LGBTQIA+ Community

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Abstract

Globalisation is said to have brought the world closer together, but the distinction between the binary and those belonging to the LGBTQIA+ community is clear as ever. In the contemporary world, the significance of mental health is not very high and the mental health of those belonging to the community is even less deliberated. This paper is an attempt to draw attention to the worsening mental health issues faced by the members belonging to the LGBTQIA+ community and further explores how a fair majority of the members cope with suicide ideation and depression through descriptive methodology and qualitative and quantitative data. The paper analyses the thoughts about suicide ideation and depression in the minds of the members of the LGBTQIA+ community of varying ages, across different parts of India. Although in recent times, the world has acknowledged the need for better accommodation of all genders and sexes, not part of the majority of the population and has become more open to accepting different types of preferences of the minority population. Yet, stereotypes towards them are still prevalent at various levels, and that leads to mental stress. Hopefully in the future, we can all value mental health and understand that "love is love".
Keywords: LGBTQIA+, depression, suicide ideation, minority stress, anxiety, personal experiences, gender diversity

1.0 Introduction

In only two decades, there has been dramatic emergence of public and scientific awareness of LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual and others) lives and issues. This awareness can be traced to larger socio-cultural shifts in understandings of sexual and gender identities owed of course to the many LGBTQIA+ movements internationally, as well as, in India. During the past two decades, there have been not only dramatic shifts in public attitudes toward LGBTQIA+ people and issues but also an emergence of research from multiple and diverse fields that have created what is now a solid foundation of knowledge regarding mental health among LGBTQIA+ youth. The question arises, if things are so much "better," why are mental health concerns for LGBTQIA+ urgent?

"There's an invisible epidemic of depression and suicidal tendencies among the Lesbian, Gay, Bisexual, Transgender (LGBT) youth," says Sriram, a volunteer with Orinam, an LGBT collective. (S. Orinam,2019)

Sexual orientation has emerged as a much-debated risk factor for adolescent suicide in recent years (Rotheram-Borus & Fernandez, 1995). To date, more than 20 studies have addressed this question, using a variety of methods and samples. In the mid-1980s, research reports began to suggest that the suicide rate was dramatically higher for gay and lesbian youths than for the general adolescent population. The debate about this issue was heightened in 1989 with the publication of the report of the US Secretary of Health and Human Services, which suggested that gay and lesbian youths are 2 to 3 times more likely to attempt suicide and that they account for up to 30% of the total adolescent suicide rate. Since that report, studies of gay and lesbian youths indicate that between 48% and 76% have thought of suicide, while between 29% and 42% have attempted suicide. The samples used in these studies were not random, however; the gay and lesbian youths represented in these research studies may have been at higher initial risk for suicide. Certainly, these rates are much higher than those for the general adolescent population; recent studies report that between 19% and 29% of the adolescent population have a lifetime history of suicidal ideation, and between 7% and 13%report ever having attempted suicide. (Faulkner & Cranston, 1998)

It is commonly believed that the difficulties of dealing with the stigma of homosexuality might lead to depression and even suicide among gay men and lesbians; this may be particularly heightened during adolescence when emerging sexuality becomes a central issue in young lives. (Russell&Joyner,2001) The paper makes an attempt to expand on this very working hypothesis and fill in the gaps in the relative research discipline.

The notion that being homosexual is wrong is all around us. So, teenagers begin to think there is something wrong with them. As they grow older, a fraction of them begins to read and learn to imbibe that there's nothing "wrong" with them per se; that there is not much that needs to be rectified within them, rather the society has to devise ways to be more inclusive of them. But often, this leads to a breach with their family – they either leave or hide their sexuality, both of which can cause problems.

Even if the family is accepting, things are not easy. Finding a job where you can be yourself, the stigma, bullying, and violence that is faced by queer people can all have a debilitating effect on their mental health.

The prevalence of mental illnesses was found to be higher in the LGBTQIA+ community not because they were more prone to anxiety or depression but because they were pushed into it due to lack of social protection having "minority stress". The paper offers a conceptual framework for understanding this excess in the prevalence of the disorder in terms of *minority stress*—explaining that stigma, prejudice and discrimination create a hostile and stressful social environment that causes mental health problems. The model describes stress processes, including the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes

1.1 Minority Stress Model

Minority stress describes well documented chronically high levels of stress faced by members of stigmatized minority groups. It may be caused by several factors, including poor social support and low socioeconomic status; well-understood causes of minority stress are interpersonal prejudice and discrimination. Indeed, numerous scientific studies have shown that minority individuals experience a high degree of prejudice, which causes stress responses (e.g., high blood pressure, anxiety) that accrue over time, eventually leading to poor mental and physical health.

The minority stress model identifies processes through which minority stress influences mental health for sexual minority people (Meyer, 2003). Mechanisms include experiences of prejudice events, the expectation of rejection or discrimination, concealment of one's sexual orientation and internalized homophobia. Minority stress related to one's sexual identity is unique to sexual minority people and reflects society's negative reactions and attitudes toward them (Meyer, 2003; Rosario, Rotheram-Borus, & Reid, 1996). The experience of these stressors is related to lower well-being and higher levels of depression and suicidal ideation (Cochran et al., 2003; Meyer, 2003). In addition to stressors associated with coming out, LGBT youth frequently experience verbal and physical victimization because of their actual

or perceived sexual identity. Results from the 2011 National School Climate Survey showed that over 80% per cent of LGBT and over 60% of transgender students reported being verbally harassed, and almost 40% reported having experienced physical violence at school during the past year (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). Experiences such as being threatened or injured are directly related to health-risk behaviours among sexual minority youth such as increased suicidality, substance use, and sexual risk behaviour (Bontempo & D'Augelli, 2002). In general, victimization across the life span occurs more often among sexual minorities than among heterosexual people (Balsam, Rothblum, & Beauchaine, 2005).

Previous research strongly indicates that it is the notion of being a burden to others that is underlying the adverse effects of minority stress on depression and suicidal ideation among LGBTQIA+ youth. (Wilson & Cariola, 2019) Perceived burdensomeness is considered both an interpersonal experience and an intrapersonal belief and studies suggest that the interpersonal cognitions of burdensomeness take precedence over the intrapersonal beliefs (Joiner et al., 2002)

Badgett in 2014 cited the results of the 2006 World Value Survey, where 64% of Indians said that they believed homosexuality is never justified, while only 14% said that it is sometimes or always justified, and 41% stated that they would not like a homosexual neighbour. (*The Economic Cost of Stigma and the Exclusion of LGBT People: A Case Study of India*, 2014) Compared to other countries, India falls in the middle concerning the acceptance of homosexuality, and attitudes have become more positive over time. However, acceptance is still a long way away, as numerous recent studies examining attitudes toward homosexuality revealed the presence of ambivalent attitudes amongst most heterosexual people and the presence of several harmful prejudices.

2.0 Significance of the Topic

Depression is a common illness worldwide, with more than 264 million people affected. Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life (World Health Organisation, 2020). Depression, otherwise known

as major depressive disorder or clinical depression, is a mood-related disorder. Those who suffer from depression experience persistent feelings of sadness and hopelessness and lose interest in activities they once enjoyed. Aside from the emotional problems caused by depression, individuals can also present with physical symptoms such as chronic pain or digestive issues. To be diagnosed with depression, symptoms must be present for at least two weeks.

The Diagnostic and Statistical Manual of Mental Disorders - 5 (DSM-5) outlines the following criterion to make a diagnosis of depression. The individual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

To receive a diagnosis of depression, these symptoms must cause the individual clinically significant distress or impairment in social, occupational or other important areas of functioning. The symptoms must also not be a result of substance abuse or another medical condition. (DSM-5, American Psychiatric Association, n.d.) Especially when long-lasting and with moderate or severe intensity, depression may become a serious health condition. It can

cause the affected person to suffer greatly and function poorly at work, at school and in the family. At its worst, depression can lead to suicide. Close to 8,00,000 people die due to suicide every year globally. Suicide is the second leading cause of death in 15-29-year-olds. (WORLD HEALTH ORGANISATION, 2021)

Negative attitudes and cultural stigmas put LGBTQIA+ youth at a higher risk for bullying, teasing and physical violence than their heterosexual peers. (Meyer, 2001) People belonging to the LGBTQIA+ community are more susceptible to mental health problems such as depression than heterosexual people. This can be due to a range of factors like discrimination and inequalities and they are more likely to experience problems such as depression, suicidal thoughts, self-harm, and alcohol and substance misuse.
In a 2016-2017 survey from HRC, 28 per cent of LGBTQIA+ youth —including 40 per cent of transgender youth — said they felt depressed most or all of the time during the previous 30 days, compared to only 12 per cent of non-LGBTQ youth (HRC Foundation 2017). Even among adults with mental illness, LGBTQIA+ adults may experience more serious symptoms. Among LGBTQIA+ adults living with mental illness, thirteen per cent had a serious mental illness that substantially interfered with major life activities. The same was true for only four per cent of heterosexual adults living with mental illness (Medley 2016). Numerous studies have shown that lesbian, gay, and bisexual youth have a higher rate of suicide attempts than do heterosexual youth.

The Suicide Prevention Resource Centre synthesized these studies and estimated that between 5 and 10% of LGBTQIA+ youth, depending on age and sex groups, have attempted suicide, a rate 1.5-3 times higher than heterosexual youth. A U.S. government study titled, ‘Report of the Secretary's Task Force on Youth Suicide’, published in 1989, found that “LGBT youth are four times more likely to attempt suicide than other young people”. (Newton, n.d.) This higher prevalence of suicidal ideation and overall mental health problems among teenagers in the LGBTQIA+ community compared to their heterosexual peers has been attributed to minority stress.

Ensuring that instances of anti-LGBT violence and discrimination do not continue to repeat themselves may require society to turn to one of its oldest tools—education. Reports from the Gay and Lesbian Alliance Against Discrimination (GLLAD) have found that increased knowledge about LGBTQIA+ people leads to lower levels of discomfort toward this community and thus can reduce anti-LGBTQIA+ discrimination which has been one of the primary antecedents for mental illness and suicidal ideation among LGBTQIA+ people. (Meyer, 2001) The purpose of this academic study thus is to shed light on this reality that plagues a significant section of our society and make known and correct the prejudices suffered by them.

3.0 Method

The sample chosen in this survey research is from a population of adults (above the age of 18) belonging to the LGBTQ+ community, who experience depression and suicide ideation. The reason why we chose this sample is two-fold. First, one of the most pivotal critiques of psychological research is representation, or therefore lack of it.

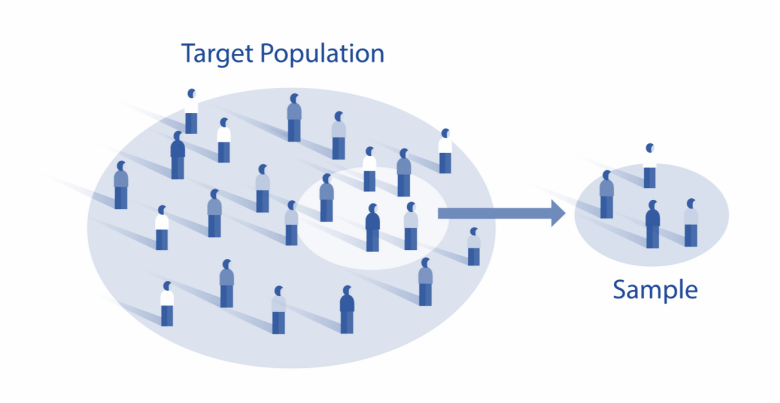
Over the past 50 years, the psychological discourse regarding same-sex sexuality shifted from an understanding that homosexuality was intrinsically linked with poor mental health toward understanding the social determinants of LGBTQIA+ mental health. Developing a better understanding of the marginalized, underrepresented, misunderstood set of youth was the central motive behind us taking this course, as our research study. Second, it was important for us to postulate how to recognize the structural circumstances within which youth are embedded and that their interpersonal experiences and intrapersonal resources should be considered as potential sources of both risk and resilience.

3.1 What is a Sample?

A “sample” is a miniature representation of and selected from a larger group or aggregate. In other words, the sample provides a specimen picture of a larger whole. This larger whole is termed as the “population” or “universe”. In research, this term is used in a broader sense; it is a well-defined group that may consist of individuals, objects, characteristics of human beings, or even the behaviour of inanimate objects, such as the

throw of a dice or the tossing of a coin.

Figure 1.0

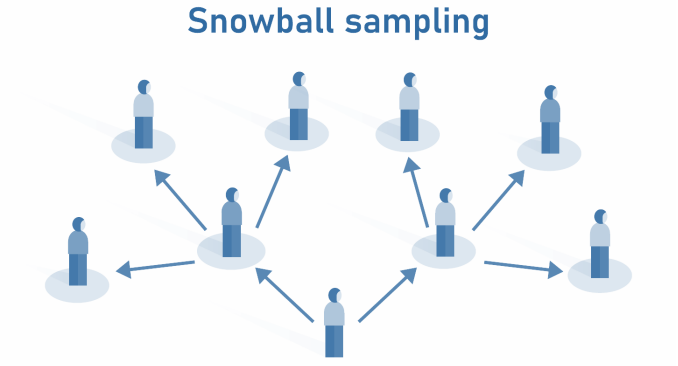


Sampling can be defined as the selection of some part of an aggregate or totality based on which a judgment or inference about the aggregate or totality is made. In other words, it is the process of obtaining information about an entire population by examining only a part of it. We cannot study entire populations because of feasibility and cost constraints, and hence, we must select a representative sample from the population of interest for observation and analysis.

3.2 Snowball Sample Method

The sampling technique used in this research is the Snowball sampling method, and the survey was circulated online, using internet services. Snowball sampling method, is a type of non-probability sampling method, wherein different members of the sample had varying levels of probability of getting selected as part of the sample.

Figure 1.1



Snowball sampling is often chosen when it is difficult for the researcher to find suitable participants for their research study. In snowball sampling, the recruitment of participants takes place via other participants. “The number of people the researcher has access to “snowball” as they get in contact with more people.”

Snowball sampling was used in this research, via google forms, which were circulated through a few participants we found, who fit the criterion of our sample. They further circulated it to other potential participants which also fit the criterion, and those participants further continued the same process. We estimated about 20-30 responses and were delighted to see that more than twice that number of people responded. Their confidentiality was maintained, they weren’t made to give out their names, their experiences and anecdotes were also not publicized.

And in addition to that, various government and non-government organizations that support and facilitate help to the youth of the LGBTQ+ community were also added to the survey, in case the participants felt the need to get help from them.

Precautions:-

1. The sample was very specific.
2. Instructions concerning the filling of the survey were made clear to every participant before starting the survey.
3. Introductory questions about demographics were added to build confidence at the starting of the survey.
4. The Likert scale of 1-5 was provided in several questions, to help formulate objectivity about the feelings of the participants.
5. Most of the questions chosen were close-ended.
6. Prompts were provided in several questions to facilitate better answering.
7. An appreciative ‘thank you note’ was added after finishing the survey, to end it on a positive note.

3.3 The Procedure of Data Collection

3.3.1 Selection of the Topic

Adolescence is a critical period for mental health because many mental disorders show onset during and directly following this developmental period (Kessler et al. 2005, 2007). Recent estimates of adolescent past-year mental health diagnoses indicate that 10% demonstrate a mood disorder, 25% an anxiety disorder, and 8.3% a substance use disorder. Further, suicide is the third leading cause of death for youth ages 10 to 14 and the second leading cause of death for those ages 15 to 24 (CDC 2012). According to a study conducted by Marshal (2011), transgender youth are far more likely than their non-transgender peers to experience depression — nearly four times the risk, according to another study (Reisner 2015).

According to the CDC's 2015 Youth Risk Behaviour Survey, 60 percent of LGBTQIA+ youth reported being so sad or hopeless they stopped doing some of their usual activities. LGBTQIA+ young people are more than twice as likely to feel suicidal, and over four times as likely to attempt suicide, compared to heterosexual youth (Kann 2016). Hence, choosing a topic related to such conditions was extremely relevant; that's also the reason why we focused specifically on depression and suicide ideation in the youth belonging to the Lesbian, Gay, Bisexual, Transgender, Queer, and others community.

3.3.2 Selection of the Procedure

Saewyc in 2011 gave two approaches that are often used to frame and explore mechanisms that exacerbate risk for LGBT youth.

a. First is to examine the greater likelihood of previously identified universal risk factors (those that are risk factors for all youth), such as family conflict or child maltreatment; LGBTQIA+ youth score higher on many of the critical universal risk factors for compromised mental health, such as conflict with parents and substance use and abuse.
b. The second approach explores LGBTQIA+-specific factors such as stigma and discrimination and how these compound everyday stressors to exacerbate poor outcomes. Here we focus on the latter and discuss prominent risk factors identified in

the field—the absence of institutionalized protections, biased-based bullying, and family rejection—as well as emerging research on intrapersonal characteristics associated with mental health vulnerability.

And the reason why we chose the survey method is that it was inclusive of both of these ideas and frameworks. The questions in the survey were not just related to personal feelings, experiences, and behaviours but also behaviours of the participant's caregivers, colleagues, peers, teachers, and the society at large. Not just that, the survey method fulfilled our aim to be inclusive of generalized as well as LGBTQ+ specific factors, such as stigma related to marginalization, discrimination, coming out, transitioning, binary characterization, etc. Therefore, the survey method was used to get in-depth information in a concrete and concise manner that was economically efficient.

3.3.3 Questions in the Survey

Questions in the survey were divided into 3 parts:

a. Demographics
b. Depression related questions
c. Suicide ideation related questions

Following this, there were a few conclusive questions asked. And the feedback was acquired.

3.3.4 Themes

a. Primary- The prevalence of anxiety and depression in the LGBTQIA+ community
b. Secondary- Drawn from personal experiences and anecdotes of different participants which they wrote about in their survey answers.

3.3.5 Analysis

- Contemporary youth come out as LGBTQIA+ at younger ages than in prior cohorts of youth.
- Younger ages of coming out intersect with a developmental period characterized by concerns with self-consciousness, conformity, and peer regulation.

- Coming out is typically stressful for LGBTQIA+ youth but is also associated with positive mental health, especially over the long run.
- LGBTQIA+ mental health must be understood in the context of other salient personal identities: gender, ethnicity, culture, and religion.
- Significant advances in knowledge of policies and practices have created supportive school environments and contributed to positive mental health for LGBTQIA+ youth.

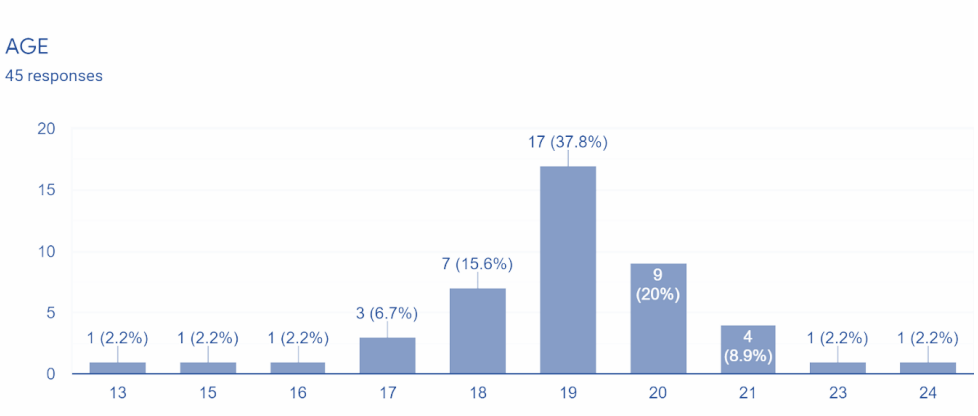
3.3.6 Conclusion

- Significant gaps remain in knowledge of clinically proven models for reducing mental health problems and promoting mental health in LGBTQIA+ youth.
- Serious gaps remain in knowledge regarding mental health for transgender youth.
- Strong evidence indicates that bisexual youth have higher rates of compromised mental health, and more research and theory are needed to understand these patterns.
- Intersectional approaches are needed to better understand the interplay of sexual orientation and gender identity with race and ethnicity, social class, gender, and culture.

4.0 Results and Discussion

The Survey featured the following questions, the responses to which have been shared below:

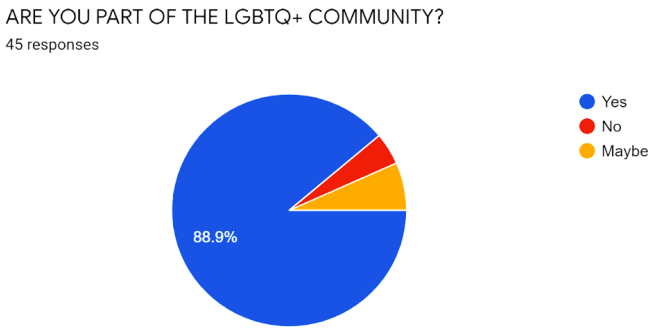
4.1 Age



The age group that participated in the survey is 13 - 24.

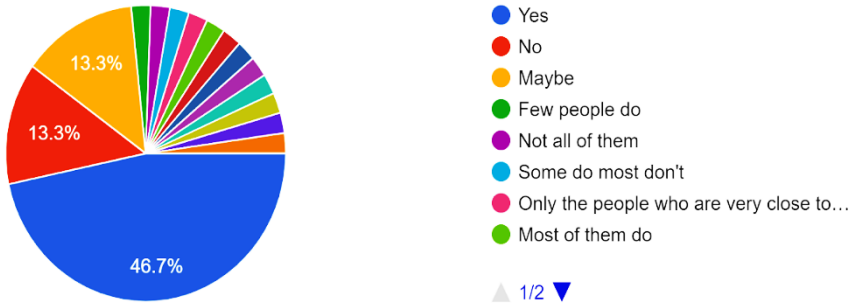
- 17 participants - 37.8 per cent ethnicity 19 years old.
- 9 (20 per cent ethnicity participants were aged 20 and 7 (15.6 per cent) were aged 18.
- Thus, most participants (33 - 62.4 per cent) belonged to the age group of 18-20.

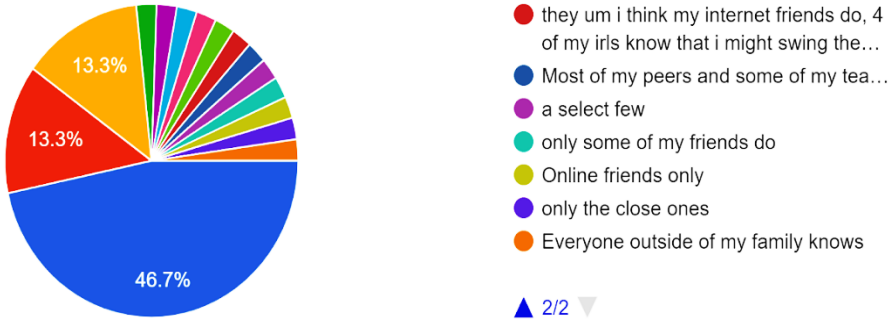
4.2 Are You a Part of the LGBTQIA+ Community?



- 40 (88.9 per cent) of the participants answered that they were a part of the LGBTQIA+ Community.
- 3 (6.7 per cent) said they are unsure/Questioning.
- 2 (4.4 per cent) of the participants were not a part of the LGBTQIA+ Community.

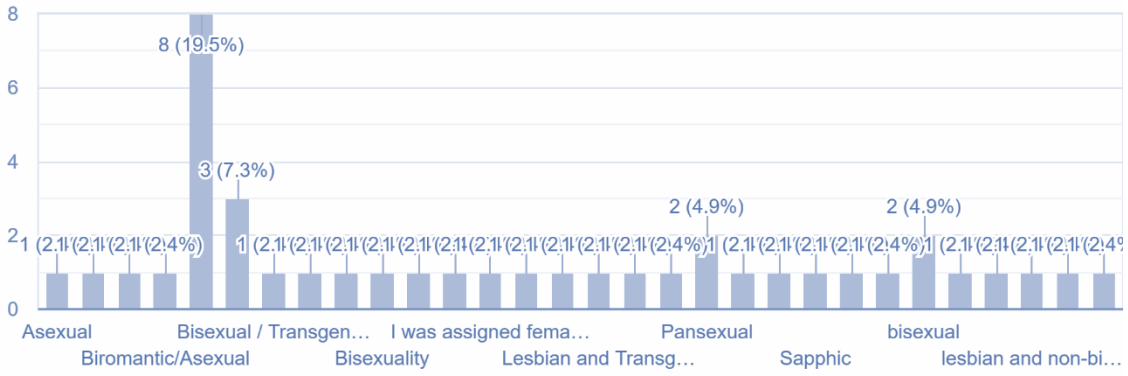
4.3 Do the People Surrounding You Know about your Gender Identity?





- 21 (46.7 per cent) of the participants said that they are outed i.e, people around them know about their gender identity.
- 6 (13.3 per cent) of the participants are closeted i.e, people around them do not know of their gender identity. 6 (13.3 per cent) were unsure.
- 9 (19.8 per cent) of the participants said that a few selective people around them know.
- 3 (6.6 per cent) of the participants said that most people around them are aware.

4.4 What Subset of the Community Do You Identify With?



The following were recorded:

Sexuality:

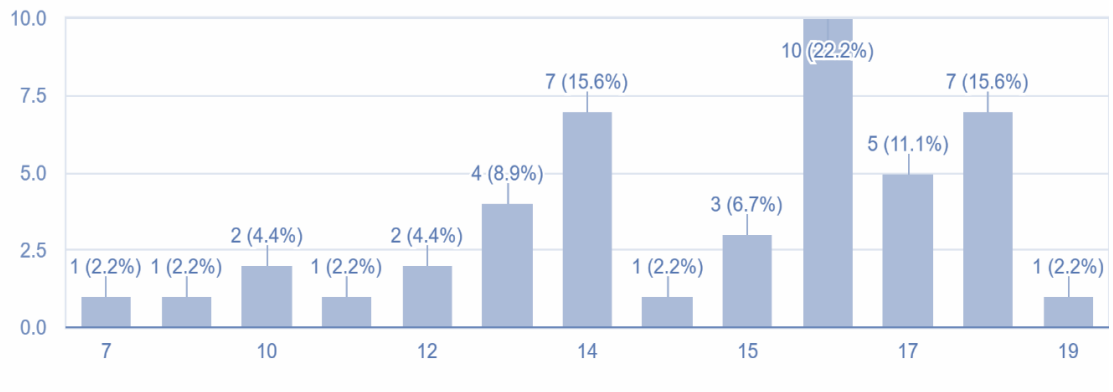
- Gay
- Bisexual
- Asexual

- Pansexual
- Queer
- Lesbian
- Sapphic[1]
- No Labels
- Sexually Fluid

Gender Identity:

- Transgender
- Non-Binary
- Transmasculine[2]

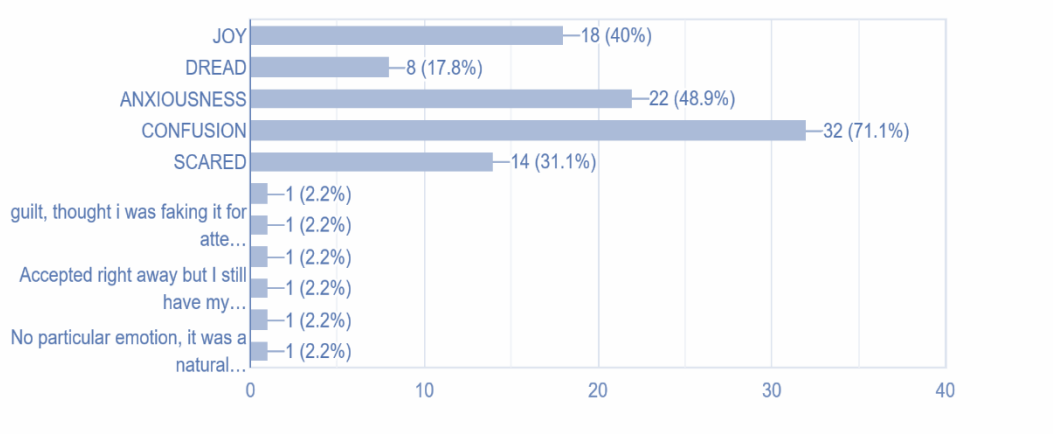
4.5 At What Age Did You Realise Your Sexuality?



- 10 participants (22.2 per cent) realized that they have non-heteronormative sexuality at the age of 16.
- 17.6 per cent or 7 of the participants realized their sexuality at the age of 14
- 7 (15.6 per cent) at the age of 18.
- The rest (2) of the participants were aged between 7 y/o and 19 y/o when they realized their sexuality.

[1] "Sapphic" is an identity term or label generally used to describe women's attraction to other women. It's an umbrella term for lesbians, bisexual/pansexual women, and queer women. It's almost used as a synonym for "WLW" or "women who love women".
[2] "Transmasculine" is an umbrella term that refers to people who were assigned female at birth but identify with masculinity.

4.6 What Emotions Did You Experience Around the Time You Realised Your Sexuality?



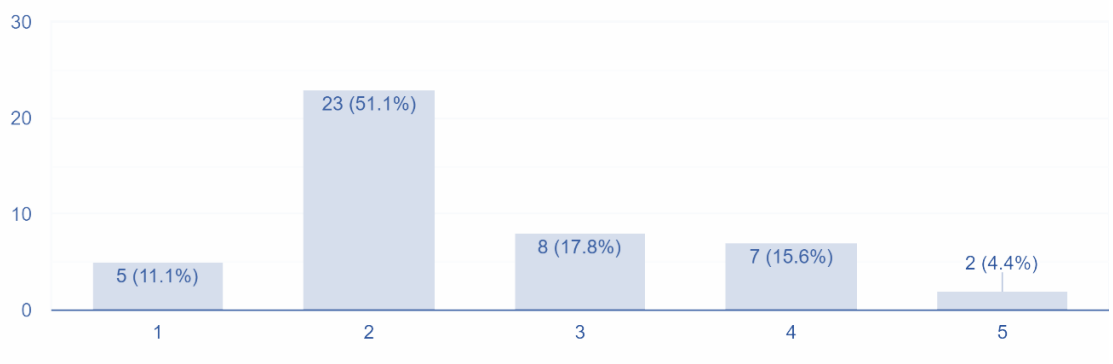
The participants experienced various emotions when they realized their true sexuality. The most common one out of these emotions were:

- Confusion: 32 (71.1 per cent) of the participants said they felt confused.
- Anxiousness/Anxiety: 22 (48.5 per cent) of the participants said they felt anxious about realizing their sexual/gender identities.

Other than these emotions:

- 18 (40 per cent) of the participants felt Joy.
- 14 (31.1 per cent) participants felt Scared.
- Guilt (1 - 2.2 per cent),
- Doubt (1 - 2.2 per cent),
- Alienation (1 - 2.2 per cent),
- Lost (1 - 2.2 per cent),
- Lack of Emotions (2 - 4.4 per cent)

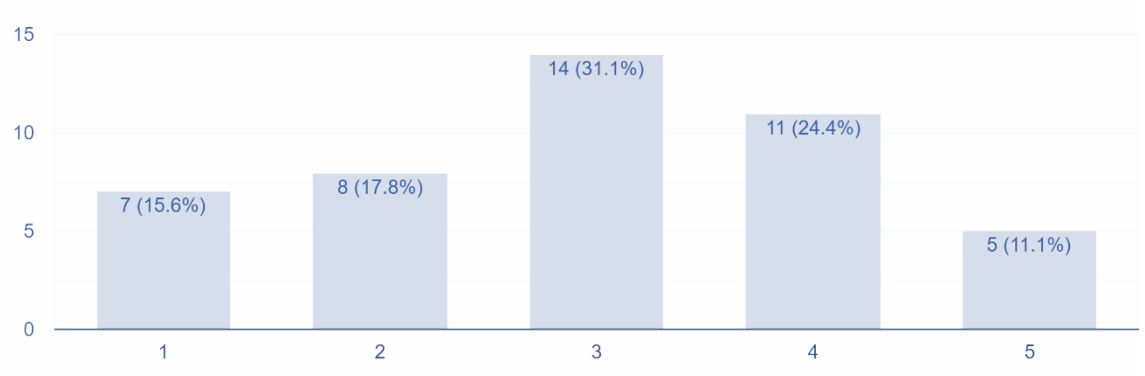
4.7 How Would You Rate Your Mental Well-Being, from 1-5? (5 being the highest)



On a scale of 1 - 5,

- about half the participants (23 or 51.1 per cent) rated their mental health to be at 2.
- 8 or 17.8 per cent of the participants rated it at 3;
- 7 or 15.6 per cent rated it at 4;
- 5 or 11.1 per cent gave it a 1, and
- 2 or 4.4 per cent of them rated it at 5.

4.8 On a scale of 1-5, How Much Do You Think the Experience Surrounding Your Sexuality/Gender Identity Affects Mental Health? (1 being of the least value and 5 the most)

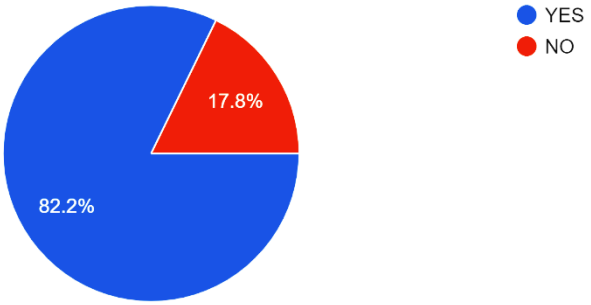


On a scale of 1 - 5,

- About a third of the participants (14 or 31.1 per cent) rated the effect of their sexuality/gender identity on their mental health as 3.
- 11 or 24.4 per cent of the participants rated it at 4;

- 8 or 17.8 per cent rated it at 2;
- 7 or 15.6 per cent gave it a 1, and
- 5 or 11.1 per cent of them rated it at 5.

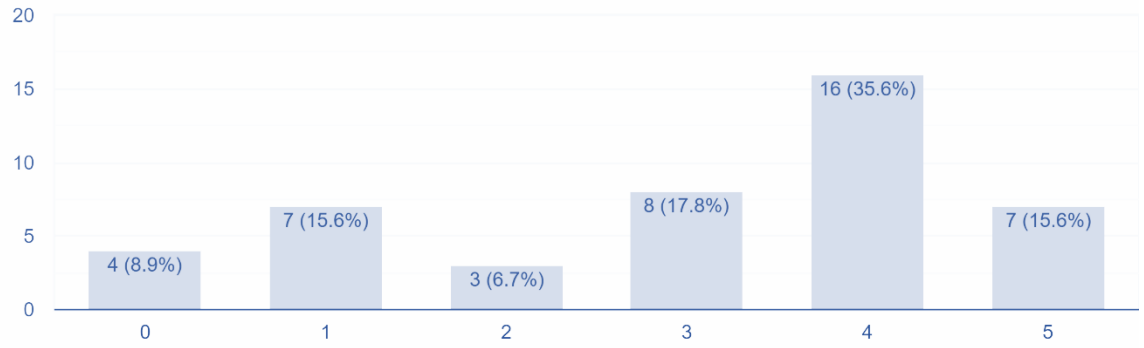
4.9 Do You Experience Depressive Episodes?



A majority of the participants (37 or 82.2 per cent) expressed that they do experience depressive episodes.

Only 8 or 17.8 per cent of them said they do not experience depressive episodes.

4.10 If Yes, How Frequently?

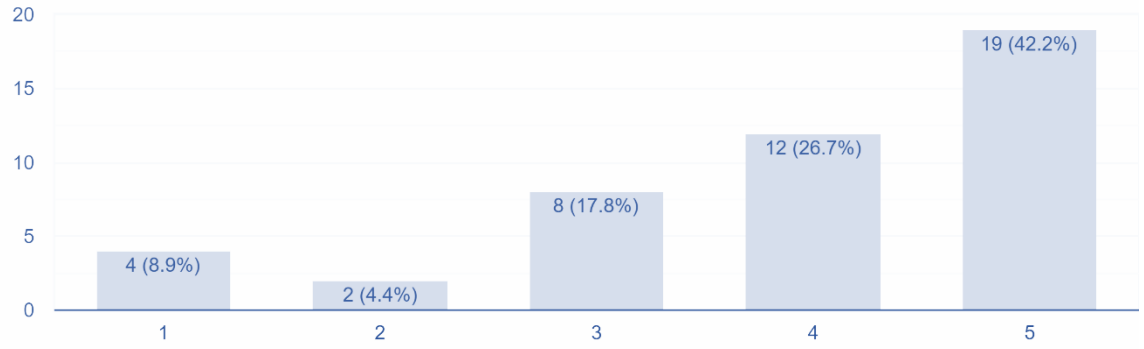


On a scale of 1 to 5, 5 being very often

- 16 or 35.6 per cent of the participants rated the frequency of their depressive episodes at 4.
- 8 or 17.8 per cent of them gave it a 3.
- 7 or 15.6 per cent of the participants rated it at 5, and

- 7 or 15.6 per cent more rated it at 1.
- 4 (8.9 per cent) of them, and
- 3 (6.7 per cent) rated it at 0 and 2, respectively.

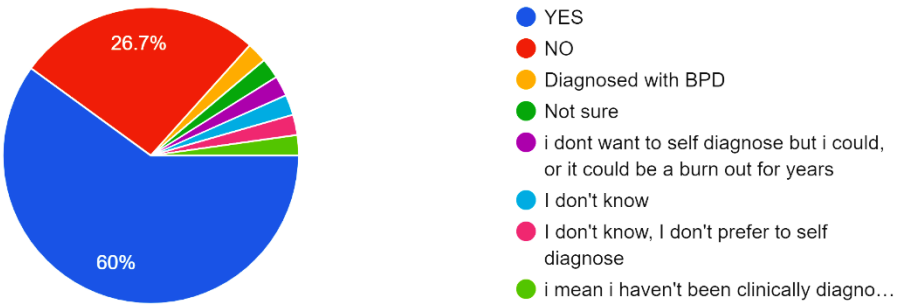
4.11 Would You Say That These Depressive Episodes Are a Hindrance to Your General Well Being?



On a scale of 1 to 5, 5 being the most

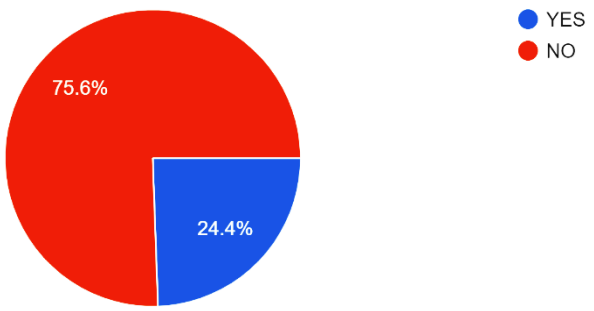
- 19 or 42.2 per cent of the participants rated the hindrance caused by their depressive episodes to their wellbeing at 5.
- 12 or 26.7 per cent of them gave it a 4.
- 8 or 17.8 per cent of the participants rated it at 3.
- 4 (8.9 per cent) of them, and
- 2 (4.4 per cent) rated it at 1 and 2, respectively.

4.12 Would You Consider Yourself As Having Depression or Having Had Depression?



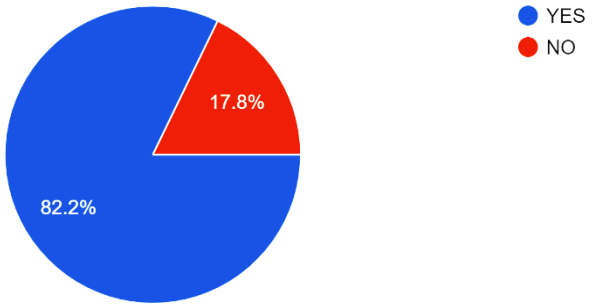
- 27 or 60 per cent of the participants said that they currently have depression or did so in the past.
- 12 or 26.7 per cent said that they have never had depression.
- 5 or 11.1 per cent were unsure/confused/unaware.
- 1 or 2.2 per cent have been diagnosed with Bipolar Disorder.

4.13 Have You Ever Been Clinically Diagnosed With Depression?



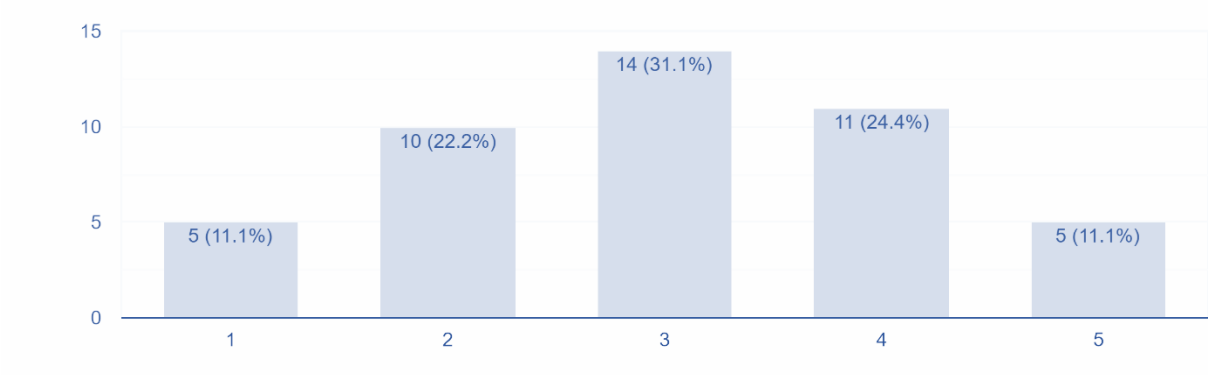
- 34 or 75.6 per cent of the participants had never been clinically diagnosed with depression.
- 11 or 24.4 per cent have been clinically diagnosed with depression.

4.14 Have You Ever Had Suicidal Thoughts?



- 37 or 82.8 per cent of the participants claimed to have experienced suicidal thoughts.
- 8 or 17.8 per cent said they have never had suicidal thoughts.

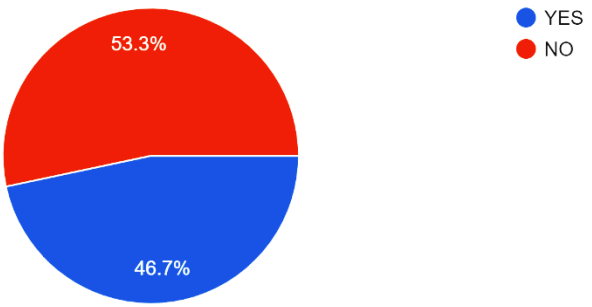
4.15 If Yes, How Frequently Have You Had Them?



On a scale of 1 to 5, 1 being never and 5 being a lot

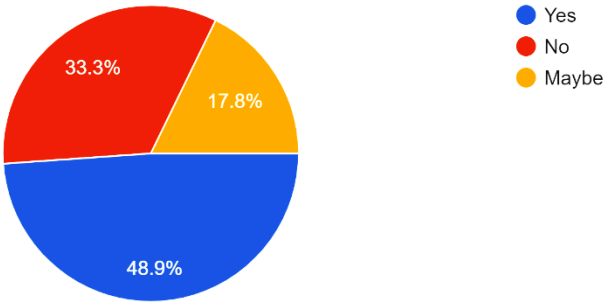
- 14 or 31.1 per cent of the participants rated the frequency of their suicidal thoughts at 3.
- 11 or 24.4 per cent of them gave it a 4.
- 10 or 22.2 per cent of the participants rated it at 2.
- 5 (11.1 per cent) of them, and
- 5 (11.1 per cent) more rated it at 1 and 5, respectively.

4.16 Have You Ever Acted Upon These Thoughts?



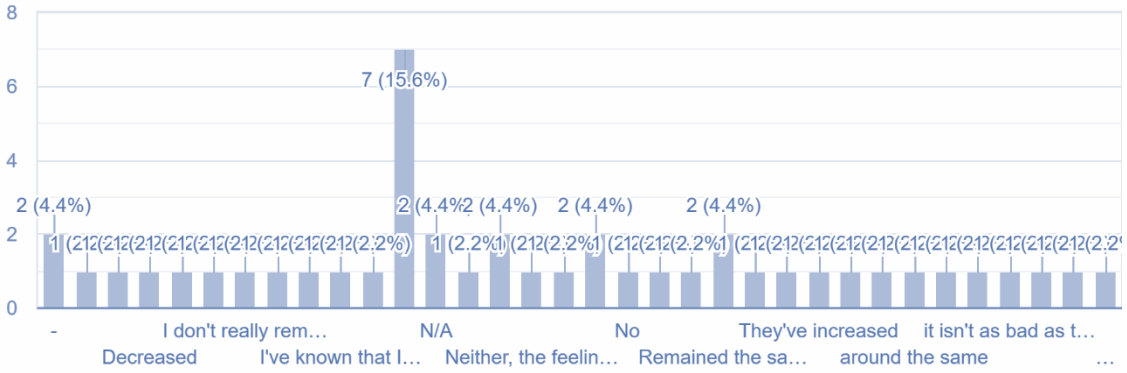
- 24 (53.3 per cent) said they have never acted upon these thoughts.
- 21 (46.7 per cent) said they have acted upon them.

4.17 Did These Exist Before You Realised Your Sexuality/Gender Identity?



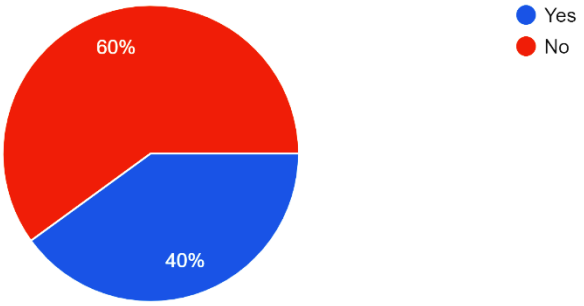
- For 22 (48.9 per cent) of the participants, suicidal thoughts existed before they had realized their sexual/gender identity.
- For 15 (33.3 per cent) of the participants, not seeking they developed after they realized their sexual or gender identity.
- 8 (17.8 per cent) of the participants were unsure.

4.18 If Yes, have they increased or Decreased, Since You've Realised Your Sexuality/Gender Identity?



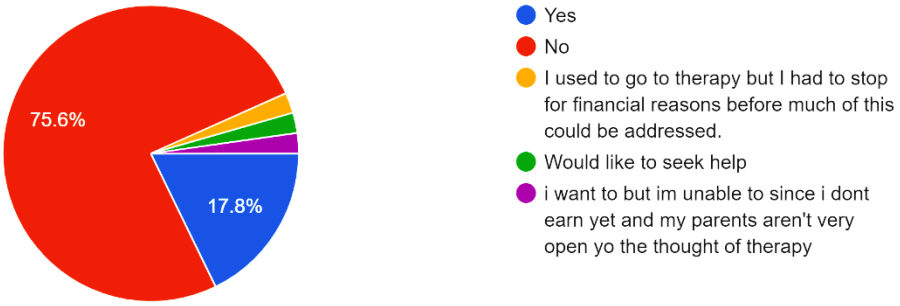
- For a large number of participants (15 or 33.3 per cent), suicidal thoughts increased around the time they realized their sexuality/gender identity.
- 10 (22.2 per cent) of the participants reported no change at all.
- 5 (11.1 per cent) reported a decrease in suicidal thoughts.
- 15 (33.3 per cent) were unsure if any change occurred.

4.19 Did You Seek Help in the Face of These Thoughts?



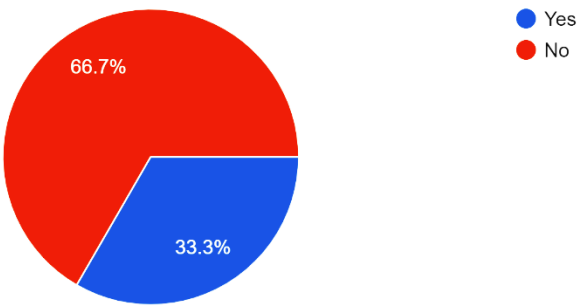
- 60 per cent or 27 participants did not seek help when they had suicidal thoughts.
- 40 per cent or 18 participants did seek help.

4.20 Are You Currently Seeking Psychological/Psychiatric Help?



- 34 or 75.6 per cent of the participants said that they are currently not seeking any form of psychological/psychiatric help.
- 8 or 17.8 per cent said they ARE currently seeking professional help.
- 2 or 4.4 per cent of them would like to seek professional help but are unable to due to various reasons (financial reasons/stigma attached to therapy)
- 1 or 2.2 per cent of the participants previously went for therapy but had to stop due to financial reasons.

4.21 Were You Seeking Psychological/Psychiatric Help in the Past?



- Most of the participants (30 or 66.7 per cent) were not seeking professional help in the past.
- 15 or 33.3 per cent were seeking psychological/psychiatric help in the past.

4.22 If No, Would You Be Interested in Getting Some Help?

- 42.2 per cent or 19 of the participants are interested and willing to get psychological/psychiatric help.
- 15 or 33.3 per cent are unsure.
- 8 or 17.8 per cent of the participants are not interested in getting professional help.

5.0 Discussion and Analysis

The sample for this survey included people from a variety of subsets of the LGBTQ+ Community belonging to the age group of 13 y/o - 24 y/o. A majority of the participants identified as Bisexual; however, some participants were also identified as gay, asexual, pansexual, and sapphic. Some participants also belonged to the Trans community and were non-binary.

The participants were aged between 7 years to 19 years when they realized their sexual/gender identity. This realization gave way to certain emotions which were experienced by many participants: Confusion, Anxiousness, Joy, Scared, Guilt, Doubt, etc. As these emotions were common amongst the sample, it can be implied that the realization of one's non-heteronormative sexual orientation/non-binary gender identity brings with it Confusion, Anxiousness but also Joy.

The participants rated their Mental Health on a scale of 1 to 5. The results showed that about half the participants (51.1 percent) rated their mental health at 2 which is on the lower end of the scale. It can also be noted that when asked to rate how much their sexuality/gender identity affects their mental health, 11 participants (24.4 per cent) rated it as a 4 on a scale of 1 to 5. 11.1 per cent or 5 of the participants rated this as 5 on the scale. Thus, this does show how 35.5 per cent of the participants' mental health is affected by their identity as part of the LGBTQIA+ Community.

Most of the participants (37 or 82.2 percent) claimed that they do experience depressive episodes and 8, 16, and 7 (68.9 percent) of the participants rated it as 3, 4, and 5, respectively, on a scale of 0 to 5. When asked to rate if these depressive episodes were a hindrance to their general well-being, 12, 19 (68.9 percent) of the participants rated it at 4 and 5 respectively. 60 percent of the participants feel they have or have had depression at some point in their lives but only 24.4 percent have been clinically diagnosed with it.

This low number could also be a result of not having access to mental healthcare professionals as almost 80 percent of the participants are unable to seek help due to various factors. 82.2 percent (37) of the participants also expressed that they had had suicidal thoughts, which is a very high number.

When asked to rate the frequency of these thoughts, 11 and 5 participants (35.5 per cent) gave a score of 4 and 5 respectively. 46.7 per cent of the participants also claimed to have acted upon these thoughts. However, for 48.9 percent of the participants, these thoughts existed before they realized their sexual orientation/gender identity. For 33.3 per cent of them, these suicidal thoughts did not pre-exist while 17.8 were unsure about it. In fact, for a large number of participants (15 or 33.3 per cent), suicidal thoughts increased around the time they realized their sexuality/gender identity.

27 or 60 per cent of the participants did not seek help when they faced suicidal thoughts. 34 or 75.6 per cent of the participants are currently not seeking professional help, and 30 or 66.7 per cent of the participants have not taken any professional help in the past.

Almost 50 per cent i.e. 22 of the participants are interested in seeking psychological/psychiatric help but are unable to do so due to financial reasons or the stigma attached to therapy. Thus, the survey does reveal a prevalence of mental health issues such as depression and suicide ideation amongst teenagers and young adults in the LGBTQIA+ Community.

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