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LGBTQ Lives — Identity, Stigma, Mental Health, and Affirmative Care

1.Uttam B Sonkamble MPhil and PhD
Deptt of English BYK College of Commerce
Nasik – 422005.
2.Ms Lekha Rajpal Chatole
Reseach Scholar Deptt of English
SN Arts, DJM Commerece and BNS Science College Sangamner

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Abstract

LGBTQ is much vogue in the recent decades for its exception contribution to culture, society and literature across the world. The LGBTQ identities, though representing since centuries in number of forms; oral traditions, poems, drama etc, remained dormant or kept neglected by the society due to their nonconformative behaviour. Cultural and social acceptance was impossible in the binary societies or even their existence in terms of articulation. What that is treated as cultural and social stigma continued to be a blow to the LGBTQ lives. Unlabelled sexuality and their queer lives continue ever since with the modernist labels as lesbian, gay, bisexual, transgender, and queer etc. This paper attempts to explore the psychological status of LGBTQ lives, and how they are met to adversities and what makes them rebuild them visible and acceptable in the society. There is a huge scope for research for this topic considering the lives across the world, but for this study, the researcher considers Indian, American, Nigerian, and Moroccan contexts only.

Keywords: LGBTQ, queer, identity, psychology, exclusion, stigma, trauma, mental health, dignity, belonging

Introduction:

Psychology, identity, and the human cost of exclusion:

Of the historical and sociocultural conditions, the psychological condtion is the sole factor that deals with the LGBTQ lives which comes within their life. All other formulate externally while psycholoical one helps building or impacting them personally. This is extremely a vital agent that receives influence of other aspects but it depends upon the LGBTQ people to fall prey to them. Those susceptable become victims and the others the stronger ones by their will refute any external influence. Because their problems do not arise being lesbian, gay, bisexual, transgender, queer, intersex, asexual, or gender nonconforming

but the distress that often emerges from the conditions created by the society of stigma, silence, rejection, fear, and discrimination. The environment shapes a person's mental health upon identity discovered, expressed, hidden, or punished. For LGBTQ entities, psychological life is consequently inseparable from family, religion, law, school, community, media, and healthcare systems.

In relation to queer community, its psychological and psychiatric history is intricate. At length, medical and psychological institutions assumed same-sex desire and gender variance as abnormal. Since homosexuality being so pathologised, many queer people were subjected to shame, conversion efforts, and psychiatric labelling. Modern psychology, however, has gradually begun recognising such identities as normal variations of human sexuality and gender. This is remarkable due to its shift for acknowledging identity from curing to accepting the socially biased damage – this is an affirmative social psychology. By applying psychological, social, and clinical lenses, thier mental health becomes more perceptable that discusses minority stress, identity development, family rejection, trauma, depression, anxiety, transgender mental health, conversion practices, resilience, and affirmative care. In Indian, American, Nigerian, and Moroccan contexts, the psychological aspect with regard to LGBTQ identities, though shaped differently by cultures but is interconnected by common themes of stigma, concealment, survival, and the need for dignity.

Pathology to Affirmation: Illness, abnormality, deviance, immaturity, or moral failure were the common historical terms seeking medicalisation produced lasting impact of social prejudice, internalising LGBTQ gender and the institutional defintion as defective. It had a long and massive impact on the individuals. The affirmative shift recognises that LGBTQ identities are valid and due therapy embedded with self-understanding, safety, autonomy, and wellbeing be extended to them. The American Psychological Association's guidelines for LGBTQ people accept stigma, due to their nonconformity, psychologically impacting them. Hence the APA guidelines acknowledge all identities including lesbian, gay, heterosexual, bisexual, queer, pansexual, and asexual. Important factor is, LGBTQ mental health care cannot be built upon assumptions, but the affirmative practice that refrains from labelling instead it helps the individuals recognise themselves without shame.

Minority stress and the psychological burden of stigma: Dealing with minority stress theory, Ilan H Meyer calls that LGBTQ individuals undergo additional stress for their belonging to a stigmatised marginal group. He refuses to call it an everyday ordinary stress but chronic socially produced, and mostly prejudice created. Meyer states:

"sexual prejudice… is stressful and may lead to adverse mental health outcomes." "the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes." (Meyer)

Meyer explains that the sexual prejudice not only creates emotional distress but stigma too which further impact mental health risk of the queer people. It impacts them treating themselves as dangerous for the society even before they learn the queer language.

Rejectional anticipation becomes their psychological habit and they happen to monitor speech, clothing, gestures, friendships, online presence, and emotional expression, results in fatigue.

Stress can operate externally and internally; external stressors include discrimination, bullying, violence, family rejection, police harassment, exclusion from school, workplace prejudice, and healthcare discrimination and internal stressors include fear of rejection, concealment, shame, internalised stigma, and inferiority complex. The psychological factor challenges their self-esteem, intimacy, trust, and emotional safety. In Indian setup, family expectations, marriage pressure, caste, religion, class, and dependence on family structures intensify their stress. Though in the United States, legal progress has improved conditions, LGBTQ individuals still face bullying, family rejection, transphobic violence, and political backlash. In Nigeria, criminalisation and social hostility make concealment a survival problem for many LGBTQ people. In Morocco, legal restrictions and moral conservatism shape fear of exposure. Across these contexts, psychological distress remains a big conflict.

Identity development, shame, and self-acceptance: LGBTQ identity development often involves a long emotional process rather than a single flash of discovery. Many LGBTQ individuals first experience difference without having verbal for it. A child may find difference from others without knowing why, a teenager may feel attraction, gender discomfort, or emotional longing that may be risky to talk about which further create silence, confusion and loneliness – a way of identity development in secrecy.

Disclosure will prove dramatic but psychologically typically a continuing process, opening up first with friends but hidden from family. The children may disclose identity in other places but remain silent in their hometown – accepting themselves privately. Some, due to high risk, may never fully come out, some individuals will find safer and healthier rather than getting explosed to risk. Visibility becomes extremely difficult and risk.

Shame is one of the most agonising psychological consequential stigmas. LGBTQ people may communicate themselves internally with their desire, body, or gender. This internalised stigma can affect relationships, confidence, body image, sexuality, spirituality, and future prospects. Self-acceptance often begins being exposed with some language, community, literature, or another person of similar experience. A person with similar experience can prove psychologically powerful and can be interruptive of the belief that single one is alone or abnormal. Therapy, peer support, queer literature, chosen family, and community space help LGBTQ individuals move from shame toward self-understanding.

Family, attachment, and emotional belonging: Family will always play a crucial role in LGBTQ psychological wellbeing because family usually provides the first source of emotional security. Many LGBTQ individuals' fear of losing family acceptance becomes one of the deepest psychological problems in societies where family honour, marriage, caste,

religion, and community status are powerful, disclosure can emotionally be throttling. In India, family is often collective, individual's identity is tied to family reputation and marriage anticipations. Disclosure will not only bring shame but disrupt sibling marriages and invite community gossip. LGBTQ people may face family denial, silence, anger, emotional pressure, or attempts to force heterosexual marriage. Even families' non-violence may become psychologically damaging. In the United States, family reactions vary widely by religion, region, race, class, and political background; some families affirm and become protective sources of resilience, others reject or expel LGBTQ youth. Family rejection can lead to mental health risks such as depression, anxiety, homelessness, and suicidal tendency. In Nigeria and Morocco, legal and religious environments may intensify family rejection, in a society that frames LGBTQ identity as immoral or criminal, families may feel pressure to discipline or hide queer children. This creates a situation that strengthens bond between the families and such children while also fearing them. Such emotional conflict can produce anxiety, grief, and affection wounds. Chosen family becomes psychologically more supportive in this environment. LGBTQ people often build support networks outside biological kinship in friends, partners, mentors, community members, and activists sharing emotional care. Though, undoubtedly, the chosen families fail to erase the pain of biological rejection, they offer new forms of belongingness showing that caring kinship is important than merely blood or marriage.

Depression, anxiety, and emotional distress: In many societies, LGBTQ individuals show higher rates of depression, anxiety, and emotional distress over the heterosexual and cisgender people. The hostile environments produce mental health burdens. The Indian review by Wandrekar and Nigudkar states:

"prevalence studies reveal that LGBTQIA+ individuals were found to show high rates of mental health concerns," "adapted minority stress model may be a crucial pathway" (Wandrekar and Nigudkar)

Depression may emerge in the face of their identity as futureless. Legitimacy denied by family, religion and society shall increase hopelessness. Anxiety emerges from constant vigilance: fear of being discovered, fear of violence, fear of being forced into marriage, fear of losing work, fear of being misgendered, fear of police or community exposure.

The queer identities may be misconstrued even within LGBTQ spaces as bisexual people being dismissed as confused, asexual being treated as immature or medically abnormal, non-binary being forced into binary categories, intersex to experience secrecy, medical trauma, or bodily shame. Care is a must to avoid treating LGBTQ idnetities as homogeneous. Wandrekar and Nigudkar note in the Indian context that despite increased public conversation after legal developments such as Section 377 and NALSA, LGBTQIA+ individuals continue to show 'poor health equity' that seeks for social acceptance, trained professionals, affordable care, and culturally sensitive services as necessary for their mental health equity.

Trauma, violence, and the body: Trauma is a big blow to many LGBTQ people especially when they face violence or humiliation. Trauma can be physical, sexual, verbal, emotional, institutional, family abuse, forced marriage, corrective violence, police harassment, conversion practices, public outing, online harassment, or denial of healthcare – causing more catastrophic impacting years of ridicule, fear, silence, and bodily monitoring.

LGBTQ body often becomes a site of public conflict in misgendering, ridicule, offensive interrogative, denial of bathrooms, lack of gender-affirming care, and violence. Gender dysphoria worsens by social rejection and lack of access to affirming support. Trauma-informed care is essential for their proper medication with warm sympathy for such identities. Hyper-vigilance, withdrawal, dissociation, anger, or distrust symptons may create survival issues. Only affirmative therapy will support their existence.

Conversion Practices and Ethical Harm: The false assumption about LGBTQ identities as defect and be corrected, conversion therapy or conversion practices are attempted to change a person's sexual orientation or gender identity. Mental health professionals, religious authorities, family members, or informal healers practise this conversion for defect correction. In fact, psychologically, change practices are detrimental that may intensify shame and self-rejection imbibing that that love, desire, or gender identity must be curbed to become acceptable, that can increase depression, anxiety, trauma, self-hatred, and suicidal thoughts. While ethical mental health practice rejected attempts to change sexual orientation or gender identity.

In India, conversion practices occurs due to family pressure, religious intervention, psychiatric misuse, forced counselling, medication, and confinement. Legal and professional opposition has increased, but social pressure remains. A young LGBTQ person may still be forcefully taken to a doctor, priest, counsellor, or healer to be 'corrected'.

Transgender mental health and gender-affirming care: Transgender mental health requires special care because transgender people often face deep social and institutional discrimination; family rejection, poverty, unemployment, housing exclusion, police violence, and healthcare barriers. In India, *hijra* and transgender communities have long histories of ritual recognition coupled with severe marinalisation. Gender-affirming care may support them live life with dignity. The clinicians should recognise stigma, discrimination, intersectionality, and the social barriers faced by transgender clients. Contradictorily an upperclass transgender woman from urban background may have access to private care, while a working-class *hijra* or rural trans person may face economic and institutional problems.

LGBTQ youth, schools, and developmental vulnerability: LGBTQ adolescence are especially vulnerable for their identity formation period, peer comparison, emotional sensitivity, and dependence on family or school. When schools become unsafe for such identities, the psychological impact of bullying, gender policing, harassment, lack of representation, and silence around sexuality can be long-term causing anxiety, depression,

school escaping, and low dignity. In India, LGBTQ topics remain restricted in many school curricula so no sexuality education. Young people may first encounter LGBTQ identity through jokes, abuses, pornography, or sensational media rather than through proper education that creates confusion and shame instead. In the United States, some schools provide LGBTQ-inclusive policies and counselling, while others restrict discussion of gender and sexuality. In Nigeria and Morocco, legal and cultural restrictions may make discussion extremely difficult.

Supportive school counsellors and teachers can make a major difference by introducng anti-bullying policies, inclusive curricula, gender-sensitive language, and safe counselling spaces and an absence of such support, silence becomes educational violence.

Indian context: law, psychology, and social transition: Legal and social change are taking place in compliance of Delhi High Court verdict, the 2018 Supreme Court judgment on Section 377, and the NALSA judgment. Mental health of LGBTQ identities in India remains uneven and that certain subgroups are underrepresented. It cannot rely on any imported models alone because family structures, caste, religion, arranged marriage, language, rural/urban dissimilarities, and economic dependence are different from other cultures that shape mental experience. A queer person in Mumbai with access to community support may face different challenges than that of a queer person in a small town who is financially dependent on family, further a dalit queer person may face caste and sexuality-based exclusion together and a transgender person may face barriers to documentation, housing, and employment that affect mental health directly. That is why India needs more queer-affirmative mental health training, community-based treatment, family education, crisis mediation, and affordable services. Therapy must be cultural sensitive and not Western one.

American context: visibility, rights, and continuing distress: Legal progress and lasting cultural conflict shape the American LGBTQ psychological setting. Due to the elimination of homosexuality from psychiatric diagnosis, the growth of LGBTQ civil rights movements, marriage equality, and broader media visibility public recognition has improved. However, mental health differences persevere due to stigma, family rejection, hate crimes, transphobia, racism, poverty, and political backlash. American LGBTQ psychology has produced its large major research on minority stress, family rejection, resilience, and affirmative care. One major research is of Meyer's minority stress which remains as foundation. It rejects the idea of legal equality automatically eliminating psychological distress because the LGBTQ individuals may still experience fear, discrimination, or internalised stigma. The American LGBTQ youth, especially transgender and LGBTQ youth of colour, remain exposed to bullying, legislative hostility, and barriers to healthcare even when there are queer communities with strong models of chosen family, peer support, crisis hotlines, LGBTQ community centres, and affirmative therapy.

Nigerian context: criminalisation, minority stress, and resilience: Criminalisation, religious conservatism, family pressure, and social danger shape Nigerian LGBTQ mental health. A research on sexual minority, adolescents in Nigeria, suffer poorer mental health,

another Nigeria-focused qualitative study states exploring how their experiences of minority stress impact mental health problems and vulnerability to HIV among gay, bisexual, and other men who have sex with men.

The Nigerian context shows psychological pressure of law; when LGBTQ identiies are criminalised or publicly condemned, people may live in constant fear of exposure. This affects in seeking help of therapists, hospitals, police, or community services fearing disclosure may place them at risk. Mental health distress is therefore not merely personal but structural. At the same time, the Nigerian LGBTQ communities demonstrate resilience with the help of private support networks, digital communication, underground community spaces, and peer unity.

Moroccan context: silence, law, and mental health under restriction: Intersection of legal restriction, Islamic public morality, family honour, and social discretion shape Moroccon LGBTQ psychological milieu. There is hardly any mental health research on LGBTQ community but little research in Middle East and North Africa (MENA) is useful. Available research argues it a 'mental health outcome' and calls 'high rated stigma, discrimination and violence', further it also notes that research remains restricted to a few countries and appeals for more research outside Lebanon, Pakistan, and Iran. Moroccan silence in research often reflects social and legal difficulty as LGBTQ identities being stigmatised or criminalised, people may dare not participate in studies so such identities are obliged to rely on private friendships, diaspora networks, literature, and online spaces for support.

Hence psychologically, silence can be both protective and isolating; though safe they may feel being concealed but long-term hiding can lead to loneliness, anxiety, and fragmentation. Abdellah Taïa's autobiographical work is one such example of emotional life behind public silence. Literature is psychologically important because it provides language where clinical research is inadequate.

Resilience, joy, and queer flourishing: In spite of LGBTQ lives' suffering exclusion, they create joy, love, and humour, creativity, chosen family, activism, art, spirituality, and resilience. Queer resilience emerges through community like meeting others with similar experiences that can help reduce shame. Queer literature can provide recognition, an affirming therapist can help rebuild trust, chosen families can provide care that biological families fail and activism can transform pain into purpose.

Positive LGBTQ psychology examines not only why queer people suffer, but how they thrive; it studies pride, connection, creativity, identity integration, and community strength. This will humanise LGBTQ lives; rejecting being victims of stigma, assume to be creators of culture, love, resistance, and new forms of belonging.

Affirmative therapy and ethical psychological practice: Affirmative therapy provides ethical LGBTQ mental healthcare and assures their valid identiites valid. It does not change sexual orientation or gender identity but it helps them explore identity safely, manage stigma, build self-acceptance, strengthen relationships, and make decisions appropriate to their

context. An affirmative therapist, acknowledging the identities, should use correct names and pronouns, avoid heteronormative assumptions, realise minority stress, recognise intersectionality, and respect cultural context. In India, for example, a therapist has to consider multiple factors; family pressure, marriage expectations, caste, class, religion, and safety. In Nigeria or Morocco, therapists have to consider legal danger and social risk. In the United States, therapists have to consider family rejection, race, class, transphobia, and political hostility. Affirmative practice should have humility and therapists should understand their diversities within the queer communiy because some want to come out, others need safety, some want gender-affirming medical care. Some hold religious identities, others have left religion because of harm. Some feel pride, others still struggle with shame. Good therapy caters to what and where one is.

Conclusion:

The psychological aspects of LGBTQ lives reveal that mental health is inseparable from dignity, recognition, and belonging. LGBTQ identities are not disorders and the distress and minority stress, many LGBTQ people experience, arises largely from social rejection, stigma, violence, concealment, and institutional exclusion that become their psychological burden. Family rejection, school bullying, legal criminalisatin, religious denunciation, and healthcare discrimination altogether affect their emotional life. At the same time, LGBTQ communities show powerful resilience with the help of chosen families, literature, activism, peer support, affirmative therapy, and self-naming. LGBTQ community creates means to survive and flourish. A humanitarian psychological understanding should therefore hold both realities together: the pain caused by exclusion and the strength created through resistance.

In Indian, American, Nigerian, and Moroccan settings, LGBTQ psychological life differs according to law, culture, family, religion, and healthcare access, yet these differences, one fact remains clear: people need recognition to live fully, mental health is not only an individual matter but is a social and ethical accountability. A society that affirms LGBTQ dignity improves both rights and the psychological conditions of human life.

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