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Symptoms of depression among lesbians, gays, bisexuals, and transsexuals: a look at mental health

A sintomatologia depressiva entre lésbicas, gays, bissexuais e transexuais: um olhar para a saúde mental

La sintomatología depresiva entre lesbianas, gays, bisexuales y transexuales: una mirada hacia la salud mental

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ABSTRACT
Objective: to examine the incidence of symptoms of depression among lesbian, gay, bisexual, and transgender (LGBT) people from two different scenarios, and their relationship with these individuals' sexuality. **Method**: this quantitative study, using statistical analysis was conducted between 2016 and 2018 by applying the Beck Depression Inventory - II (BDI-II) to 76 participants at the Gaffrée e Guinle University Hospital and the Alfredo Pinto School of Nursing, both in Rio de Janeiro city. The study was approved by the research ethics committee. **Results**: indications of minimal depression were found at the hospital, while at the school of nursing, indications of moderate depression were observed. These disparities may be explained by the age difference, the impacts of the disclosure process, and stigmas attached to people with HIV. **Conclusion**: the family was found to be fundamental in mental health among LGBT people, and further research on the subject is needed.
Descriptors: Sexuality; sexual and gender minorities; depression; mental health.

RESUMO
Objetivo: analisar a incidência da sintomatologia depressiva entre lésbicas, gays, bissexuais e transexuais (LGBT), de dois cenários distintos, e sua relação com a sexualidade desses indivíduos. **Método:** pesquisa quantitativa, mediante análise estatística, realizada entre os anos de 2016 a 2018, e que aplicou o Inventário de Depressão de Beck - II (BDI- II) do Hospital Uiversitário Gaffrée e Guinle (HUGG) e na Escola de Enfermagem Alfredo Pinto (EEAP), ambos localizados no município do Rio de Janeiro. Participaram 76 pessoas. A pesquisa foi aprovada por Comitê de Ética. **Resultados:** No HUGG foi observado indicativo de depressão mínima. Na EEAP, foi observado indicativo de depressão moderada. As disparidades podem ser justificadas pela diferença de idade, os impactos do processo de disclosure e estigmas do portador de HIV. **Conclusão:** observou-se que a família é fundamental na saúde mental entre LGBT e que é necessário mais pesquisas sobre o tema.
Descritores: Sexualidade; minorias sexuais e de gênero; depressão; saúde mental.

RESUMEN
Objetivo: analizar la incidencia de sintomatología depresiva entre lesbianas, gays, bisexuales y transexuales (LGBT), en dos escenarios distintos, y la relación de esos individuos con su sexualidad. **Método:** investigación cuantitativa por medio de un análisis estadístico, realizada entre 2016 y 2018, con la aplicación del Inventario de Depresión de Beck-II (BDI-II) del Hospital Universitario Gaffrée e Guinle (HUGG) y en la Escuela de Enfermería Alfredo Pinto (EEAP), ambos ubicados en la ciudad de Río de Janeiro. Participaron 76 personas en total. La investigación fue aprobada por el Comité de Ética. **Resultados:** En el HUGG, se observó un indicativo de depresión mínima. En la EEAP, se observó un indicativo de depresión moderada. Las disparidades pueden estar justificadas por las diferencias de edad, los impactos del proceso de divulgación y los estigmas del portador del VIH. **Conclusión:** Se observó que la familia es fundamental para la salud mental LGBT y que hace falta más investigación sobre dicho tema.
Descriptores: Sexualidad; minorías sexuales y de género; depresíon; salud mental.

INTRODUCTION

Depression is a disease increasingly present in contemporary society. In 2017, the World Health Organization (WHO) stated that more than 300 million people live with depression and also pointed out an increase of 18% between 2005 and 2015[1].

Due to the contemporary lifestyle, guided by capitalism and the pursuit of personal growth governed by the principle of meritocracy, the population is being subjected to higher stress burden by an increasingly accelerated routine, which reduces relaxing time and self-care of the individuals. Thus, vulnerability to mental disorders increases, including depression and the onset of its symptoms[2].

Depression is a common mental disorder, which has among its main characteristics continuing sadness, depressive mood, and reduction of the capacity to feel pleasure in activities previously considered pleasant. Discouragement or a feeling of losing energy, social withdrawal, and apathy are also common symptoms, with the possibility of evolution into thoughts and even attempts to self-harm and suicide[3].

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Its causes are divided into three categories: biological, genetic and psychosocial. The biological factors are sustained by chemical changes in the affected individual's brain, specifically neurotransmitters and receptors[4]. As for the genetic factor, there are psychiatric studies that show a higher frequency of this disorder in certain families[5] and that the risk for first-degree relatives of depressive individuals is two or three times higher[6]. The psychosocial factors, on the other hand, are related to the way a person perceives and interprets life's events, how they deal with their feelings and especially the stress of social pressure[4].

Allied to this, we focus on the lesbian, gay, bisexual and transgender (LGBT) population, which, due to behaviors that differ from the social convention of the majority, i.e., heteronormativity, is affected by public displays of prejudice; physical, verbal and/or psychological aggression, and having their rights violated, among others. Thus, the Report on LGBTFobic Violence and the Report on Homophobic Violence in Brazil, a Federal Government's initiative, released systematic data in the country. In 2012, the Human Rights Direct Line (Dial 100) received 3,031 complaints, in 2013 the violent incidents in this population generated 1,906 victims; finally, there were 21,060 violations between 2011 and 2016[7,8].

Brazil has one of the highest rates of violence against LGBT individuals in the world, and these cases are often treated with neglect and impunity[9]. Such a scenario generates intense psychosocial suffering, resulting from an anxiogenic social atmosphere, which often results in internal conflicts, anguish, and insecurity, leaving the LGBT population more likely to manifest depressive symptoms[10].

Therefore, this research aims to analyze the depressive symptomatology incidence among LGBT individuals from two distinct scenarios, and its relation to the sexuality of the participants.

LITERATURE REVIEW

The study was based on the National Integral Health Policy for Lesbians, Gays, Bisexuals, Transvestites, and Transgenders (LGBT) within the Unified Health System (*Sistema Único de Saúde*, SUS). The title was chosen because it marks a significant national advance and one of the main Brazilian government documents that serves this population[11]. We highlight what is mentioned in the Specific Objectives section of this Policy, in item XX, which intends "to reduce the problems related to mental health, drug addiction, alcoholism, depression, and suicide among lesbians, gays, bisexuals, transvestites and transgenders, acting in the prevention, promotion and health recuperation"[12:21], since the data obtained may contribute to the direction of actions aimed at this population.

We understand that the origin of this prejudice against LGBT individuals in Brazil is related to the moral and religious bases upon which the country was built. This structure maintained until nowadays, reflects in this population as oppression, frustration, self-shame, low self-esteem, among others, promoting the sickening process of these individuals[9].

Although there are constitutional developments aimed at ensuring health and its access to the LGBT population, the social stigma cannot be ignored, especially in their social relationships, like family and health services[13]. As for the latter, there is a resistance from these users to access such devices, as they feel insecure and afraid to express their sexuality, due to the social fear and unpreparedness of the professionals in dealing with the specific issues inherent in this group. It is good to emphasize that this theme is scarcely treated in the health workers training, who are also culturally and historically crossed by the heteronormativity[14]. Therefore, the challenge lies in modifying this scenario, so that the concepts of universality, integrality, and equity are embraced.

It is important to define some terms, such as sex and gender. Sex is defined at birth by organic factors such as the sexual organ. Gender is a socially acquired characteristic based on behaviors and aspects socially assigned to each biological sex, thus being a personal classification of identity. This identification may or may not be consistent with the expression assigned to one's gender of birth, which is based on sex. When the sex-gender dyad is concordant, we call the individual cisgender; when it differs, we have the term transgender. Transsexual is a generic term for transgender people[15].

It is important to remember that these roles are not only a biological process but also a result of the socio-cultural environment and that, in the case of our heteronormative mode of society, any disparity that is not within the dual and morally accepted standard of "man" and "woman" is seen as an abnormal and even pathological condition[14].

Sexual orientation, on the other hand, refers to an individual's sexual-affective attraction. It is governed by gender, and not by sex. Thus, when it is an attraction to the opposite gender, it is classified as heterosexual; when to the same, homosexual; when it is to both, bisexual. We still have the term asexual for people who are not attracted to either gender[15].

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METHODOLOGY

The present study is a quantitative, descriptive and exploratory research. The research took place between September 2016 and September 2018 and in two scenarios: an Immunology Outpatient Clinic of the Gaffrée and Guinle University Hospital, located in the city of Rio de Janeiro (Scenario I), and at the Alfredo Pinto Nursing School (Scenario II). This choice was made because of their convenience and proximity, and the presence of the study target population in both locations empirically observed.

As an inclusion criterion, it was established that the participants had to be 18 years old or older and self-identified as members of the LGBT population. Such correspondence was given in the presentation of the research to the candidates when the objectives were explained and participation was proposed. As an exclusion criterion, it was established that it would be the individual who self-declared to be an exclusively heterosexual-oriented cisgender.

In all, 78 subjects were interviewed: 14 from Scenario I, and 64 from Scenario II. In the latter, however, two were not accounted for, as both called themselves exclusively heterosexual-oriented cisgenders.

First, with the invitation to participate, the study was presented along with the Free and Informed Consent Form, clarifying the candidates about the study and their role in it. Those who accepted were given instruments with their respective fill in guidelines.

The first was the Subject's Contextualization Inventory *(Inventário de Contextualização do Sujeito*, ICS), which was applied to obtain basic information for the analysis, such as the individual's sexual orientation. The Kinsey Scale was used, a seven-level table designed to classify more specifically and flexibly human sexual orientation. The levels are the following: exclusively heterosexual; predominantly heterosexual, having only incidentally homosexual relations; predominantly heterosexual, but having more than incidentally homosexual relations; bisexual; predominantly homosexual, having only incidentally heterosexual relations; predominantly homosexual, but having more than incidentally heterosexual relations; exclusively homosexual[16].

The second instrument was the Portuguese-translated version of the Beck Depression Inventory-II (BDI-II), to identify symptoms of depression. BDI-II consists of a 21-item questionnaire with different alternatives that correspond to the classifications given in increasing order of severity. The questions have answers ranging from 0 to 3. By summing the values of the chosen options, it is possible to obtain the total, which is classified this way: minimal (from 0 to 13 points), mild (from 14 to 19 points), moderate (from 20 to 28 points) and severe (from 29 to 63 points)[17].

Data analysis was performed by the quantification found in BDI-II, related to the respondents' profile, collected from the ICS. For the treatment of these elements, the statistical analysis was applied, with calculations of absolute and percentage frequency and of central tendency measures.

Numbers were adopted to identify the respondents, in order of participation, separated by scenarios, so that their identities were not exposed.

The project was submitted to the Research Ethics Committee of the Federal University of the State of Rio de Janeiro's and approved under Opinion No. 1,672,502, according to Resolution No. 466/2012 of the National Health Council, which regulates research involving human beings. Confidentiality regarding the research participants' identification was maintained in all the phases of the study.

RESULTS AND DISCUSSION

A total of 78 study participants were obtained, of which 14 were from Scenario I and 64 from Scenario II. However, only 76 were accounted for, since two individuals met the exclusion criteria.

Scenario I

From the 14 participants, we obtained all cisgender individuals. The age group varied between 28 and 52 years old, with a mean age of 39, a median of 40.5 and a mode of 30.

Due to the characteristic of this scenario, 12 (85.7%) respondents were Human Immunodeficiency Virus (HIV) carriers.

Regarding sexual orientation[16], the majority, 10 (71.4%), self-declare exclusively homosexuals, as shown in Table 1.

When they were asked about discrimination/disrespect feelings concerning their sexual orientation/gender expression, five options were presented: always; frequently; sometimes; rarely; never. To this question, only 4 (28.6%) respondents of the sample reported “never” having experienced this feeling. However, the sentiment is still present in a considerable number, 10 (71.4%). This result is pertinent, as the long-term exposure to discriminatory and disrespectful feelings was identified as the highest contributor to the disparity in the prevalence of injuries in the mental health of the LGBT population when compared to individuals within the heteronormativity[15].

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TABLE 1: Distribution of LGBT individuals from Scenario I by sexual orientation. Rio de Janeiro - Brazil, 2018. (n=14)

Sexual orientation	f (%)
Exclusively heterosexual	-
Predominantly heterosexual, having only incidentally homosexual relations	-
Predominantly heterosexual, having more than incidentally homosexual relations	2(14.2)
Bisexual	1(7.1)
Predominantly homosexual, having only incidentally heterosexual relations	-
Predominantly homosexual, having more than incidentally heterosexual relations	1(7.1)
Exclusively homosexual	10(71.4)

Regarding the feeling of sadness due to life experiences concerning the sexual orientation/gender expression, 13 (92.9%) answered they do not feel it.

It is important to highlight that the only participant who answered this question affirmatively, justified their sadness triggered by the prejudice experienced in daily life, not because of their sexual orientation/gender expression, but for being an HIV carrier and, therefore, suffering the stigma.

This grievance is still marked by the prejudice linked to the LGBT population in association with negative faces such as mortality and fear. This HIV and LGBT correlation is historical, as from the beginning of the Acquired Immune Deficiency Syndrome (AIDS) pandemic, in the 1980s, there has been an expressive number of cases in this group[18].

In the results obtained from the second instrument, BDI – II, we had a mean score of 11.2 (minimum), a median of 11.5 (minimum) and mode of 10 (minimum).

Although gay and bisexual men are twice as likely to be diagnosed with depression as heterosexual men[15], the data showed scores with a predominance of minimal and mild depressive symptoms, 13 (92.9%) and 1 (7.1%) moderate. These numbers are consistent with those presented in the question about feelings of sadness due to life experiences related to sexual orientation/gender expression, where only 1 (7.1%) of the respondents reports the feeling and yet the major discomfort is caused by a disease stigma rather than their sexuality. As an example, we can cite public figures who experienced HIV and were stigmatized and labeled for their association with non-heteronormativity, such as singers and songwriters Cazuza and Freddie Mercury[18].

In addition, the values are justifiable if analyzed in conjunction with the fact that 12 (85.7%) of these respondents are HIV positive, which is in line with Reed's Theory of Self-transcendence. In this theory, Reed states that self-transcendence is a developmental capacity that becomes evident in situations that confront a person with their personal mortality, through health experiences such as aging, illness, and loss, facilitating well-being at times when a person experiences vulnerability or is trying to overcome a difficulty[19].

Scenario II

Of the 62 counted participants, 60 (92.8%) were identified as cisgenders and 2 (3.2%) as transgenders. The age group ranged from 19 to 50 years old, with a mean age of 23.6 years old; a median of 23 and mode of 22. Here a population mainly composed of young adults can be perceived.

Of this sample, only 11 (17.7%) reported having some kind of chronic disease, such as systemic arterial hypertension and lupus, for example.

Concerning sexual orientation[16], the majority, 28 (45.1%), understand themselves as bisexual, followed by exclusively homosexual: 15 (24.1%) of the respondents, according to Table 2.

As for the feeling of discrimination/disrespect regarding their sexual orientation/gender expression, 59 (95.2%) reported the feeling on a larger or smaller scale. Such number stands out as alarming, since the frequent exposure to discrimination, disrespect, and many ways and levels of aggression are factors that affect negatively these individuals' mental health, increasing the risks of anxiety, depressive symptoms, substance abuse, self-harm and suicide[20].

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TABLE 2: Distribution of LGBT individuals from Scenario II by sexual orientation. Rio de Janeiro - Brazil, 2018. (n=62)

Sexual orientation	f (%)
Exclusively heterosexual	1(1.6)
Predominantly heterosexual, having only incidentally homosexual relations	2(3.2)
Predominantly heterosexual, having more than incidentally homosexual relations	1(1.6)
Bisexual	28(45.1)
Predominantly homosexual, having only incidentally heterosexual relations	14(22.5)
Predominantly homosexual, having more than incidentally heterosexual relations	1(1.6)
Exclusively homosexual	15(24.1)

As for sadness due to life experiences related to the orientation/gender expression, 39 (62.9%) individuals confirmed they feel it, either due to the discrimination suffered or to a feeling of non-acceptance from society. The moral values of a society infer in the right of the individual to liberty of expression. At the current juncture, the "stress of the minorities", an expression that defines the main stressor of a particular social minority group, is mainly based on hiding their sexuality and gender. This stressor stems, for example, from fear of violent manifestations of LGBTphobia[9].

In the questionnaire, of those who answered affirmatively, 23 (59%) related sadness with family issues, for not feeling safe to express their sexuality, due to the fear of reprisals. Many times, this situation is manifested by an implicit oppression in this environment, illustrated by homophobic and religious speeches, crossed by the family's power relationship over the subject, still dependent on its support.

The development of the young individuals' biopsychosocial health within the family dynamics is inferred by each member; in a situation when this individual feels excludes for not meeting the socially established standards, the bonds among them get fragile, being a risk factor for multi-axial grievances[13]. Family rejection has been shown to be an aggravating factor for depression and suicide attempts. On the other hand, support is seen as protector of these factors rather than as support from cause fellows or other important people[21].

Corroborating this fact, there are the results obtained from BDI-II score with mean of 22.5 (moderate), a median of 22 (moderate) and mode of 30 (severe). We identified that 22 (35.4%) respondents presented the severe symptomatology, which is the level with the highest incidence, as shown in Table 3.

TABLE 3: Distribution of LGBT individuals from Scenario II, according to the classification of BDI-II, Rio de Janeiro - Brazil, 2018. (n=62)

CLASSIFICATION IN BDI-II	f (%)
Minimum	14 (22.5)
Mild	13 (20.9)
Moderate	13 (20.9)
Severe	22 (35.4)

Given the importance of the family to the mental health of the young LGBT members', the impact on the mental health of this group is explained, where of the 23 (59%) participants that justified the family as a source of sadness, more than half, 12 (52.2%), present the "severe" classification.

The data are worrying, as of the 35 (56.4%) participants classified as moderate and severe, 23 (65.7%) also reported not looking for a health service to support these issues. In this context, the SUS recognizes the demand specificities of this group but understands the challenges of formulating universal access measures based on equity[14], which may interfere in the lack of health support reported by the respondents.

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Disparities between the scenarios.

Among the scenarios studied, the data differ in some aspects. While in Scenario I the feeling of sadness regarding the sexual orientation/gender expression was exposed by only 1 (7.1%) of the respondents, in Scenario II this is reversed, with a majority of 36 (62.9%) of the 62 respondents in this axis. Similarly, the frequency of the feeling of discrimination/disrespect follows, where in Scenario I, 9 (64.3%) respondents answered "never" and "rarely", compared to only 16 (25.8%) of the same answers in Scenario II.

As already mentioned, long-term exposure to feelings of discrimination/disrespect increases the risk of mental health damage[15]. Thus, we can see a higher risk for the participants of Scenario II, due to a higher prevalence of reports of these feelings.

There are also scores obtained in the BDI-II. Scenario I presented milder results (mean classified as "minimum") when compared to Scenario II (mean classified as Moderate).

Still in this aspect, another disparity to be considered is each group's age. While in Scenario I the sample consisted of a more mature population, with a mean of 39.2 years old, in Scenario II we have a predominance of young individuals aged about 20 years old. Thinking that young adults may encounter related stressors when it comes to establishing their identity, building a professional carrier and achieving independence, when they are an integrating part of a minority these same young people encounter a major stress burden[22]. This can be translated as another warning signal regarding these individuals' mental health since variables such as prejudice display, lack of social and familial support, and victimization are factors associated with mental health issues in the LGBT population[23].

Moreover, it is also possible to relate it to the disclosure process, a term that means the moment of disclosure and manifestation of one's own sexuality in society[24]. Even though this process may expose a person to hostility and prejudice from others, it represents the individual's positive relationship with themselves, and this has been linked to positive health results[21].

It is also highlighted that disclosure fortifies the ties within the LGBT group, which usually feel more comfortable expressing themselves in front of those with whom they share the same particularities[24], establishing their identity, which is directly related to the feeling of being part of a group. This leads to mutual support bonds, social connections and a sense of belonging, alleviating the negative effects of the stress suffered due to discrimination[22].

This statement is relevant since poor social support, with disconnection and low sense of community belonging, leads to loneliness and is related to damage to the physical and mental health of this group[25].

For clarity in justifying the differences observed, let us return to Scenario I. This is a more mature group, with only 5 (35.7%) participants still living with parents/relatives, indicating a population that has already reached certain levels of independence and overcame the various stressors of youth. This is in line with Reed's Theory of Self-transcendence. It states that self-transcendence is a developmental capacity that becomes evident in limit/extreme experiences, portraying a change that occurs in the person and the context surrounding them[26]. HIV - present in 12 (85.7%) participants of the sample - added to the stigma of this condition[27], when related to the milder scores obtained in the BDI-II, indicates the influence of the vulnerability, self-transcendence and well-being triad, supported by Reed.

CONCLUSION

The LGBT population has a vulnerability regarding mental health issues. Frequent exposure to discrimination and disrespect added to the expectation of rejection and the need to conceal their identity negatively impacts these individuals' mental health. Results of this were mainly exposed in Scenario II, where the mean obtained among the participants was classified as moderate, according to BDI-II.

However, disparities were found between the groups. They may be justified by the participants' age difference in the scenarios, where Scenario I presents a more mature and independent population compared to the second. This inference is defended by what is stated in Reed's Theory of Self-transcendence when considering that the participants in Scenario I have already had stressful experiences typical of youth. Besides, the fact that most of them are HIV carriers, a chronic and yet unhealable problem, collaborates with the above theory. In fact, such frequency and the absence of larger numbers for analysis is a result of the available scenario, pointing out a limitation of the study.

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The family is a decisive factor, since most of the participants studied in Scenario II live with parents/relatives. The relevance of the family is expressive also appearing in the justifications of sadness experienced by more than half of the participants. Of these, there was a predominance of severe classification in BDI-II.

Also, the disclosure process represents a positive relationship between the person and their own sexuality, and this has been associated with positive mental health outcomes. Assuming their identity strengthens the bonds within the LGBT community itself, which is usually more comfortable expressing themselves in front of those with whom they share such particularities.

Finally, this research highlighted the need for further studies on the LGBT population's mental health and on their relationships with family and society, in order to elucidate the negative impact that the non-acceptance of the differences have on these individuals and thus highlight the ways to fight it.

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