Stigma, Vulnerability, and Resilience: The Psychosocial Health of Sexual Minority and Gender Diverse People in Canada

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This special edition of the *Canadian Journal of Community Mental Health* features a range of contributions that explore the mental health of "sexual and gender minorities," a term that encompasses people who identify as gay, lesbian, bisexual, transsexual, transgender, Two-spirited, queer, and questioning (LGBTQ people), as well as people who would choose other labels (or no labels) but whose sexual attractions or behaviours, gender identity or gender expression diverges from the heteronormative models that dominate most social contexts in Canada. From a sociological perspective, this minority status is not due primarily to the size of the population or its various sub-groups, but from the stigma they are assigned because of their sexual orientation or their gender identity. Despite relatively recent legislative victories, such as access to marriage for same-sex couples, the individuals and groups who make up sexual and gender minorities continue to be marginalized, which impedes their full participation as citizens (Fraser, 2005).

From a mental health perspective, LGBTQ people can be considered a vulnerable population. Several studies in the past decade have documented mental health inequities compared to their heterosexual peers, such as higher rates of depression, anxiety, alcoholism, problem substance use, and suicidality, whether among adults (Julien and Chartrand, 2005) or among adolescents (for a review, see Saewyc, 2011). It has been theorized that sexual and gender minorities face these inequities because of the extent they are targeted for stigma, marginalization, and discrimination throughout society, i.e., minority stress theory, which was first developed by Brooks in 1981 in research with lesbian women, then extended by Meyer in 2003 in research with gay and bisexual men, and expanded by Hatzenbuehler in 2009. However, there are relatively fewer Canadian studies connecting theory and evidence, empirically linking that stigma and discrimination with mental health.

In a recently published report (Institute of Medicine [IOM], 2011), a committee of U.S.-based experts were tasked with listing the issues and research needs with regard to the health of sexual and gender minorities. They highlighted the need for more research that better reflects the diversity of individuals and groups who are included under the term "sexual minorities." For a number of reasons, notably the need to respond

to the early years of the HIV epidemic, the majority of research has focused on men who have sex with men (MSM), or primarily gay men. There has been less attention paid to issues for sexual minority women, transgender people, bisexual men, or diverse groups within these wider categories, such as those from rural vs. urban areas, different ethnocultural groups, immigrants, or those with disabilities. We require dynamic approaches that take individual and collective agency into consideration, in order to understand not only victimization but resilience factors, whether those are personal traits, behavioural strategies, supportive relationships, or the various policies, measures and resources communities engage to prevent or counter discrimination toward sexual and gender minorities.

The IOM report (2011) suggested four approaches to exploring the multiplicity of individual identities and contexts, as well as their interactions, which influence all the dimensions of health. In addition to *the minority stress model*, described above, they also identified *the life-course perspective*, which situates events, experiences and individual decisions at the centre of a trajectory, itself embedded within a life situation and a historical context; *the intersectional perspective*, which focuses on the multiplicity of social identities that individuals may claim, or that are imposed upon them, which trace back to entrenched logics of oppression, intersections of gender, class, race, ethnicity, geographic location, disability, etc.; and finally, *the social ecology perspective*, which asks us to take into account the full range of health determinants at various levels: individual, relational, community and societal. The complementary nature of these approaches makes it possible to pinpoint our existing knowledge and our knowledge gaps, and to orient future research with a better accounting for diversity, complexity and dynamic interaction between stigma and resilience processes that affect the mental health of sexual and gender minorities.

This special issue has dual goals: we aim to present recent research, primarily from Canada, in the field of LGBTQ mental health, but more importantly, to broaden our understanding of sexual and gender minorities, and complexify our approaches to studying the mental health inequities of marginalized groups. The ten contributions included here present original results of nine studies: two Canada-wide studies using online survey technology, three carried out at the provincial level (the BC Adolescent Health Survey in British Columbia, the Trans PULSE Project in Ontario, and "Homophobie en milieu scolaire" in Québec), and two municipal-level studies (in Montréal and Toronto), as well as a study carried out in France with a sample of young gays and lesbians. The balance of language (seven articles in English and three in French) reflects the geographical origin of the studies, except for one bilingual online Canadian study, on the use of the internet for health purposes by sexual and gender minorities, whose results are presented in English. The diversity of topics, sophistication of methods, populations studied, and the size of samples used in the quantitative studies, are all signs of the sustained growth of this field of research across Canada.

The papers in this special issue deal with populations at various stages of the life course—from early adolescence, to youth, adulthood, and aging—and examine processes of victimization and of resilience, as well as risk and protective factors specific to these age groups. Most of these papers incorporate intersectional perspectives, focused on an ethnocultural sexual minority adolescent group, for example, or exploring gendered differences in mental health and discrimination experiences. Some focus on the mental health issues in specific populations that are too often left out of research, or folded into other sub-groups: depression among transgender people, distinguishing between trans men (FtM) and trans women (MtF) in Ontario, or differentiating health issues between Canadian gay and bisexual men.

While it is important to improve our understanding of the mental health issues of these diverse groups, it is also important to identify innovative practices for mental health promotion, or social and health services adapted to the needs of sexual and gender minorities. Only one article in this special issue looks explicitly at mental health work, focused on professionals who provide services tailored to sexual and gender minorities in the greater Toronto area, identifying the systemic barriers that impede access to appropriate mental health services and proposing avenues for systems-level interventions. There is far too little evaluative research on policies, programs, and intervention measures to address the mental health of sexual and gender minorities. All of the articles in this issue suggested intervention approaches, however, with a view to preventing or reducing various forms of social stigma and mitigating their negative impacts, while taking into account the particularities of the populations and situations under investigation and their environmental contexts.

If we wish to support young people dealing with the stigmatization of their sexual orientation or gender identity, it is crucial that we analyze not only the difficulties they face, but also the resilience processes among those who manage to surmount those difficulties—which are the majority of sexual minority and gender diverse youth. After first reminding us of the endemic nature of homophobia in schools and of its consequences on the mental health of LGBTQ adolescents, Petit and colleagues employ qualitative approaches to discern the factors that some sixty young people feel have helped them in their lives.

The article by Charbonnier and Graziani extends beyond adolescence and beyond school, to focus on family relationships. They examine the relationship between parents' attitudes after their children come out, as perceived by young gays and lesbians aged 18 to 25, and the young people's suicidal ideation and suicide attempts, their worries, and their relationship difficulties.

In a study of mental health among youth defined as belonging to a double minority—sexual and ethnocultural—Poon and colleagues examine the links between sexual orientation, experiences of victimization at school, the use of alcohol and other illicit substances, negative social consequences resulting from that substance use, and protective factors that reduce the odds of those problems in a sample of more than 5,000 secondary students of Asian origin in British Columbia, a province where a quarter of the population is made up of visible minorities.

The research on vulnerability of sexual minority youth often focuses on suicide risk as a health challenge, but more rarely do we think of teen pregnancy involvement, a risk that is paradoxically higher for these youth than for heterosexual youth. To explain this situation and suggest intervention strategies that reflect the perspectives of queer youth, Travers, Newton and Munro spoke with youth, who described the overall effects of homophobia and heterosexism that are present in all social spheres—observations that should serve as a call to action to youth health and education program designers.

Beyond adolescence and young adulthood, Morrison presents results from one of the first online Canadian studies linking discrimination with psychological health in a sample of gays and lesbians. Using the Meyer model, the study explores relationships between reported experiences of discrimination and mental health indicators, with a gender-based analysis. These observations confirm the need to design measures and carry out analyses that are sensitive to gender differences.

Many of the studies conducted up to this point in Canada have not made distinctions between gay and bisexual men, in part because of limitations in sampling, although studies elsewhere suggest there may be

different levels of exposures and different health concerns. Using data gathered in a recent pan-Canadian online survey regarding health-related uses of the Internet, with 500 bisexual men and about twice that number of gay men, Engler and colleagues created differentiated profiles of the health concerns of each group in the social, sexual and psychological realms.

Two papers in this special issue present the results of the largest Canadian study to date with transgender people, the Ontario-based Trans PULSE study. The two articles echo one another in taking up the same objectives, that of estimating the prevalence of depression in a sample of 205 trans men and 186 trans women, exploring potential risk and protective factors. This study, doubly innovative in terms of its methodology, used a multi-phase community-based research approach that relied on respondent-driven sampling, a method developed for the recruitment of hidden populations. The community contribution was central to every step of the research design, from establishing a list of factors potentially associated with depression by calling on the experience of the trans members of the research team to drawing on interpersonal networks to recruit participants while introducing corrective measures to avoid the effects of homogenization that occur in the traditional snowball sampling method. In these two papers, Rotondi, Bauer and their colleagues draw two distinct portraits for trans men and trans women.

An article by Wallach illustrates the need to pay attention to the health of aging HIV-positive people, as the improved treatments have transformed the illness into a chronic condition, and thus the number of elderly people living with HIV are increasing in number. Drawing from a sub-sample of interviews carried out for a larger study, the researcher looks at resilience and coping mechanisms among men who are potentially facing the triple stigmatization of homosexuality, HIV-positive status and aging.

The observation of disparities relative to the mental health of sexual and gender minorities in comparison to the rest of the population highlights the need to provide appropriate and accessible mental health services, as with other minorities. McIntyre and colleagues investigate the systemic barriers that limit or prevent access to appropriately targeted mental health services through interviews with service providers in the Toronto region. This article enriches the existing body of work, which until now has been focused on barriers to general health services, and not specifically on barriers to mental health services.

We hope that the articles published here will inspire deeper thinking and further research about the mental health of diverse sexual and gender minority populations. We also hope the knowledge will support mobilization and action among the many individuals and organizations who are fighting for full social equality for sexual and gender minorities, to reduce stigma and vulnerability, and promote resilience and mental health.

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