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Citation: Garcia, C., Grant, E., Treharne, G. J., Arahanga-Doyle, H., Lucassen, M. F. G., Scarf, D., Taumoepeau, M., Veale, J. & Rapsey, C. (2023). 'Is it worth potentially dealing with someone who won't get it?': LGBTQA+ university students' perspectives on mental health care. *Journal of the Royal Society of New Zealand*, pp. 1-15. doi: 10.1080/03036758.2023.2235297

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Link to published version: <https://doi.org/10.1080/03036758.2023.2235297>

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To cite this article: Claudia Garcia, Eddy Grant, Gareth J. Treharne, Hitaua Arahanga-Doyle, Mathijs F. G. Lucassen, Damian Scarf, Mele Taumoepeau, Jaimie Veale & Charlene Rapsey (2023): 'Is it worth potentially dealing with someone who won't get it?': LGBTQA+ university students' perspectives on mental health care, Journal of the Royal Society of New Zealand, DOI: [10.1080/03036758.2023.2235297](https://doi.org/10.1080/03036758.2023.2235297)

To link to this article: <https://doi.org/10.1080/03036758.2023.2235297>



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Published online: 16 Jul 2023.



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'Is it worth potentially dealing with someone who won't get it?': LGBTQA+ university students' perspectives on mental health care

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ABSTRACT

LGBTQA+ university students have unique mental health needs and high rates of mental distress compared to their cisgender heterosexual peers; however, it is likely that many LGBTQA+ individuals remain untreated or receive inappropriate or insensitive care. The aim of this study was to explore the experiences and preferences in mental health care of LGBTQA+ university students in Aotearoa New Zealand. Twenty-eight young adults participated across 12 focus groups or interviews in which they were asked about their experiences and preferences. We used thematic analysis to identify patterns of meaning in the data. Researchers developed three themes of 'I can do this on my own, but others should seek help; you have to be lucky to access mental health care; and 'therapists just need to be a bit more like up with the programme'. The results of this study mirror those found in more general studies of LGBTQA+ mental healthcare experiences, however, also adds to considerations for university campus healthcare services. The findings of this study should be considered by all mental health providers working with LGBTQA+ young adult university students.

ARTICLE HISTORY

Received 3 March 2023


Accepted 5 July 2023

KEYWORDS

Mental health care; student; education; LGBT; queer; healthcare; qualitative

Introduction

Young adults who are lesbian, gay, bisexual, transgender/trans, queer, asexual and others diverse in terms of their sexuality and gender (LGBTQA+) likely comprise a large part of the university student population, with almost a quarter of the LGBTQA+ population in Aotearoa New Zealand aged between 18 and 24 years old (Stats NZ 2021). According to cross-national epidemiological studies, LGBTQA+ university students report higher rates of mental disorder and distress compared to their cisgender heterosexual peers (Kerr et al. 2014; Mortier et al. 2018; Rentería et al. 2020; Gmelin et al. 2022). LGBTQA

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+ students often report minority stressors such as on-campus verbal and physical victimisation, discrimination, misgendering, and interpersonal and structural microaggressions (Treharne et al. 2016; Goldberg et al. 2019; Allen et al. 2020; Garcia et al. 2022). In every country, LGBTQA+ university students likely have unique mental health needs in response to the effects of minority stressors in differing social contexts, yet there has been little investigation of LGBTQA+ university students in Aotearoa New Zealand.

Additionally, LGBTQA+ university students may experience minority-related stressors with few stable support networks to buffer them (Christie 2021). When minority stress overwhelms an individual's ability to cope, it can lead to the development of psychological distress (Brooks 1981; Hatzenbuehler 2009; Hendricks and Testa 2012; Meyer and Frost 2013; Riggs and Treharne 2017; Feinstein 2020; Tan et al. 2020). In health care settings, negative interactions with providers are related to increased experiences of minority stress (Neville and Henrickson 2006; Baldwin et al. 2018; Treharne et al. 2022), however, increased exposure to minority stress may also heighten sensitivity to discrimination (Cronin et al. 2021b).

LGBTQA+ university students and youth, compared to cisgender heterosexual peers, are more likely to utilise mental health services (Dunbar et al. 2017; Baams et al. 2018; Bruffaerts et al. 2019) and to have previously engaged with a mental healthcare provider¹ (Lucassen et al. 2011; Bartholomew et al. 2019). However, these higher rates of engagement may be driven by higher rates of mental distress in LGBTQA+ populations (Mortier et al. 2018) and so many individuals may remain untreated. One survey of LGB Australians found that only 18.2% of those reporting current distress had accessed mental health services in the past month (Cronin et al. 2021a). Similarly, only 16.4% of university students with 12-month mental disorders receive any 12-month mental health treatment (Auerbach et al. 2016).

LGBTQA+ students face multiple barriers to accessing mental health care (Cronin et al. 2021a). University students often find it difficult to schedule regular appointments, deprioritise self-care and are unaware of available resources (Davis et al. 2021). Fewer financial resources also limit students' ability to pay for private or extended periods of care (Horwitz et al. 2020), with LGBTQA+ populations tending to have lower disposable incomes than cisgender heterosexual populations (Stats NZ 2021). Minority stressors can additionally undermine one's ability to seek help (Hatzenbuehler 2009), with LGBTQA+ young adults often perceiving mental health settings as embedded in heteronormative and cisnormative contexts (Fraser 2020).

Tailored interventions with positive therapeutic outcomes during one's university education can prevent psychological difficulties from worsening and becoming chronic (Gibb et al. 2010; McGorry et al. 2011; Bruffaerts et al. 2018; McGorry and Mei 2018). Understanding LGBTQA+ university students' perspectives is vital for informing mental health providers' work with LGBTQA+ students. As part of a larger study seeking to adapt an online mental health intervention for LGBTQA+ university students, we explored mental health care experiences, perceived challenges and strengths, and suggestions on changing an existing mental health intervention. Only results relevant to mental health care experiences are reported here.

Method

Data were collected and analysed using Braun and Clarke's (2006, 2021) guidelines to reflexive thematic analysis. We used an inductive critical realist-contextualist approach,

in order to be primarily driven by the data and to assert that participants have differing accounts of reality due to contextual factors and social positioning, while acknowledging that interpretation is not devoid of researcher influence (Braun and Clarke 2021). We coded from a mostly semantic and experiential orientation, which focuses on more surface level meaning and experience, framing language as a tool for communicating meaning and offering a window into the psychological world of participants (Braun and Clarke 2021). This approach aligns with the field of clinical psychology (the first author's field of study) and other mental health professions (the intended audience of this paper). Staying close to the lived experiences of participants allows us to address the larger study's research aim of adapting an online mental health intervention.

This study was granted ethical approval by the Ethics Committee of the institution where the research was conducted [reference H21/100].

Recruitment

We aimed to recruit LGBTQA+ university students aged 16–25 years old. Participants had to self-identify as LGBTQA+ and be able to attend an in-person session at a predetermined time at a university office. The study was advertised by way of posters distributed in high-traffic areas of campus and shared on social media to relevant groups and organisations. Once recruited, participants were encouraged to snowball sample. Sixty-eight individuals expressed interest in participating, and the final sample size was 28 participants, with the main reason for non-participation being scheduling conflicts or residing outside of the study location.

Focus group and interview procedure

The overarching aim was to explore the experiences of LGBTQA+ university students in order to adapt an online mental health intervention for this population. CG facilitated all focus groups and interviews. To build rapport with participants, CG introduced herself as a doctoral student, clinical psychology trainee, and identified as cisgender, queer, bisexual, and Pākehā (New Zealand European)/Mexican. CG described the rationale of the study to the participants, asked them to read the information sheet, sign the consent form if they agreed to proceed, and fill out a demographic questionnaire. Within the questionnaire, participants were asked to write-in a pseudonym to illustrate their quotes. Those who did not indicate a pseudonym were assigned one by CG, from a list of internet-generated gender-neutral names. Participants were given a \$30 NZD (\$19.90 USD) supermarket voucher to cover expenses associated with participation.

The participants were asked semi-structured, open-ended questions about their mental health care experiences, informed by the early World Health Organization World Mental Health International College Student qualitative interview protocol (Qualitative Working Group, personal communication, 2021). Questions included 'what might prevent you from getting mental health help, or what has prevented you from getting help in the past?', 'what might help you, or has helped you, to seek mental health help?', and 'if you were to, or when you did seek mental health help, what would you or did you look for in a therapist or service?' Questions were expanded

upon and clarified when necessary, and flexibility in the question order and phrasing was used to facilitate flow and participant understanding.

Data collection occurred between July and August of 2021, with each session lasting between 57 and 100 minutes ($M = 80.25$ minutes, 12 total sessions). Each participant completed one session each. Although we intended to conduct focus groups, some participants requested individual interviews, or interviews only alongside a partner or friend. As a result, there were three individual interviews, five dyadic interviews and four focus groups consisting of three or four people each. All interviews and focus groups were audio recorded and then transcribed verbatim, checked for accuracy and anonymised by CG. Quotes presented here were edited to omit repetitions and longwinded speech only when it does not alter meaning, indicated by ‘...’. Square brackets were used to add clarifying contextual information.

Participants

The 28 participants were aged 17–25 years old and self-reported 1–8 years of university education. Ten participants self-reported prior or current psychological diagnoses, such as depression, generalised anxiety disorder, or post-traumatic stress disorder. Sixteen participants self-reported prior engagement with mental health services, and their length of engagement ranged from seven weeks to 10 years.

Many of the participants reported more than one gender, sexuality and/or ethnicity in response to the open-ended demographic questions. Demographic responses were aggregated where possible to ensure participants could not be identified. Those who reported more than one gender, sexuality, or ethnicity that could be aggregated were recorded in all applicable categories, such as ‘trans masc/male’ being recorded in both ‘men/male’ and ‘transgender’ categories. For responses that could not be aggregated, we report participants descriptions verbatim. Regarding gender, 64% of participants reported being women/female, 21% as men/male, 14% as non-binary, 7% as transgender and 4% as another gender (e.g. ‘female (?)’). Regarding sexuality, 37% of participants reported being bisexual, 29% as lesbian, 25% as queer, 21% as gay, 18% as another sexuality (e.g. polyamorous, takatāpui², fluid and ‘just gay I think’), 14% as asexual spectrum (including demisexual) and 11% as pansexual. Regarding ethnicity, 71% of participants reported being NZ European/Pākehā, 14% as Asian, 14% as white other and 11% as Māori.

Data analysis

Two coders, CG and EG, analysed the data. EG was recruited as co-analyst to contribute to a more reflexive analysis with increased interpretative possibilities and perspectives (Berends and Johnston 2005). At the time of analysis, EG had experience in cross-cultural qualitative research and identified as non-binary, lesbian and Pākehā. Furthermore, the wider research team held a diverse range of identities, including trans, non-binary, cis-gender, lesbian, gay, bisexual, heterosexual, Māori, Pacific, Pākehā and British identities. Multiple team members had lived experience of being mental health service users.

CG and EG begun analysis by familiarising themselves with the data, independently reading the 12 transcripts and noting standout features. CG and EG then discussed a

third of the transcripts, noting whether early patterns were evident and any differing interpretations. CG and EG then independently assigned preliminary codes to a quarter of the transcripts, before discussing and integrating differences in interpretation. CG assigned codes to the remaining transcripts, with EG being consulted when required and performing random checks to ensure adherence to earlier coding decisions. Codes were then refined and organised, with preliminary themes and sub-themes also being identified in this stage. These themes and sub-themes were further refined by CG and EG using visual representation through thematic maps, sticky notes, in discussion with the other authors, and then upon revision of Braun and Clarke (2021). Early topic summaries were sent to all participants for review and feedback. Two individuals replied, both endorsing the summaries and with no suggested changes.

Results

Themes

We developed three themes from the data, relevant to participants' perspectives on mental healthcare. The following are descriptions of these themes, illustrated by quotations from the participants.

I can do this on my own, but others should seek help

Within the theme of I can do this on my own, but others should seek help, participants presented a contradiction in who 'should' be receiving mental health care. Participants framed the seeking of mental health care positively, with Brooklyn suggesting that 'everyone should try therapy at least once'. Participants asserted that everyone was deserving of care and that distressed individuals should seek support, yet simultaneously described previous experiences when they were struggling and did not seek help.

Participants evoked comparison between themselves and 'others' who they perceived as more legitimate, as 'there are people who really need it' (Cate). The division between participants and 'others' suggests that there is a particular population which mental health services are 'for', and for Hope, this took 'wait[ing] until you reach a crisis point to, before reaching out for professional support'. Only few participants recognised the contradiction of encouraging others to seek help while not seeking it for themselves, with Lucy describing how she can recognise her own self-stigmatising thoughts while others often cannot:

I know even when I'm having those thoughts of oh, like you're stupid for needing mental health care, I can be like hold on a minute, and step back and, like, you know everyone has those thoughts, it's not just me. People who don't necessarily have that education which is most people can't really get that perspective on it.

Participants described wanting to manage their mental health difficulties on their own, often believing they were not suffering 'enough' to meet a perceived threshold of needing external support. This idea was simultaneously paired with minimisation of their own difficulties, as articulated by Saffron:

I always second guess myself, like, 'oh this isn't like worth talking to someone about, like it's not serious enough' ... it will be fine in like a week or two, so I never really take my mental

health very seriously. Which means I don't really end up ever acting on it ... I don't feel like I'm ever bad enough to go and get the help.

Participants assumed that by seeking out mental health care, others who needed it 'more' were losing out: 'I feel like [service name] is far too overwhelmed for me to just kind of rock up and be like, 'I'd like to talk about how I'm sad' [laughs]' (Robin). Furthermore, in articulating a concern about limited resources, participants created a sense of mental health care being for 'them' rather than 'us', despite messaging from organisations encouraging people to seek help regardless of the magnitude of their difficulty:

The mental health foundation here, they've said ... 'no matter how big or small you think your challenge is, book [an appointment], it doesn't matter, like, people are there to support you' ... I've still had that second guessing, like 'oh it's not for me like I'm not as bad as other people, you know, it's something for others' (Saffron).

Regarding their mental health difficulties, some participants expected themselves to be independent and self-sufficient, echoing the 'just get on with it' (River) and 'she'll be right' attitude pervading Aotearoa New Zealand. This attitude implies that participants should be unconcerned about their mental health and just 'soldier through it' (Saffron). Further, this attitude encourages dismissal and suppression of emotions, which perpetuates non-seeking of mental health care.

Additionally, an attitude of self-sufficiency may be fostered within LGBTQA+ individuals out of necessity. Often, LGBTQA+ individuals must be self-sufficient and independent in multiple facets of their lives, in response to feared or actual social rejection for their identities. This self-sufficiency is articulated by Kate when describing helping a friend change his name:

There's no one who's really there to like help or support you with it, you just have to at 18 be able somehow to be your own advocate ... even if you have a friend, like I was there with him, but I was also an idiot 18-year-old, like I don't know what we're supposed to do if something goes wrong. Like we have no, no one's there to give us advice, or like what legal rights we have ... we just have to hope for the best.

However, participants were not completely self-sufficient regarding their mental health. Specifically, participants' LGBTQA+ friends could facilitate access to mental health care by normalising the process and providing recommendations of providers: 'having a friend that might have gone through counselling and stuff and they would know some good recommendations' (Tyler). These recommendations increased the 'chance of [therapy] turning out well' (Grace). By explaining the role of friends, participants highlighted the importance of others in bridging the divide between 'us' and 'them', by invoking a realisation that they may be the ones who require help, too:

... for me it was people around me going like, do you need this [mental health care] and [a] doctor telling me that it was time to look for help I guess. And me kind of realising, yeah, it's time to, to not let this, like, be a hole over me (Eden).

You have to be lucky to access mental health care

Within the theme of you have to be lucky to access mental health care, participants described a sense of luck in being able to access services. In describing this luck, participants framed access to mental health care as requiring multiple privileging factors, such

as psychological skills, knowledge, educational opportunities and knowledgeable friends. Two participants were explicitly aware of these factors, with Lucy articulating the life-changing privilege of gaining knowledge of funding options:

My knowledge of how to access that funding was, like, very helpful because I know a lot of people wouldn't know how to access that, or that they could access it, or what you can access it for, how to do the whole thing so, all of that knowledge was like a lot of privilege that I was bringing into it ... It's something that's really helped me. I didn't used to know about them until friends sort of introduced me, and that's, was like sort of revolutionary.

Similarly, Jasmine articulated how her chosen field of study made finding a suitable therapist easier:

Finding somebody that had it [queer identifying] listed on the website was just like, very hard, and it just happened that I knew of one [mental health provider], because of [educational background] so that really sped up that process but like if I'd just been looking through everybody's website that would have been a nightmare.

This knowledge also created a 'knowing' of the process of engaging with mental health providers. Knowledge removed the psychological barrier of the 'uncertainty of who you're talking to' (Thomas), therefore increasing accessibility to mental health care, as it was acknowledged that: '[there] is a dauntingness [*sic*] to face to face [therapy] as well ... I think for a lot of people that's quite a step to make like it's quite a big thing to do'. (Cate).

Luck was also involved in accessing 'good' mental health care, which contrasted with accounts of negative experiences. For participants, hearing about negative experiences contributed to a hesitancy to engage with mental health care providers in case they themselves became unlucky. Grace provided an example of a 'bad' provider in response to being asked to explain what a 'horror story' meant to her:

Mostly just about male psychologists and not being great ... hearing all these girls talk about how they were told they're crazy or like it's all in their head and stuff like that. It's not the most encouraging. But, you know, it's one of those things where I know people, when they have a good psychologist, stick with them and it's great and so helpful ... and the people who tell me these stories aren't trying to like scare me it's just like, you know, it happens.

The chance of encountering a 'bad' provider was reminiscent of an era of widespread discrimination and pathologisation of LGBTQA+ identities, perpetuated by mental health care providers and organisations. Participants were safe in the knowledge that they legally could not be discriminated against for their identities, illustrating the impact of protective laws and social progress in Aotearoa New Zealand. However, participants remained hesitant to engage with mental health care providers in case of negative judgement:

I wouldn't- don't even know if I'd necessarily bring it [sexuality] up, even if it was a problem for whatever reason, just because it's like, is it worth potentially dealing with someone who won't get it, and who won't be respectful of that? ... There's like often that expectation of, 'but like I'm gonna be seen differently' [by the provider] (Cate).

The privilege of accessing good quality mental health care was conveyed as providing protection from suicide, a topic so taboo that no participant spoke it out loud in

direct reference to themselves, instead alluding to ‘what would have happened’ (Thomas). As a result, suicide was positioned as the ultimate consequence of the failure of the mental health system, with the luck of receiving quality care not being afforded to everyone:

I have a few experiences of friends of mine that have unfortunately lost their lives while in the care of respite or while, [they were] supposed to be looked after ... and it’s really, it’s sad because I wonder if their [LGBTQA+] identity was different, or if they were able to vocalise different would they have been more cared for? (Gilbert).

Although Gilbert references individual factors such as being ‘able to vocalise different’, the service user is positioned as non-agentive; there is luck involved in having the skills to self-advocate and control one’s own narrative within the mental health system.

Therapists just need to be a bit more like up with the programme

Within the theme of ‘therapists just need to be a bit more like up with the programme’, participants described the importance of interacting with LGBTQA+ competent mental health care providers:

As a field therapists just need to be a bit more like up with the programme in terms of all types of cultural competency but like specifically, queer, like you just, you just should know it ... you shouldn’t be waiting until you have a queer client to be like, ‘shit, I probably need to know this’ because like what are you going to do if you end up with a client and they’re questioning you’re like, ‘oh god, what do I do.’ (Jasmine).

Being ‘up with the programme’ was conveyed as individual mental health providers being proactive rather than reactive in seeking knowledge, having values conferring respect for LGBTQA+ people, and conveying support in small, meaningful ways. Conveying support could be through displaying LGBTQA+ posters and flags: ‘anything [in the environment] saying, you know, ‘queer people are welcome here’, ‘we specifically want to support this community’, [is] always so helpful and that would make it so much more welcoming’ (Stevie). Mental health providers who are ‘up with the programme’ help to build a better therapeutic alliance with the client, which contributes to success in talk-therapies (Flückiger et al. 2018).

When speaking about their preferences for mental healthcare providers, almost all participants explicitly asserted they would ‘prefer if they were also queer of some kind’ (Riley). Providers with an LGBTQA+ identity facilitate shared understanding and reduce the education burden being placed upon the client, as illustrated by one participant questioning her gender:

I would want someone who’s either like identifies as female, or non-binary or like basically anyone but a man [laughs] like a cis man specifically, just because of struggles relating to gender ... someone who understands those struggles with gender, would be really helpful [laughs] so you just don’t have to unload all of the, ‘and I hate this because of my experiences as people perceiving me as a woman.’ (Robin).

For participants with intersectional or minoritised identities, having a culturally competent mental health care provider, such as one with a similar identity, was framed as vital. Shared experiences contributed to increased trust and produced higher quality mental health care.

If we know that a therapist was disabled, physically disabled, it would incentivise us more to be like, oh I trust them a bit more, even though it might be a wildly different disability, there's some shared experiences which I think is the same with, just because someone's not lesbian doesn't mean that we won't have shared queer experiences (Grace).

Given the constraints of living in a small city and among the already-constrained mental health services, it was often difficult for participants to be selective of mental health care providers, leading them to accept 'queer-friendly' as their minimum standard:

I would say capacity of the people out there, which you've alluded to, is like actually finding a q- or someone allud- I think we all did in one way or another, but a) that is known, either to be queer friendly or just good. (Skylar).

In contrast, negative interactions with providers not 'up with the programme' had large ramifications, by either preventing or delaying participants from seeking mental health care. Mental healthcare providers deemed incompetent by participants had negative reputations among their social circles, illustrating the power of word-of-mouth among the LGBTQA+ student community:

I can talk to other queer people in social spaces and say, 'hey, don't go and see such and such person to, because reasons'. Or 'do see such and such, person has such a good time with them, because reasons.' (May).

Participants' emphasis on a hard-to-gain but easy-to-lose sense of trust revealed a system seen as inherently untrustworthy, with participants' individual negative experiences 'shak [ing] trust quite a lot' (Skylar) and bringing into question their sense of safety: 'the thing that would stop me from going is like being scared. You've never been somewhere before. But also maybe not knowing who you're going to see or if they're going to understand you'. (Ellis).

Discussion

LGBTQA+ students have unique mental health needs and report higher rates of mental disorder than their cisgender heterosexual peers (Kerr et al. 2014; Mortier et al. 2018; Bartholomew et al. 2019; Goldberg et al. 2019; Rentería et al. 2020; Gmelin et al. 2022). Additionally, LGBTQA+ students are at risk of negative experiences within mental health care services due to societal stigma around their minority identities. Participants in the present study discussed their experiences and preferences in mental health care, many relating to their gender and sexual identities. Themes were: I can do this on my own, but others should seek help; you have to be lucky to access mental health care; and 'therapists just need to be a bit more like up with the programme'.

A notable barrier to care for the present study's LGBTQA+ participants was negative societal attitudes around accessing care and fearing stigma or discrimination towards their identities from providers. This fear of stigma has been described by LGBTQA+ participants in other studies (e.g. Cronin et al. 2021a; Lim et al. 2021, 2022; Fraser et al. 2022). A novel finding was that participants demonstrated internalisation of these attitudes, creating a barrier to accessing mental health care. Participants minimised their own difficulties, believing that they were not worthy of support and that using services would deprive others who needed it more, while simultaneously expressing that those struggling should seek help. Multiple campaigns within Aotearoa New Zealand

encourage those experiencing mental health difficulties to seek help, such as the Mental Health Awareness Week (Mental Health Foundation 2023), however, the results of this study suggest that efforts also need to explicitly target this attitude of self-sufficiency.

Echoing another study describing a ‘postcode lottery’ in accessing gender-affirming healthcare (Fraser 2020), participants spoke about the luck involved in accessing facilitating factors, which highlights the systemic unequal access to mental healthcare in Aotearoa New Zealand. The recent establishment of Te Whatu Ora as a nationalised healthcare system intends to increase consistency and equity of healthcare (Te Whatu Ora - Health New Zealand 2022), yet changes in access to mental healthcare remain to be seen. Participants additionally discussed the privilege of their own knowledge of the mental healthcare system and being informed by the experiences of those close to them. These factors highlight the importance of building public knowledge of mental healthcare services and psychological literacy, with university being a well-placed point of capture to educate many young adults.

Participants in the present study emphasised the need for more LGBTQA+ mental health providers, who are perceived as more culturally competent by LGBTQA+ service users (Bartholomew et al. 2019; Goldberg et al. 2019; Bishop et al. 2022b; Bishop et al. 2022a). Additionally, the systemic shortage of providers stresses the need to increase the number and diversity of those in training programmes, including those who are trans, gender diverse, disabled, Māori and other ethnic minorities. LGBTQA+ individuals are more likely to attend services that are culturally competent (Bishop et al. 2022a), which contributes to positive therapeutic outcomes. Conversely, a lack of cultural sensitivity and understanding are barriers to accessing mental health care (Rucklidge et al. 2018; Feinstein et al. 2019; Flanagan and Peters 2020; Horwitz et al. 2020; Cronin et al. 2021a).

A limitation of the present study was that participants were pragmatically unable to be grouped by their identities in focus groups and dyadic interviews. This limitation could have constrained the depth of discussion of specific minority experiences by reducing shared group understanding. In-depth discussion was apparent in an unintentionally cis-gender bisexual grouping, which facilitated participants’ talk about bisexual specific experiences. In-depth discussion would have been valuable for understanding underrepresented LGBTQA+ subpopulations such as trans, non-binary, asexual and intersectional people, who may experience additional or overlooked minority stressors. This limits our ability to make specific recommendations for improving the mental health care experiences of these minority groups, and future research would benefit from focusing on underrepresented identities.

Recommendations for mental health care providers

While individual providers should act upon these recommendations, it is also the responsibility of training programmes to enact many of these changes. Incompetence of individual providers is grounded in fields which are not inclusive of LGBTQA+ identities, and systems which do not allow marginalised identities to enter mental health professions easily (Scarf et al. 2019).

Aotearoa New Zealand guidelines for mental health providers working with LGBTQA+ clients outline the necessity of respectful and validating care (New Zealand

Psychological Society 2002; Social Workers Registration Board 2016; NZ Psychologists Board 2019; Psychotherapists Board of Aotearoa New Zealand 2019; New Zealand Association of Counsellors 2020; The Royal Australian and New Zealand College of Psychiatrists 2021). However, our results suggest these guidelines may not always be at the forefront of practice. Providers must strive to increase supportive interactions with LGBTQA+ clients, as these can facilitate future help seeking (Panchal et al. 2022) and are associated with better mental health amongst transgender people (Treharne et al. 2022). Non-supportive interactions can contribute to one's decision to cease therapy (Simeonov et al. 2015). Non-supportive interactions include burdening clients with educating the provider regarding LGBTQA+ identities, stereotyping, or invalidating the client's identity (Mizock & Lundquist 2016; Goldberg et al. 2019; Rees et al. 2021; Zullo et al. 2021; Treharne et al. 2022).

Practically, LGBTQA+ friendliness is communicated through having accessible bathroom facilities (Fraser 2020; Panchal et al. 2022), asking about gender and sexuality on intake forms, displaying visual cues of support (Feinstein et al. 2019; Fraser 2020; McNamara and Wilson 2020; Zullo et al. 2021), and avoiding cisnormative and heteronormative language (McCann and Sharek 2013; Simeonov et al. 2015; Rees et al. 2021; Zullo et al. 2021). Effective mental health care also involves considering how confidentiality, trust and inclusion relates to LGBTQA+ populations historically and contemporaneously (McDermott et al. 2021). Further, individuals and organisations should be visible advocates for social and policy change that improve LGBTQA+ lives and reduce minority stress (Benson 2013; Oliphant et al. 2018; Feinstein et al. 2019; McDermott et al. 2021; Panchal et al. 2022). Providers who are visible advocates signal safety and develop positive reputations as LGBTQA+ affirmative providers (Benson 2013). With providers who remain silent, LGBTQA+ people must navigate apprehension or fear of coming out (Fraser et al. 2022) adding to their experiences of minority stress.

Conclusion

Too few LGBTQA+ university students needing mental health care receive support, despite this population having unique needs compared to cisgender heterosexual peers. Therefore, it is important to understand this population's experiences to provide appropriate and targeted mental health care. The present study's findings add to the consideration of LGBTQA+ experiences at a pivotal stage of development and point of capture. The results of this study should be considered by mental health providers and student health services who work with LGBTQA+ young adult students at both individual and organisational levels across Aotearoa New Zealand and beyond.

Notes

1. In this paper the term 'mental healthcare provider' refers to individuals who can identify and treat mental health conditions using talk therapies in Aotearoa New Zealand. This definition includes clinical, health, and counselling psychologists, psychotherapists, psychiatrists, counsellors, and mental health social workers.
2. Takatāpui is an indigenous Māori term, originally referring to an intimate companion of the same sex. It has been reclaimed by Māori who identify as non-cisgender and/or non-heterosexual to describe themselves.

Acknowledgements

Ngā mihi nui to the participants—without you, this research would not have been possible.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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