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Social Integration And The Mental Health Needs Of Lgbtq Asylum Seekers In North America

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Abstract

This study examined the mental health burden of LGBTQ asylum seekers and associated psychosocial risk factors with a focus on barriers to social integration. This study also characterized LGBTQ asylum seekers' interest in interventions aimed at alleviating mental distress and social isolation. Respondents (n = 308) completed an online survey which included the Refugee Health Screener (RHS-15), the NIH Loneliness scale, and an adapted scale of sexual identity disclosure. Most respondents (80.20%) screened positive for mental distress. Loneliness (*OR* = 1.14, *95% CI* = 1.09, 1.19) and LGBTQ identity disclosure (*OR* = 3.46, *95% CI* = 1.01, 12.02) were associated with screening positive for mental distress. Transgender identity (*OR* = 3.60, *95% CI* = 1.02, 16.02) approached significance for a positive association with mental distress. Those who had been granted asylum (*OR* = 0.36, *95% CI* = 0.169, 0.75) or had higher English language proficiency (*OR* = 0.35, *95% CI* = 0.12, 0.94) were less likely to screen positive. Most of those who screened positive (70.45%) were interested in receiving mental health counseling. Almost all participants wanted more LGBTQ friends (83.1%), wanted to mentor an LGBTQ newcomer (83.8%), and were interested in joining an LGBTQ community center (68.2%). LGBTQ asylum seekers are highly likely to experience mental distress and are interested in participating in mental health treatment and LGBTQ community building. Loneliness, outness, indeterminate immigration status, and low English proficiency are unique risk factors associated with mental distress.

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Introduction

Background

In the 1990s in North America, a series of federal court cases and statutory reforms transformed an individual's sexual orientation from being a basis for immigration exclusion to being a basis for immigration relief under international human rights law (1)(2). Decisions from immigration courts extending similar relief on the basis of gender identity soon followed (3). Since that time, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer)[1] immigrants have claimed asylum on the basis of sexual orientation or gender identity every year, coming from over 80 countries around the world where it is a crime or generally unsafe to be LGBTQ (4). The United States and Canadian Governments do not publish records on the number of individuals who claim or receive asylum on the basis of sexual orientation or gender identity. However, one inquiry to the Canadian government revealed that 1,351 asylum claims on the basis of sexual orientation had been made in 2004 (5). The Williams Institute has estimated that 2.4% of documented immigrants and 2.7% of undocumented immigrants to the United States identify as LGBTQ (6). Applying an even more conservative estimate of 2% to the 225,750 individuals who filed for asylum in the U.S. in 2016 (7) would suggest that at least 4,515 of them were LGBTQ. In addition to a paucity of population data, there are

[1] The acronym LGBTQ is frequently used in Western academic and activist circles as an umbrella term for all sexual and gender minorities. It does not reflect the full diversity of identities articulated across cultures, such as hijra people in Southeast Asia, or two-spirit people in various Native American tribes. For the sake of brevity, the term will be used to refer to all immigrants claiming asylum on the basis of sexual orientation or gender identity in the common law court systems of the United States and Canada. The term LGB will be used to refer to sexual minorities only, as opposed to gender minorities including transgender and other gender non-conforming individuals.

few published quantitative or qualitative studies examining LGBTQ immigrants in general, and asylum seekers in particular.

Persecution Experiences

All asylum seekers have experienced or anticipated persecution in their home countries, but LGBTQ asylum seekers frequently experience distinct patterns of persecution. A program for survivors of torture in New York City compared LGB asylum seekers with asylum seekers of the same country of origin and sex who had been persecuted for other reasons and found that sexual minority asylum seekers were more likely to have experienced sexual violence, persecution during childhood, and persecution from a family member (8). Similarly, a retrospective chart review of LGB patients at a program for survivors of torture in Boston found that 74% had been persecuted by their own families and 50% had experienced rape or sexual assault (9). A mixed-methods study of men who have sex with men and transgender women in Mongolia found that almost 15% of respondents had experienced sexual assault within the past three years (10). Another study of Mexican transgender asylum seekers found that most interviewees had experienced physical assaults, particularly from family and community members, and that many had experienced sexual assault (11). Common forms of violence against LGBTQ people documented by the United Nations High Commissioner for Refugees include state-sanctioned beatings, imprisonment and police torture, honor killings, and "corrective rape," which is rape with the intent to change the sexual orientation or gender presentation of the victim (12). Once they have arrived

in the United States or Canada, LGBTQ asylum seekers, and particularly transgender asylum seekers (11), can continue to experience persecution related to their sexual orientation or gender identity, often in the form of harassment and discrimination when seeking employment and housing (11)(13)(14).

Mental Health

LGBTQ asylum seekers' particular persecution experiences can have a significant impact on their mental health. The matched comparison study mentioned above found that LGB asylees were more likely than other asylum seekers to endorse suicidal ideation (8). Other research has found extremely high rates of major depression (76%), PTSD (70%), and generalized anxiety (28%) in LGB asylum seekers (9). Many post-migration stressors and demographic factors likely contribute to the mental distress of LGBTQ asylum seekers, as we will explore below. Given that recent arrivals in this population are generally uninsured (9) and that asylum seekers overall have significant difficulty accessing mental health services (15), LGBTQ asylum seekers with mental health concerns also face substantial barriers to accessing dependable and appropriate mental health services (16).

Social Integration

It is well established within psychological literature that social connectedness is important for both mental and physical health (17)(18)(19), and that strong social networks have a protective effect for those who have experienced significant trauma (20)(21), including refugees (22)(23) and LGBTQ individuals in the general population

(24)(25). For recent immigrants, strong social networks are also often the primary, or only, means of securing housing, employment, and guidance in navigating the complexities of day-to-day life in a new country (16). However, LGBTQ immigrants may have a particularly difficult time forming a robust and supportive social network once they have arrived in the United States or Canada because of the real or perceived risk of persecution at the hands of both immigrant communities and non-immigrants (11)(14). Furthermore, cultural and linguistic barriers may prevent asylum seekers from forming supportive relationships with broader LGBTQ communities in North America (2)(14). At least one recent study has identified social isolation as a significant concern for transgender asylum seekers (11) and it has been observed in several qualitative studies in Canada that support groups and organizations created specifically for sexual and gender minority refugees help to address social isolation and promote self-acceptance (2)(14).

Existing psychological literature on social isolation differentiates between objective and subjective social isolation. Objective measures of social isolation include the size of a person's social network and its strength in terms of frequency and duration of contact. More subjective measures include a respondent's rating of emotional closeness for each member of the network. The most subjective measure of social isolation is loneliness, which has been defined in the literature as a "discrepancy between desired and achieved patterns of social interaction" (26) that results in emotional distress. Two recent systematic reviews have suggested that social networks that are objectively large and contain "high-quality" relationships in terms of both

frequency of contact and perceived levels of emotional support protect against depression (27)(28). However, other studies have found that the subjective feeling of loneliness is both an independent, and more significant, risk factor for depression when compared to the size of one's social network or frequency of contacts (20)(30)(31)(32). Research has also suggested that the subjective feeling of loneliness has an impact on physical health, as well as mental health, independent of social network size and frequency of contact (29)(33).

Previous research on LGB American youth and adults has specifically shown that sexual minorities tend to experience greater loneliness than their heterosexual counterparts (34), and that lower levels of loneliness (35) and higher satisfaction with social support (36) are correlated with better mental health. While quantitative assessments of loneliness in LGBTQ asylum seekers have yet to be conducted, a confluence of factors prevent this population from forming social connections with members of both immigrant and LGBTQ communities. Thus, they are likely to experience higher levels of both subjective and objective social isolation than the average American or Canadian, along with higher levels of mental health morbidity.

Connection to LGBTQ community has also been associated with better mental health outcomes in sexual and gender minorities. A recent study of transgender and gender non-conforming individuals (37) and an earlier study of LGB individuals (38) found an association between LGBTQ community connectedness and psychological wellbeing. A similar study found that respondents with a connection to the transgender community had lower mental distress and symptomology (39). Asylum seeker's connection to LGBTQ community has not been

studied quantitatively, although qualitative studies have pointed to clear psychological benefits. (2)(14).

Outness

LGBTQ asylum seekers are likely less open about their sexual orientation and/or gender identity than LGBTQ Americans or Canadians, although the outness of this population has never been studied. The relationship between identity disclosure and mental health in LGBTQ asylum seekers is also unclear. In U.S. populations, studies of the relationship between mental health and sexual orientation concealment have had variable results. When it comes to gender identity concealment and mental health, only qualitative studies have been conducted, and these are complicated by the need to differentiate between concealment of one's assigned sex and gender history in an individual who "passes" (a concealment which can be seen as affirming one's gender identity) and concealment of one's true gender identity in an individual who is still perceived to be the sex they were assigned at birth (a concealment which denies one's gender identity) (40).

Some research has found a correlation between identity concealment and increased symptoms of depression and anxiety, and proposed a causal relationship based on the stress that concealment imposes in terms of maintaining separate life spheres, social isolation, and ongoing feelings of shame, guilt and internalized stigma (41)(42)(43)(44). However, several other studies have suggested that those who conceal their sexual orientation have fewer mental health problems, possibly because they are

able to avoid the stigma, discrimination, and resultant stress that come with increased visibility (45)(46)(47)(48). A 2015 population-based study of over 1,200 LGB adults in the U.S. looked a how the relationship between identity disclosure and mental health varies between cis-men and cis-women. The research found that sexual minority men who were out were more likely to be depressed than those who had remained in the closet, while the converse was true for sexual minority women (49). Researchers attributed this difference to the greater stigma experienced by visible sexual minority men compared to women.

Overall, it is clear that the impact of outness on mental health depends upon the circumstances (voluntary or involuntary) and consequences (support, acceptance, and connection or rejection, discrimination, and isolation) of being out (50)(51)(52). It is also clear that these circumstances and consequences vary greatly between different sub-populations of LGBTQ people (42)(41). While no quantitative research has examined the relationship between outness and mental health in immigrant populations, qualitative ethnographic research has suggested that the ability to voluntarily conceal one's sexual identity may have particular mental health benefits in LGB immigrant populations (53).

Demographic Characteristics

There are several demographic characteristics that may influence the mental health outcomes of LGBTQ asylum seekers. Research in U.S. LGBTQ populations has found that younger age and lower education level are both associated with greater

mental health symptomology (37). Studies have also found an increased mental health morbidity in transgender people (54), cis-women compared to cis-men (55), and bisexual women (56). Research on non-LGBTQ immigrant populations has also found that lower English language fluency (57) and awaiting an immigration status determination (58) are associated with worse mental health outcomes.

Study Objectives

The present study aims to be the first to describe, in a survey, the mental health burden and experiences of social integration of LGBTQ asylum seekers in North America using a valid mental health screener and a battery of social determinants (e.g., perceived social support, identity concealment, social acceptance of one's LGBTQ identity, barriers to mental health care) of mental health across a large, diverse sample of LGBTQ asylum seekers. We also aim to examine associations between these social determinants and mental health. With the goal of spurring intervention development among this population, we finally aim to characterize LGBTQ asylum seekers' interest in interventions aimed at alleviating mental distress and social isolation. Our findings will inform future efforts aimed at improving the mental health of this vulnerable and underserved population.

Methods

Participants

The survey's target population included individuals over the age of 16 identifying as LGBTQ currently living in the United States or Canada. The target population must have applied, or been planning to apply, for immigration status as an asylum seeker on the basis of their sexual orientation and/or gender identity by filing a form I-589 with United States Customs and Immigration Services or a Basis of Claim form with the Immigration and Refugee Board of Canada. The survey was available for participants to complete between March 5, 2018 and September 24, 2018.

Potential survey participants were contacted by partnering with non-profit organizations and individual service providers in the United States and Canada who work with LGBTQ asylum seekers. Partner organizations and individual providers distributed the online survey to clients via email. Participants who completed the survey received a $20 gift certificate. Partner organizations included Immigration Equality, Greater Boston Legal Services, the Yale Center for Asylum Medicine, the Russian-Speaking American LGBT Association (RUSA LGBT), the Translatina Coalition, LGBT Freedom and Asylum Network, Rainbow Railroad, and the LGBT Asylum Taskforce. The assistance of individual legal services and mental health providers in distributing surveys was also solicited online via the Society of Refugee Healthcare Providers Listserv and in-person at the 2017 North American Refugee Health Conference.

Survey Development

A draft survey was written in English and then translated and back-translated using professional interpreters in Spanish, French, Arabic, and Russian. Some elements of the survey included validated psychometric instruments that were already available in those languages and were therefore included in the final translated survey in unaltered form. This includes the Refugee Health Screener (RHS-15) (59) which was available in Spanish, French, Russian, and Arabic (60) and the PROMIS and NIH Toolbox scores for loneliness and emotional support available in Spanish (61)(62).

The draft survey was piloted with asylum seekers who provided feedback on readability of the Spanish, French, Russian, and Arabic versions of the survey. Feedback on readability was also solicited from legal service providers at Immigration Equality. Once readability adjustments to the survey were made, the survey was distributed using Qualtrics software (63).

Measures

Demographic Characteristics

Participants were asked their birth country, current country and state/province of residence, years spent in current country, age, gender identity (cis-male, cis-female, transgender male, transgender female, genderfluid/genderqueer, or other), sexual orientation (lesbian, bisexual, gay, heterosexual, or other), asylum status ("application not submitted," "application submitted," "application submitted and work permit received," "asylum status granted, " or "asylum status denied"), spoken

English language proficiency (excellent, very good, good, fair, or beginner) (64)(65), educational attainment (no formal education, primary school, secondary school, or post-secondary school), employment status, and school enrollment.

Mental Distress

To our knowledge, no screening tool for mental distress has been validated for online administration in a population of asylum seekers. However, the Refugee Health Screener (59) was specifically developed to quickly and efficiently screen for the need for referral to a mental health provider in refugee populations and was chosen for this study to assess the mental health burden of LGBTQ asylum seekers. During pilot testing, several asylum seekers from East Africa, Latin America, Europe, and the Middle East completed the RHS-15 online with no difficulty.

The RHS-15 was first validated in 2013 in a population of over 200 refugees from Asia and the Middle East, where it was found to correlate with diagnostic proxy instruments for depression, anxiety, and PTSD with a sensitivity of 81-95% and specificity of 86-89% (59). Since that time, the RHS-15 has been translated into twelve languages (66) and is used at over 160 healthcare sites across the globe (67). The instrument has been validated for use in a variety of refugee populations in clinical and public health settings (68)(69)(70).

The first 13 items on the RHS-15 are Likert scale type questions asking respondents to characterize the extent to which they are experiencing particular symptoms of distress, with responses ranging from zero ("not at all") to four ("extremely"). These questions have an accompanying visual aid – a series of jars

ranging from empty to full – to help illustrate the concept of increasing degrees of symptom experience in a more culturally universal manner. Question 14 asks about a respondent's ability to cope with life stressors, with responses ranging from zero ("able to cope with anything") to 4 ("unable to cope with anything"). A respondent will screen positive if their total score for the first 14 items is 12 or greater. The final question is an illustrated emotional distress "thermometer" with responses ranging from zero ("no distress – things are good") to ten ("extreme distress – I feel as bad as I ever have"). A score of 5 or greater on the distress thermometer will also indicate a positive screening regardless of responses to the first 14 questions.

Social Isolation

For our study, we chose a 4-item version of the recently developed NIH Toolbox Loneliness measure, with each item offering five Likert scale type response options (61). This measure is part of a suite of brief self-report emotional and social health scales validated for use in large survey studies in several languages (71)(72)(73)(74). The NIH Toolbox Loneliness measure was validated in direct reference to the 20-item UCLA Loneliness Scale (R-UCLA), showing a strong correlation with the original (72).

We used a second social support measure, the 4-item PROMIS Short Form v2.0 Emotional Support scale (75), which was developed using similar methods and for the same applications as the measures in the NIH Toolbox (76)(75). The scale was designed to capture the "appraisal support" component of the Interpersonal Support Evaluation List (77)(78). The scale provides a positive measure of support and includes Likert scale

type questions focused on ascertaining the degree to which respondents have access to individuals with whom they can experience validation and sympathy.

One of the greatest advantages of both the NIH Loneliness and PROMIS Emotional Support measures is that they are scaled so that they can be directly compared to U.S. adult population averages. The NIH Toolbox measures use a U.S. national reference sample of 4,859 English and Spanish speakers (79) and the PROMIS uses a national reference sample drawn from the 2000 General U.S. census. (80). Raw scores from both of these measures are converted to scores scaled to a distribution with a mean of 50 and standard deviation of 10 (81).

Outness

To our knowledge, no existing scales of sexual orientation or gender identity disclosure have been validated for use in immigrant LGBTQ populations. For our study, we modified a scale that has been validated in U.S. LGB populations, the Outness Inventory Scale (OI) (82)(83). The OI assesses the degree to which respondents' LGBTQ identity is known or talked about within different social spheres of their life. The scale asks participants to rate on a 7-point Likert scale how open they are about their sexual orientation in different areas of their social life: family, coworkers/school peers, religious community, and non-LGBTQ friends.

We modified the OI to include both sexual orientation and gender identity ("sexual orientation status" was changed to "LGBTQ identity"). While a Likert scale framework provides more granular detail regarding Outness, we wanted to reduce the complexity of response options give our target population. Therefore, we created

three response options for each social domain: “no such group of people in my life, ” “know about your LGBTQ identity” or “do not know about your LGBTQ identity.” Given that many LGBTQ asylum seekers are often forced to live with strangers or family friends, we also added an item: “people I live with in a house or apartment.” Also, given that less than 50% of respondents ultimately endorsed membership in a religious community in the United States or Canada, we did not use that item in our overall score tabulations. We calculated Outness scores as the average of all responses, with “no such group of people in my life” coded as "NA". For descriptive purposes, for each social domain where respondents indicated they were out, we also asked if their identity was "accepted" or "not accepted" by members of that social domain.

We performed exploratory factor analysis to evaluate whether our Outness scale represents a unitary factor. Many statistical tests are available for determining the optimal number of factors and there is no consensus on which methods to use; therefore, we use a method agreement procedure that employs 9 different methods and chooses the number with the highest consensus (84). The method agreement procedure found that the optimal number of factors underlying the Outness scale is 1, with 8 out of 9 (88.89%) methods identifying one factor (VSS Complexity 1,Optimal Coordinates, Acceleration Factor, Parallel Analysis, Kaiser Criterion, Velicer MAP, BIC, and Sample Size Adjusted BIC) and the remaining method identifying three factors (VSS Complexity 2). Thus, we proceed under the assumption that the Outness scale is unitary.

LGBTQ Community and Social Support

To better characterize our respondents' connections with LGBTQ community and their sources of social support post-migration, we asked about respondents' LGBTQ friendships and number of LGBTQ friends and sources of social support. Specifically, we asked 1) if respondents had LGBTQ friends in their current country of residence, 2) if they had LGBTQ friends from their country or culture in their current country of residence, 3) if they wanted more LGBTQ friends or LGBTQ friends from their country or culture, and 4) the number of LGBTQ friends they had. We also asked respondents to pick 1-3 primary sources of social support (options included family, significant other/partner, immigrant community, LGBTQ resource center, religious organization, work/school, LGBTQ friends from online, LGBTQ friends from bars or clubs, and housemates).

Intervention Interest

To assess respondent's interest in different types of interventions aimed at improving the mental and social health of LGBTQ asylum seekers, we asked participants to indicate their interest in joining a private Facebook group for LGBTQ immigrants, meeting other LQBTQ people from their country or culture through an anonymous website, joining a local LGBTQ community center, mentoring an LGBTQ immigrant who has just arrived in the United States or Canada, and seeing a mental health counselor. We also asked respondents if cost had ever been a barrier to accessing mental health services since their arrival in their host country.

Data Analysis

In order to control for survey response quality, we established three criteria for survey inclusion. A survey must have been completed up to at least the first five question sections, the survey response time needed to be at least nine minutes, and the survey needed to contain no more than one inconsistent, exclusionary, or illogical answer. Unacceptable answers included listing "country of origin" as the U.S., Canada or another country from which LGBTQ people do not seek asylum, listing age as less than 16 or greater than 100, listing both heterosexual for sexual orientation and cis-gendered for gender (respondent does not identify as LGBTQ), listing a country other than the U.S. or Canada as current country of residence, listing number of years living in U.S. or Canada as greater than stated age, a response of "yes" to the question "Do you have LGBTQ friends in the U.S. or Canada?" while also listing zero for the specific number of LGBTQ friends, and vice versa. Following these criteria, 308 out of 476 collected surveys were included in the study (65%). We discarded 77 surveys that did not meet completeness criteria, 10 surveys that contained 2 or more unacceptable answer choices, and 81 surveys that had a response time of less than 9 minutes.

We used logistic regression to investigate which factors predict screening positive on the RHS-15. We considered 11 predictors that we expected to influence RHS-15 results, including 5 continuous predictors (Outness Score, Emotional Support Score, Loneliness Score, age, and log years lived in the U.S./Canada) and 6 binary

predictors (post-secondary education, good/excellent English proficiency, granted asylum, transgender, cis-female, and bisexual).

We present results from two modeling approaches. First, we fit 11 separate single-variable logistic regression models for each predictor. Second, we fit a multiple logistic regression model including all 11 predictors.

Results

Participant Characteristics

Survey participants came from 48 different countries and were currently living in 29 different states or provinces. A plurality of participants were aged 30-39, cis-gender male and gay, originally from Russia, living in New York State, employed, and had a post-secondary education and above average fluency in English. See Table 1 for a summary of participant characteristics.

Table 1

Participant Characteristics (n = 308)

	n	%
Survey Language		
English	160	51.9%
Russian	122	39.6%
Spanish	18	5.8%
French	6	1.9%
Arabic	2	0.6%
Region of Origin		
Europe/Central Asia	155	58.9%
Caribbean	35	13.3%
Latin America	34	12.9%
Sub-Saharan Africa	25	9.5%
Middle East/North Africa	8	2.6%
Asia	6	2.3%

Country of Origin (Top 5)		
Russia	113	36.7%
Jamaica	27	8.8%
Uganda	14	4.5%
Nigeria	13	4.2%
Belarus	13	4.2%
Current Country		
United States	293	95.1%
Canada	15	4.9%
Current State/Province (Top 5)		
New York	130	42.2%
California	46	14.9%
Florida	37	12%
Massachusetts	26	8.4%
Ontario	15	4.9%
Gender Identity		
Cis-Male	215	69.8%
Cis-Female	56	18.2%
Genderqueer/Genderfluid/Other	23	7.5%
Transgender Female	11	3.6%
Transgender Male	3	1%
Sexual Orientation		
Gay	205	66.6%
Lesbian	47	15.3%
Bisexual	40	13%
Heterosexual	10	3.2%
Other	6	1.9%
Age Range		
<21	4	13%
21-29	121	39.3%
30-39	154	50%
40-49	26	8.4%
50+	3	9.4%
Years in US or Canada		
< 1	42	13.6%
1-2	91	29.5%
3-4	92	29.9%
5-6	29	9.4%
7-8	11	3.6%
9-10	15	4.9%
11-12	2	0.6%
12+	26	8.4%
Stage of Asylum Process		
Application not submitted	40	13%
Application submitted	20	6.5%
Work permit received	138	44.8%
Application granted	107	34.7%
Application denied	3	1%

Spoken English Proficiency		
Excellent	84	27.3%
Very Good	92	29.9%
Good	82	26.6%
Fair	40	13%
Beginner	10	3.2%
Education		
No Formal	1	0.3%
Primary	3	1%
Secondary	56	18.2%
Post-Secondary	248	80.5%
Employed		
Yes	223	72.4%
No	85	27.6%
In School		
Yes	70	22.7%
No	238	77.3%

Descriptive Statistics

In our sample, 80.20% of participants screened positive for mental distress and a need for referral to mental health services. Of those who screened positive, 70.45% indicated they would be "interested in seeing a mental health counselor to help with feelings or symptoms they are having." Of those who screened negative, 44.26% also expressed interested in seeing a mental health counselor. Over a third (38.60%) of our survey participants stated they had not been able to access mental healthcare since arriving in the Unites States or Canada because of cost.

Across respondents, the mean scaled loneliness score was 63.19 (SD = 10.86) and the mean scaled emotional support score was 46.71 (SD = 9.42). This indicates disproportionately low social and emotional support compared to US population norms.

In fact, the reference U.S. population norms for both loneliness and emotional support were *M* = 50 (*SD* = 10).

The mean outness score was 0.73 (*SD = 0.30; range = 0-1*). On average, participants were out in the majority of their social domains, although most reported concealing their identity in at least one domain. Participants were most likely to be out to, as well as accepted by, their housemates, co-workers and classmates, and non-LGBTQ friends. Participants were least likely to be out to, and accepted by, their biological family and religious organizations. Table 2 summarizes participants' outness and acceptance.

Almost all participants reported having LGBTQ friends in the U.S. or Canada, and most had LGBTQ friends from their own country or culture. The most commonly cited source of social support was a significant other, followed by LGBTQ friends made via the Internet. A majority of respondents expressed interest in interventions that involved in-person interaction and mental health services. A majority were also interested in joining a private Facebook group for LGBTQ asylum seekers and almost 50% were interested in joining an anonymous website to connect with other LGBTQ asylum seekers. Table 2 summarizes participants' intervention interest.

Table 2

Descriptive Statistics (n = 308)

Outness and Acceptance	*n*	%
Biological Family		
Not out	94	30.5%
Out, not accepted	127	41.2%
Out, accepted	74	24%
Not applicable	13	4.2%
Work/School Peers		
Not out	101	32.8%
Out, not accepted	30	9.7%
Out, accepted	159	51.6%
Not applicable	18	5.8%
Religious Community		
Not out	84	27.3%
Out, not accepted	21	6.8%
Out, accepted	39	12.7%
Not applicable	164	53.2%
Housemates		
Not out	64	20.1%
Out, not accepted	24	7.8%
Out, accepted	194	63%
Not applicable	28	9.1%
LGBTQ Community	***n***	**%**
Have LGBTQ Friends		
Yes	281	91.2%
No	27	8.8%
Have LGBTQ Friends from Home Country or Culture		
Yes	238	77.3%
No	70	22.7%
Want more LBGTQ Friends		
Yes	256	83.1%
No	52	16.9%
Want More LBGTQ Friends from Home Country or Culture		
Yes	216	70.8%
No	89	29.2%
Number of LGBTQ Friends		
0	17	5.5%
1-2	65	21.1%
3-5	99	32.1%
6-10	65	21.1%
11+	62	20.1%

Intervention Interest	*n*	%
Private Facebook Group	198	64.3%
Yes	62	22.1%
No	41	19.5%
Unsure		
Private Website		
Yes	150	48.7%
No	96	31.2%
Unsure	60	19.5%
LGBTQ Community Center		
Yes	210	68.2%
No	70	22.7%
Unsure	26	8.4%
Mentor LGBTQ Newcomer		
Yes	258	83.8%
No	30	9.7%
Unsure	18	5.8%
Mental Health Counseling		
Yes	201	65.3%
No	63	20.5%
Unsure	42	13.6%

Predictors of Mental Distress

Three predictors were significant in the univariate models predicting mental distress. Emotional support and being granted asylum were negatively associated with mental distress, whereas loneliness was positively associated with mental distress (Table 3). Four predictors were significant in the multivariable model. Outness, English proficiency, and being granted asylum were negatively associated with mental distress, whereas loneliness was positively associated with mental distress (Table 3). Transgender identity approached significance and was positively associated with mental distress.

Table 3

Psychosocial predictors of mental health (n = 308)

	Single Variable Models			Multivariable Models		
Variable	OR	95% CI	p-value	OR	95% CI	p-value
Outness[1]	1.14	(0.44, 2.83)	0.79	3.46	(1.01, 12.02)	0.048*
Emotional Support	0.94	(0.91, 0.96)	< 0.001***	0.98	(0.94, 1.02)	0.27
Loneliness	1.13	(1.09, 1.17)	< 0.001***	1.14	(1.09, 1.19)	< 0.001***
Age	1.01	(0.96, 1.05)	0.78	1.00	(0.94, 1.05)	0.85
Years in Host Country[2]	1.13	(0.81, 1.59)	0.48	1.30	(0.82, 2.09)	0.27
Post-Secondary Education	1.02	(0.48, 2.00)	0.97	1.46	(0.61, 3.34)	0.38
English Proficiency	0.74	(0.31, 1.59)	0.46	0.35	(0.12, 0.94)	0.05*
Asylum Status Granted[3]	0.55	(0.31, 0.98)	0.04*	0.36	(0.169, 0.75)	0.007**
Transgender[4]	2.20	(0.83, 7.69)	0.15	3.60	(1.02, 16.02)	0.06
Cis-Female	1.17	(0.57, 2.59)	0.69	1.08	(0.37, 2.84)	0.87
Bisexual	1.46	(0.62, 4.02)	0.42	2.09	(0.66, 7.83)	0.24

[1] Respondents were divided into those who were out in all social domains and those who were not out in any social domains.
[2] Years were log transformed.
[3] Respondents were divided into those with post-secondary education and those with all other education levels.
[4] Respondents were divided into those whose asylum status was granted and those who did not have status because they had not applied, had not yet had their status granted, or had been denied.
[5] This category includes all respondents who listed their gender as "transgender female," "transgender male," "genderqueer/genderfluid," and "other.

Discussion

This study demonstrates that LGBTQ asylum seekers in North America have a high burden of mental distress and a common desire to seek mental health treatment. Those who were lonely, awaiting an asylum status determination, not proficient in

English, and those who had disclosed their LGBTQ identity in all major social domains of their life were 3-4 times more likely to screen positive for mental distress than those with greater perceived social support, who were granted asylum, proficient in English, and those who had not disclosed their identity in all social domains. Transgender respondents were marginally more likely than cis-gender participants to screen positive for mental distress. A majority of participants wanted more LGBTQ friends and primarily relied on other LGBTQ people or LGBTQ organizations for social support. A majority of participants were interested in most proposed social support interventions, with interventions involving in-person interactions being the most popular.

Mental Health

Four out of five respondents screened positive for mental distress. This result is consistent with previous research among survivors of torture showing high rates of diagnosed mood, anxiety, and stress-related disorders (9)(85). A large percentage (70.45%) of those who screened positive on the refugee health screener also indicated that they were interested in seeing a mental health counselor. Acceptance of referral to mental health services varies widely among different immigrant populations (59)(86)(87). Our findings are consistent with a survey conducted by the LGBTQ asylum seeker support organization LGBT-FAN, in which 85% of respondents they "needed" or "urgently needed" mental health care (16).

Over a third of our survey participants also indicated that they had not been able to access mental healthcare since arriving in the Unites States or Canada because

of cost. In the United States, asylum seekers who have not yet been granted status must generally rely on non-profit organizations or charitable hospital programs to receive mental health services (88) . Gaining permanent residence allows asylum seekers to apply for Medicaid and in some cases removes barriers to purchasing private insurance in state Affordable Care Act exchanges (89). In Canada, LGBTQ asylum seekers awaiting status determinations can access some free health services via the Interim Federal Health Program and provincial programs such as the Ontario Temporary Health Program (90). However, in both the U.S. and Canada, even asylum seekers with access to healthcare coverage often face long wait times and limited access to mental health services (90)(91), along with variable expertise in the care of immigrant and LGBTQ populations (91). Given the great need for mental health services identified in this population, further research on the feasibility of different forms of mental health support such as peer health counseling and telepsychiatry is warranted, in addition to overall investment in mental health services and provider competency training (92).

Social Integration

As a whole, it appears that our sample respondents have been able to form social relationships with other LGBTQ individuals in the U.S. or Canada but consider the extent of their social network to be insufficient. While some respondents depend on family or immigrant communities as their primary means of social support, other LGBTQ people (e.g., romantic partners, online friends or community center staff or members) were the most common source of primary support. This appears to be in contrast with prior research with sexual minority asylum seekers in which 54% of respondents said

they had connections to "heterosexual community" and only 18% said they had connections to "LGB community" (9). This difference may be due to the fact that our sample population had spent more time in a host country before being surveyed; in fact, most of our participants had spent at least one year in the U.S. or Canada. Our sample was also recruited online and thus was more likely to be connected to internet-based LGBTQ communities. Previous research has found that sexual minority asylum seekers intentionally avoided associating with members of their own ethnic group due to concerns regarding homophobia and traumatic triggering (9), which is consistent with the infrequent endorsement of family and immigrant communities as a primary source of social support in our study. Indeed, almost half of our respondents reported being out to, but not accepted by, their own family members. Religious organizations, a common source of social support in many immigrant communities, were the least popular forms of support in our sample. Religious organizations can be sources of persecution for LGBTQ asylum seekers in their home countries (93). LGBTQ asylum seekers may also have higher rates of agnosticism and atheism, as do more general U.S. LGBTQ populations (94).

Despite the prevalence of LGBTQ friendships reported by our sample, a third of respondents also reported being in the closet at work or school, and a fifth were in the closet to housemates. Close to 10% of respondents had to work, study, or live with others who knew of their LGBTQ identity but did not accept it. The stress associated with this lack of acceptance from peers may explain the association between higher outness scores and mental distress, as discussed below.

Respondents' average loneliness score was over one standard deviation above the U.S. population mean, while respondents' average emotional support score was below the U.S. population mean, but still within one standard deviation. Taken together, these results suggest that LGBTQ asylum seekers are significantly lacking in social support. In our analyses, being one standard deviation above the mean on the loneliness scale was associated with more than three times the odds of screening positive for mental distress. It may be that loneliness and mental distress are strongly correlated because both are negative affective states with similar underlying risk factors, or because depression predisposes one to feelings of loneliness. However, studies using cross-lagged or longitudinal study designs have found evidence for a causal pathway from loneliness to depression (29)(30). Emotional support was significant in the single variable analysis, but not in the multivariable analysis. Perhaps emotional support was only significant in the single variable analysis due to its moderate negative correlation with subjective loneliness. In fact, after controlling for the effect of loneliness in the multivariable models, emotional support had no independent effect on mental health. Previous research has also found loneliness to be a stronger predictor of depression than more objective measures of social support (31)(32).

In our multivariable analysis, higher identity disclosure scores were associated with screening positive for mental distress. Previous U.S. research has suggested that sexual orientation concealment and gender conformity may shield LGBTQ individuals from stigma and resultant mental health morbidity (45)(46)(47)(48). Research on a large population of sexual minority adults across 28 countries in Europe has shown that

concealment of sexual orientation mitigates the detrimental mental health effects of structural stigma and discrimination, particularly in high-stigma countries (95). LGBTQ asylum seekers are, by definition, from high-stigma countries and may be embedded in high-stigma immigrant communities (11). One study of LGB asylum seekers found that a majority of those who disclosed their sexual orientation to another individual in the U.S. received a negative reaction (9). Other U.S. studies showing a positive association between identity disclosure and mental health (42) or an association that varies with gender (49) suggest that further research focused on the circumstances and consequences of identity disclosure in different sub-populations of LGTBQ asylum seekers would be needed to further elucidate this complex relationship.

Demographic Characteristics

In the present study, being granted asylum, and therefore legal permanent immigration status, was protective against screening positive for mental distress. This effect was independent of the amount of time spent in the host country. In addition to granting asylees access to healthcare coverage and other government benefits, a grant of asylum can relieve an enormous mental burden that has been previously correlated with greater depression, anxiety, and PTSD symptomatology in asylum seekers (58). This finding highlights the importance of granting timely decisions to asylum seekers and providing mental health services to those awaiting status determinations.

Transgender identity approached significance in our multivariable model and was associated with a 3.6 times greater odds of screening positive for mental distress. This likely reflects the fact that transgender status is associated with greater levels of

mental distress but that our statistical power to detect a relationship is small given the small number of transgender respondents in our survey (*n* = 37, or 12.13 % of the study population). Existing research has shown that compared to the general population, and compared to LGB peers, transgender individuals in North America are especially vulnerable to depression, anxiety, suicidality, and other mental health concerns. (54)(96)(97). While no quantitative research has specifically assessed the mental health burden of transgender asylum seekers, given the high rates of ostracism and violence (98) as well as lack of legal recognition (99) that transgender people face worldwide, it is not surprising that transgender asylum seekers would have exceptionally high rates of mental distress.

Low spoken English proficiency was associated with screening positive for mental distress. Lack of English language proficiency is a barrier to healthcare access for immigrants in general, and particularly to mental healthcare access (100)(101). However, the connection between language proficiency and symptoms of mental illness is not as well understood. Some research finding a link between lower English language proficiency and incidence of depression has interpreted language proficiency to be a proxy for acculturation (57) and various studies have shown that immigrants who are more integrated into host country culture have more favorable mental health outcomes (102)(103). This explanation may apply to our study population as well, although further research is needed to understand the mechanisms of this association. Lower English language proficiency may also serve as a barrier to social connection and contribute to respondent's objective social isolation.

Intervention Interest

Given respondents' high levels of interest in making LGBTQ social connections, high loneliness, and low emotional support, it was not surprising that all of the proposed LGBTQ community building interventions were popular. Interventions involving in-person, rather than online, social connections were the most popular. This may be because online friendships were already accessible to many respondents, or because respondents viewed in-person community as being more emotionally rich or otherwise important. Over 80% of respondents wanted to serve as a mentor for a more recent LGBTQ arrival. Respondents may have favored this option because of its potential to provide participants with a sense of accomplishment and service. This result points to the promise of investing in LGBTQ asylum seekers as community advocates and peer health workers (104). Many are already activists and organizers, and some have founded their own asylum support organizations (105).

Implications

Overall, these findings suggest that interventions aimed at reducing the loneliness of LGBTQ asylum seekers could lead to significant improvements in mental health. The results of this research can also help to guide mental health professionals working with LGBTQ asylum seekers who are trying to evaluate the risks and benefits of coming out in different spheres of their social life. Specific mental health resources might need to be devoted to those awaiting asylum determinations, and for those who are not proficient in English. For these populations, peer mental health and group support my be particularly useful because they can allow for communication in

preferred languages, may be feasible on a larger scale for those without health insurance, and may result in concurrent reductions in social isolation and increased material support (14). Participants' interest in LGBTQ community building, as well as the more collectivist cultures in the countries of origin of some LGBTQ asylum seekers, may also make group therapy a particularly effective form of mental health intervention (106). Systematic reviews examining the impact of interventions such as support groups, one-to-one support, and cognitive behavioral interventions have noted that interventions can improve mental health outcomes, at least in the short term (107)(108), but additional research is needed to understand which specific interventions are effective in particular populations (109).

Limitations

This study consists of the largest known survey on the social and mental health experiences of LGBTQ asylum seekers in North America using validated and normed measures among a diverse population of asylum seekers. However, study results should be interpreted in light of several important limitations. First, our study was cross-sectional and so causation cannot be inferred from the associations identified. Also, because our survey was distributed via email, it was only accessible to those who were computer literate, had regular Internet access, and were literate in one of the five survey languages. Because our survey was distributed via service providers, nonprofits, and immigrant community networks that had an online presence, we were only able to reach asylum seekers who had a connection to at least one service provider or community group.

Despite containing a wide range of participant characteristics, our convenience sampling method resulted in a group that was biased towards certain demographic factors. Most notably, a large number of participants were from Russian-speaking countries. One reason for this predominance is the existence of an active online community of Russian-speaking LGBTQ immigrants that is run by activists who were persecuted in their home countries (110). Few other LGBTQ asylum seeker subgroups are similarly organized and active online. Another possible explanation is the large wave of LGBTQ immigrants coming from Europe and Central Asia in recent years in response to state-sponsored crackdowns on LGBTQ people in Russian-speaking countries (111)(112).

The overrepresentation of gay cis-men in our sample, even relative to the average distribution of different LGBTQ identities based on population surveys, may be due to an overrepresentation of cis-men in LGBTQ asylum activist networks, or due to higher persecution rates of LGBTQ cis-men relative to cis-women. This overrepresentation likely limited our ability to detect the affect of cis-male versus cis-female gender on mental distress (power = 0.22). The small number of bisexual respondents (n = 40) may have similarly limited our power to detect an association between bisexuality and mental distress (power = 0.10). The underrepresentation of respondents with less than a post-secondary education (n= 60) may also have limited our power to detect a relationship between education level and mental distress (power = 0.163).

We utilized a screening tool for identifying mental health risk rather than diagnoses. Therefore, our survey does not capture the burden of specific *DSM*-defined mental illnesses such as major depression, generalized anxiety disorder, or PTSD. Furthermore, as a clinical tool, this screener was designed to be administered in person by a trained professional, not self-administered online, and so its accuracy may be reduced. However, the only study that found the RHS-15 to be invalid was conducted in a group of extremely low-literacy refugees (113). As mentioned above, a majority of our sample of asylum seekers had a post-secondary education and above average spoken fluency in English, which likely minimized inaccuracies related to self-administration.

Conclusion

Whereas prior quantitative research has examined the mental health burden of LGBTQ asylum seekers in small site-specific studies, our study examined associations between mental distress and psychosocial factors related to post-migration experiences in a large sample of LGBTQ asylum seekers across North America. The present findings suggest that LGBTQ asylum seekers have a high mental health burden and need for professional evaluation and treatment. Loneliness, identity disclosure, immigration status, English proficiency, and transgender identity represent potentially significant barriers to social integration contributing to this population's high burden of mental distress. LGBTQ asylum seekers have a strong interest in participating in mental health treatment and LGBTQ community building interventions, particularly those involving in-

person interaction. Further research regarding LGBTQ asylum seekers' intervention preferences and the feasibility of such interventions is needed to lay the foundation for more effective mental health treatment and social support for this vulnerable segment of the LGBTQ population.

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