
ORIGINAL ARTICLE**“They still think that I don't know enough about myself”- lived experiences of mental health distress among sexual minority women in Maharashtra, India***Dhammasagar Ujagare^{1,2}, Seema Sahay^{1,3*}*

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Abstract

Background: Sexual Minority Women (SMW) in India experience significant mental health disparities, yet their specific needs remain understudied. *Aim and Objectives:* To explore the lived experiences of mental health distress and mental health needs among SMW. *Material and Methods:* Between 23 May 2022 and 27 February 2024, a total of 29 interviews (19 in-depth and 10 key informant interviews) were conducted, face-to-face and telephonically in Maharashtra, India. Participants were recruited purposively through LGBTQ+ NGOs and using the snowball sampling method. Data were audio-recorded, verbatim transcribed, and translated in English, and analysed using a grounded theory approach. *Results:* Participants reported persistent family non-acceptance, moral judgment, and dismissal of their self-knowledge, which contributed to emotional distress and led to corrective treatments by health care providers. These experiences were compounded by a lack of queer-affirmative knowledge among healthcare professionals. Additionally, judgmental attitudes and high costs of counselling emerged as barriers to accessing mental healthcare services. SMW expressed their mental health needs, highlighting the need for safe, affordable, and queer-affirmative services delivered by trained health care providers. *Conclusion:* SMW's mental health challenges arise from social and institutional exclusion, underscoring the need for queer-affirmative training, strict legal laws for conversion practices, and expanding accessible public mental health services.

Keywords: India, lesbian, mental health, healthcare access, qualitative research, sexual minority women

Introduction

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals are at increased risk of mental, physical, and sexual health risks such as emotional distress, anxiety disorders, self-harm, suicidal ideation, substance use, sexually transmitted diseases, and cervical and breast cancers due to marginalisation and minority status [1]. Further negative encounters during healthcare access, such as discrimination, invalidation of identity, and lack of queer affirmative care, contributes to delayed or forgoing of healthcare among LGBTQ individuals [1-3]. In scientific research, the focus has been predominantly on human immunodeficiency virus (HIV) and other Sexually Transmitted Infections

(STIs) in homosexual men, with limited focus on Sexual Minority Women (SMW), viz. lesbian, bisexual, and queer women. More often, the health needs of SMW are either ignored or are assumed to be the same as those of women in the general community or the same as those of LGBTQ people. Most health studies among SMW are conducted in high-income countries

In India, despite legal advancements recognizing same-sex relationships, LGBT individuals continue to face significant disparities, particularly in health care services [4]. In the Indian LGBTQ context, studies have predominantly focused on Men who have Sex with Men (MSM) and Transgender

Women (TGW), especially about HIV and STIs. Studies among SMW have a limited focus on psychiatric care, marriage, and substance use [5,6]. Women's perceptions of distress and their health-care-seeking behaviour are often influenced by gender norms and sociocultural expectations [7], which may further shape how SMW access healthcare. Furthermore, owing to existing prejudices, discrimination, and heteronormative attitudes among health care providers in health care settings; SMW hesitate, cannot communicate, and delay in accessing health care, and suffer mental trauma [1,5]. Cultural norms, patriarchal structures, and a lack of space to deviate around sexuality further shape the lived experiences and health-seeking behaviours of SMW. There is a paucity of data on how identity invalidation and family affect their mental health and healthcare access. We conducted a qualitative study aimed at exploring the lived experiences of SMW in the context of their mental health distress and needs.

Material and Methods

Saturation is considered the cornerstone of rigor in determining sample sizes in qualitative research, which can be achieved in a narrow range of interviews (9–17) or focus group discussions (4–8), particularly in studies with relatively homogenous study populations [8]. Accordingly, between May 2022 and February 2024, a total of 29 interviews, including 19 in-depth interviews (IDIs) among SMW, and 10 key informant interviews (KIIs) among LGBTQ community representatives, LGBTQ NGO leaders, college teachers, and LGBTQ healthcare providers, were conducted using a grounded theory approach. Participants were recruited using purposive and snowball sampling through LGBTQ NGOs and the community network. IDIs included women who

were assigned female at birth who self-identified as lesbian, bisexual, pansexual, or queer.

Interview/topic guides were developed with the focus of enquiry on SMW's social status and issues, health needs, networks, and relationships. The KII guide focused on the KIIs' experiences with the SMW community, their social issues, networking, health problems, access to healthcare, and solutions to the SMW's problems. The socio-demographic data were captured on age, gender, sexual identity, education, occupation, and income.

As directed by the institutional ethics committee, IDIs were conducted by master's-level, educated women interviewers with more than four years of experience in qualitative research. These interviewers were trained and supervised by the PhD scholar (DU) and the guide (SS) to work with the sensitive population. IDIs and KIIs were conducted by master's-level women interviewers and DU, respectively, in-person (face-to-face) or virtually, i.e., telephonically or through zoom meetings, as per the participants' request, in a confidential setting convenient to the participants, in their preferred language. Interviews were conducted until saturation was achieved. No pictures were taken during the interview. The IDI/KII lasted between 30 and 170 minutes. FGD was not conducted to prevent breach of confidentiality.

Using GoldWave software, all audio-recorded interviews were transcribed and translated verbatim into English by DU. All the audio-recorded files and identifying forms were stored separately, with access only to DU and SS. The translated transcripts were thoroughly reviewed by DU and SS. Using a grounded theory approach [9], initially, open coding was used to break the data into smaller units, allowing the emergence of new concepts and categories directly from the data. A total of 534

codes were developed during the open coding process. Data were constantly compared across interviews, and related codes were grouped. Selective coding was used to integrate categories into themes representing SMW experiences.

The data were managed and analyzed using NVivo 14 software. Four coders were involved in the coding process for generating the code list. Each coder independently coded different transcripts, and the resulting code lists were compared and discussed to resolve discrepancies and reduce the influence of individual researchers' assumptions on the findings.

Data triangulation was ensured by incorporating both IDI and KII. During interviews, participants' responses were clarified, and key points were briefly summarised and checked with the participants for correct understanding of the researcher about the issue being discussed and to ensure accurate interpretation. Verbatim quotations are presented in the findings to ensure the interpretation remains grounded in participants' narratives. Due to the sensitive nature of the study population, transcripts were not returned to participants for comments to protect confidentiality, respecting their privacy and sensitivity. The study was approved by the Institutional Ethics Committee of ICMR-National Institute of Translational Virology & AIDS Research. Written informed consent was obtained from all the participants before conducting and audio recording the interview.

Definitions/terms used

'Sexual Minority Women' refers to women who are assigned female at birth and self-identify themselves as lesbian, bisexual, queer, or any identity or label other than cis-woman, straight, or heterosexual women.

'Queer-affirmative' care refers to healthcare practices that recognize, validate, and support sexual identities without any attempts to change or 'psychiatrization' of identity.

Results

The IDI respondents' ages ranged from 23 to 72 years; all were literate, and more than three-fourths of the participants reported completing a bachelor's degree (Table 1). The majority of the participants were unmarried (15/19). Of the 19 participants, 7 reported living with a romantic partner. There were seven students, and the rest were working as IT personnel (05); social workers (03); a therapist (01); a pub hostess (01), while 02 were unemployed. Out of the 10 key informants, 2 identified as male, 5 as female, and 3 as transgender (Table 2). Key informants reported diverse occupations. Their experience working in the LGBTQ field ranged from 3 to 31 years.

Participants narrated their experiences of identity expression, family responses, and encounters with mental health systems. Through the iterative coding process, following grounded theory principles, a code list of 534 codes emerged. Using the constant comparison method, codes were merged. Finally, 58 related codes were grouped during axial coding into broader categories, including identity disclosure, acceptance of SMW identity, cultural norms, internalized stigma, mental health issues, conversion treatment, barriers to accessing mental health care, and needs for inclusive and accessible mental health services. These categories were further compared and four core emerging themes captured the layered mental health challenges faced by SMW: (i) Limiting the autonomy with conditional threat – psychosocial distress, (ii) non-affirmative health system, (iii) mental health needs, and (iv) addressing the gap: mental healthcare.

Table 1: Socio demographic information of SMW participants

Characteristics	Response	N= 19 (%)
Median age (range)	25 years; range (22-72)	
Gender	Woman	18 (95)
	Non-binary	1 (5)
Highest education completed	High school/ Higher secondary	4 (21)
	Graduate	9 (47)
	Postgraduate and above	6 (32)
Sexual orientation	Lesbian	13 (68)
	Bisexual	3 (16)
	Pansexual	3 (16)
Marital status	Unmarried	15 (79)
	Married	2 (11)
	Separated	1 (5)
	Divorced	1 (5)
Currently living with	Family	6 (32)
	Living alone	3 (16)
	With friends	1 (5)
	With a male romantic partner	2 (11)
	With a female romantic partner	5 (26)
	Hostel	2 (11)
Occupation	Unemployed	2 (11)
	IT sector	5 (26)
	Student	7 (37)
	Social work	3 (16)
	Therapist	1 (5)
	Hostess (pub)	1 (5)

Table 2: Socio demographic information of KII participants

Characteristics	Response	N= 10 (%)
Gender	Male	02
	Female	05
	Transgender person	03
Highest education completed	Graduate	02
	Masters and above	08
Occupation	Programme/ researcher	02
	CBO/NGO leader	02
	Community leader	02
	Teacher	01
	Health care providers	03
	Therapist	01
	Psychiatrist	01
	Medical officer	01
Years of experience	Up to 5 years	01
	6-10 years	05
	11 years and above	04

KII – Key informant interview; CBO – community based organization; NGO – nongovernmental organization

Limiting the autonomy with conditional threat – psychosocial distress

“They still think that I don't know enough about myself.” SMW voiced this in the study. When family members discovered participants' sexual identity, either because the participant disclosed it or by accident, the family often responded with denial, disbelief, or rejection.

“So, she [/mother/] was full on against it [/lesbian identity/] that there is nothing like this [/lesbian/],

this [/lesbian/] is all nonsense.” [IDI-02, lesbian woman]

The non-acceptance by family is due to the heteronormative norms and concerns regarding social reputation in society. A participant narrated her conversation with her mother regarding her sexual identity, where she outrightly rejected her identity, framing it as morally unacceptable and socially risky.

“You know, like, she said [/mother/], what are you

saying, this is not right, what will those people say?" [IDI-16, lesbian woman]

Another participant narrated how rejection is not a single event but a continuous struggle she is facing with her family. She further highlights how parents think that she is confused or lacks understanding of her own identity. This repetitive invalidation resulted in psychological distress.

"With my family, my parents, I did face lot of trouble. I am still facing a lot of trouble, because they don't agree or accept the idea that I am, [/or may/] may not [/be/] straight, they still think that I don't know enough about myself, they are in continuous denial... That struggle is still ongoing. I don't think that reduces any time soon." [IDI-01, pansexual woman]

Non-affirmative health system

This theme captures the frustration of participants with healthcare providers who lacked the knowledge, sensitivity, or willingness to treat SMW with dignity. It illustrates how structural ignorance and heteronormativity constrained women's ability to access meaningful care, even when they urgently needed support.

Mental healthcare providers lack basic scientific understanding of SMW identities, as cited by a key informant.

"99% of the doctors do not have scientific knowledge about this [/LGBTQ/]." [KII-01, community representative]

The non-acceptance of identity by family is a major setback for SMW, affecting their mental health. This distress further becomes intolerable when parents take SMW to the doctors to fix them.

As elicited by a key informant, doctors prescribe conversion therapy:

"I would like to stress about the conversion therapy that people from this community undergo, they are

forced by their parents, sometimes even by the doctors, who recommend their parents to take them to conversion therapy, and they will be fine." [KII-05, psychiatrist]

This shift in sexual orientation is often pursued through conversion therapies. Participants emphasized that such treatments, aimed at "fixing" or "converting" one's identity, can be highly traumatic.

A bisexual woman stressed the pain she had to endure during the conversion treatment. Unable to bear, out of compulsion, she chose marriage as an escape.

"For almost one and half month to two months, he was giving me shock [/shock treatment/]... what he [/doctor/] used to do through syringe [/injection/] he [/doctor/] was giving me some kind of medicine and due to that my body used to get 'Jhatke' [/get seizures/], then sometime in every 15 days, he used to keep cloth in my teeth and used to give me electric shock... Then I thought, rather than enduring all this, it is better to get married, and so I got married." [IDI-14, bisexual woman]

Similarly, a key informant reported that a psychologist suggested her friend to go through the conversion therapy, where the doctor would attempt to gauge her reaction to pornographic images. She was subjected to aversion therapy, which she found to be extremely humiliating.

"To my friend... he [/psychiatrist/] was like just go through this therapy, whatever I do at the end of it if it doesn't work out, you can tell your parents you did manage, I'll tell your parents I was not successful... but they made her go through that process. They made her go through 'aversion therapy' where the doctor did try to gauge her reaction to different pornographic images, and it's extremely humiliating." [KII-04, psychologist]

This treatment to 'fix' or to 'convert identity' is not only because of family pressure and non-acceptance

but is also reflected in the healthcare provider's own lack of queer affirmative understanding, combined with heteronormative assumptions embedded in clinical practice as described in the theme 'Mental health needs'.

Mental health needs

SMW kept talking about the lack of affirmative care and how they experienced stigma and non-affirmative treatment when they needed mental health care. It is a matter of grave concern that mental health professionals who are needed the most are actually putting SMW through the dreaded conversion therapies. Experience of stigma was shared.

“Oh yes, the doctors they talk to, usually are very homophobic and transphobic. So it's a challenge for them while they are talking about their sexual health or when they are talking about their mental health also. So when I am talking about mental health, the mental practitioner will be the psychiatrist or a therapist who is homophobic and also puts into conversion therapies which like leads to lot of like mental trauma and even suicide for lot of people. So that is an issue a community as a whole is facing right now.” [KII-02, community representative]

This lack of affirmative mental health care, along with persistent heteronormative ideology among mental health care practitioners to cure a person's identity, can be seen in the narration below, where a participant emphasized the importance of choosing Healthcare Professional (HCP) very wisely.

“I have chosen a therapist who is queer-affirming. That also, I had to choose very wisely. My friend has been to a therapist, and they told her that you know, like... let's cure you and make you 'a straight', you know, and this is in 2022, and this still happens and in places like =Mumbai= [/big metro city in India/], and I don't really have a lot of hope, but I had to sit and choose very wisely.” [IDI-01, pansexual woman]

Another SMW expressed that HCPs should be well-oriented towards the SMW, so that they can feel comfortable; a lack of this leads to stopping her therapy.

“Yeah, there was one [/time/] when I stopped going for therapy because the therapist was not well-oriented with the queer community. I don't feel comfortable, because even if I, even I know that they're going to be very understanding, but if that person is not well oriented, then they will never really understand us.” [IDI-11, lesbian woman]

Thus, the presence of judgmental, heteronormative behaviours, and coercive conversion practices were highlighted in the themes above. However, participants also voiced a clear vision of what supportive mental health care could look like, which is described in the theme 'addressing the gap: mental health care'.

Addressing the gap: mental health care

SMW expressed that the healthcare system should be more inclusive and understanding towards them. Training of general practitioners in mental health care emerged as an expectation.

“Like I said, I think even a generic doctor needs to be taught some basics of mental health and how to behave with a patient [/SMW/]. That should be very important... I think there should be a little awareness.” [IDI-18, lesbian woman]

The curriculum needs to be inclusive of diversity so that doctors are non-judgmental and can provide due care, including mental health care, at the initial stages of diagnosis.

“So, even I don't think there's a lack of knowledge. I'm sure this is somewhere covered in their education about the LGBTQ community, but there is a lack of acceptance among these doctors. They don't want to accept that these people exist... I think even a generic doctor needs to be trained on some

aspects of mental health.” [KII-09, NGO representative]

The need for online mental health counseling was cited.

“I think nowadays everyone's comfortable with online, like, counseling and therapy. I think that would be a good thing, online counseling.” [IDI-09, pansexual woman]

There is a need for affordable mental health counselling, as there is a lack of public therapy. Online therapy can close the gap. Virtual sessions may allow SMW to access therapists, which is an affordable and accessible option available anywhere.

“There is no public therapy available. There are no public therapists which are affordable. Like, there are no government therapy spaces. So, therapy becomes expensive. So, they don't go for counseling. You know, they live with that burden. They live with that. Things have, of course, changed now over the years.” [IDI-06, bisexual woman]

Further participants expressed the need for a separate healthcare facility with queer-affirmative counselling due to the presence of stigma towards SMW.

Discussion

This study brings out an urgent need to build inclusivity among HCPs, which requires strong structural curriculum improvements to include SMW care [10]. The findings from this study highlight a multilayered mental health landscape for SMW in India, shaped by family rejection, coercive psychiatric interventions, structural barriers in healthcare, and the absence of accessible queer-affirmative mental health services. Participants repeatedly described non-acceptance of identity within families, often expressed through moral condemnation, and questions of 'what people will say.' These align with global evidence, where

family rejection significantly affects the mental health outcomes of LGBTQ+ individuals [11]. In the Indian context, the family plays an especially central role in regulating sexuality and conformity. The belief that SMW do not know themselves enough, voiced by participants' families, resonates with findings that Indian families often frame same-sex desire as confusion or immaturity [12], thereby legitimizing subsequent corrective actions.

Following this rejection, participants reported being taken by families to doctors or healers in attempts to “fix” them. These interventions ranged from moral advice and visualization exercises to unnecessary medication and coercive practices. Participants described these experiences as highly traumatic, echoing with evidence that conversion therapy increases the risk of depression, self-harm, and suicide [13]. Despite condemnation of conversion therapies, such practices continue in India due to weak regulatory frameworks [14], where HCPs reinforce societal expectations of heteronormativity.

Among participants, healthcare setting emerged as a site of fear and exclusion. Participants cited a lack of queer-affirmative HCPs, judgmental attitudes, and heteronormative assumptions as barriers for identity disclosure and care-seeking [1,3]. Mental health needs emerged as a foremost need of the SMW population who are vulnerable and in need of support and care. Additionally, India's large privatization of mental health hinders access to care. Collectively, these barriers reproduce minority stress [15], reinforcing psychological burden on SMW and avoid healthcare. The National Tele Mental Health Programme of India aims to exponentially scale up the reach of mental health services to anybody who reaches out, across India, any time, by setting up a 24x7 tele-mental health

facility in each State and UT in India, and to extend services to vulnerable and difficult to reach populations [16]. However, visibility of this program is limited among LGBTQ+ populations, as none of the participants spoke about it. We recommend enhancing the visibility of these services through banners displayed in all primary health care facilities, private hospitals, and through television and radio broadcasts.

SMW expressed a need for queer-affirmative therapists, inclusive counselling spaces, and mental health professionals to be trained in LGBTQ specific concerns. The need for affordable and accessible services underscores the integration of queer affirmative training into medical and psychological curricula. Other studies have also highlighted the need to incorporate LGBTQ health issues into medical education to improve healthcare providers' knowledge and cultural competence [10, 17]. Addressing these gaps is essential to reducing mental health disparities among SMW and to ensuring equitable and affirming care.

Conclusion

This study highlights that mental health challenges among SMW in India arise not only from sexual identity but from social and structural exclusion. Family non-acceptance often leads to corrective or

conversion-based treatment through healthcare, leading to emotional distress. The lack of queer affirmative HCPs, judgmental attitudes, high costs of therapy, and confidentiality concerns compound these experiences. Participants emphasized the need for safe, affordable, respectful, and affirming mental health services delivered by trained professionals. Strengthening queer-affirmative competencies and expanding accessible public mental health services are essential steps to support the well-being of SMW in India.

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