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DEPRESSION, ANXIETY, STRESS BETWEEN LGBTQIA+ AND HETEROSEXUAL PEOPLE: A STUDY WITH UNIVERSITY STUDENTS IN THE HINTERLANDS OF PARAÍBA

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ABSTRACT

LGBTQIA+ people have vulnerabilities resulting from the exclusion processes in which they suffer, leading them to illness and affecting their health care. By not performing the ideals of heteronormativity and being victims of prejudice, stigmatization and discrimination, these individuals may have higher levels of anxiety, depression and stress. This research aimed to verify the relationship between internalized LGBTQIAphobia, sexuality disclosure, experiences of stigma and prejudice with stress factors, anxiety and depression in a private institution, located in the city of Cajazeiras – PB, with 110 college students. For data collection, a sociodemographic questionnaire, the Minority Stress Assessment Protocol (PEM-LGB-BR), the Prejudice Scale against sexual and gender diversity and the Depression, Anxiety and Stress Scale (DASS-21) were used. The results showed that LGBTQIA+ people have higher scores of stress, anxiety and depression than heterosexuals, corroborating the results of the scientific literature.

KEYWORDS: Depression, Anxiety, Stress, College students.

DEPRESSÃO, ANSIEDADE, ESTRESSE ENTRE PESSOAS LGBTQIA+ E HETEROSSEXUAIS: UM ESTUDO COM UNIVERSITÁRIOS NO SERTÃO PARAIBANO

RESUMO

As pessoas LGBTQIA+ apresentam vulnerabilidades resultantes dos processos de exclusão nas quais sofrem, levando-as ao adoecimento e afetando seus cuidados em saúde. Por não performarem os ideais da heteronormatividade e serem vítimas do preconceito, estigmatização e discriminação, estes indivíduos podem apresentar maiores níveis de ansiedade, depressão e estresse. Esta pesquisa objetivou verificar a relação entre a LGBTQIAfobia internalizada, revelação da sexualidade, experiências de estigma e preconceito com os fatores de estresse, ansiedade e depressão em uma instituição privada, localizada no município de Cajazeiras – PB, com 110 estudantes universitários. Para coleta de dados foi utilizado um questionário sociodemográfico, o Protocolo de Avaliação do Estresse de Minoria (PEM-LGB-BR), a Escala de preconceito contra diversidade sexual e de gênero e a Escala de Depressão, Ansiedade e Estresse (DASS-21). Os resultados evidenciaram que pessoas LGBTQIA+ possuem escores mais elevados de estresse, ansiedade e depressão do que heterossexuais, corroborando com os resultados da literatura científica.

Palavras chave: Depressão, Ansiedade, Estresse, Universitários.

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1 INTRODUCTION

The LGBTQIA+ population in society presents a set of vulnerabilities that can corroborate the perpetuation of the exclusion processes that they are inserted, leading them to illness and making their health care difficult (Costa-Val et al., 2022). Rejection by the family, psychological and physical violence practiced by LGBTQIAphobic people, shame and fear in relation to their own sexual orientation, their condemnation motivated by religious discourse, beliefs of promiscuity associated with their lifestyles and the discourse about not being able to form a family are elements that can affect their mental health (Cordeiro, 2022; Dourado & Zandonadi, 2018). This social vulnerability works as a barrier that contributes to the development of anxiogenic conditions, depression, suicidal ideation, excessive use of alcohol and other drugs, development of sexually transmitted infections and stress in this public (Ferreira et al., 2022).

One of the obstacles that the LBGTQIA+ population faces in accessing health services is the professionals' lack of knowledge of the specificities of the individuals who are part of this population group. Health professionals end up comparing them to 'any other' subject who uses the service, undermining the recognition of the needs and care processes of this population (Calazans et al., 2021). Another difficulty is the non-appropriation of the discussion around gender and intersectionality, which are important structural determinants of health in guaranteeing comprehensive care (Galvão, 2021).

Unlike heterosexual individuals who have privileges and opportunities that facilitate their insertion in society, as they fulfill the ideals of heteronormativity, the LGBTQIA+ population suffers prejudice and discrimination, carrying the stigma that characterizes LGBTQIAphobia associated with their sexual orientations and gender identities (Borrilho, 2010). Consummate prejudice on the part of the majority group, heterosexuals, leads the community, which is a victim, to direct these negative ideas to itself (Antunes, 2017).

According to Crochík (1996) one of the aspects in relation to prejudice involves the attribution of certain characteristics, behaviors, judgments as belonging to objects, as well as being related to a distorted perception or understanding of reality. One of the best-known definitions of prejudice is that of Gordon Allport (1954), an American psychologist who pioneered personality theories, who characterized it as a hostile attitude towards an individual who belongs to a group that is socially devalued. For this author, prejudice has two main aspects: 1) prejudice as a cognitive failure characterized by a flawed and inflexible generalization; 2) prejudice as an emotion (antipathy). This definition, in turn, differs from the prejudice that involves previous judgments, being the prejudice more resistant to the information that questions it.

In this sense, the suffering of the LGBTQIA+ population is enhanced, since feelings of oppression are more frequent and reinforced due to intolerance, stigmatization and exclusion (Silva et al., 2021). According to Meyer (2015), an American psychiatric epidemiologist, social minorities are affected by additional specific stressors and everyday stressors. Daily stressors refer to events that cause a change in the organic balance and that are autonomous in the face of the minority condition. While the specific stressors are related to experiences whose minority

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group is a victim and their impasses in dealing with their sexual orientations, which are at odds with the heteronormative model.

For Butler (2019) compulsory heteronormativity is a concept that alludes to the set of norms around sex, gender and desire, taking heterosexuality as a reference. The term "compulsory" is related to a repetition around this heterosexual discourse that serves as a parameter for subjects to identify themselves, as in the case of a subject who is born of the "masculine" sex, he must identify himself as a man, perform masculinity and desire the "opposite gender". It should be noted that heteronormativity is guided by binary (male and female) and what is socially agreed based on these oppositions.

Those subjects who perform behaviors, gestures, express their gender and have an affective-sexual orientation that do not fit heteronormative standards are not considered "intelligible" subjects, being marginalized and made invisible by the majority group in different spaces, such as school, university, health services, workplaces, etc. (Louro, 2014). Thus, this population ends up developing specific stressors that negatively affect their mental health, reflecting the (in)equities resulting from prejudice and discrimination (Bezerra et al., 2019).

It is highlighted that the prejudice, as a stressor, is also present in other spaces, for example in school institutions that do not accommodate individuals who are part of the gender-sexually diverse community, as in the case of Maria Luisa's social prejudice. This is a case of trans experience and micro and macro aggressions experienced by Luisa, portrayed in a documentary, in the city of Rio Grande do Sul, Brazil. These authors bet on the documentary tool showing the importance of this in education as a mechanism of awareness in the school space (Rhoden, Silva & Oliveira, 2019). There is a precariousness in the debate on issues that portray the themes of gender and sexuality.

Regressions have only been observed since basic education, in which they can contribute to the perpetuation of situations of prejudice and exclusion, for example that the ways of living and exploring the body and sexuality are still connected within the school with biological and health questions. Professors are inclined to rely on approaches considered more "scientific" and limit themselves to the question of sexuality in reproduction and insist on heteronormative concepts (Guizzo & Ripoll, 2015). From this, it is possible to deduce that the school functions as a way of legitimizing exclusion processes that cause suffering to students (stress, anxiety and depression), or that it would not also be different when these matters are not only dealt with at the university level, considering as specificities of each group that is part of sexual and gender minorities.

In this context, stress can be defined as any condition that has the potential to trigger an individual's adaptive mechanism. It can also be linked to pressure, physical, mental or emotional tension caused by stressors (Torquarto, et al., 2010). These, in turn, can be characterized as events and conditions (loss of a job, end of a romantic relationship, mourning of a loved one, family conflicts) that lead to a change and demand that the subject adapt to the new situation or contingency of life (Antunes, 2019).

On the other hand, Meyer (2003) presents the concept of "minority stress" which encompasses extrinsic and intrinsic (personal) elements of stress to which sexual and gender

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minorities are subjected. To assess this stress, it is necessary to consider four elements: objective LGBTIphobic events and conditions, whether chronic or acute; the expectation of LGBTIphobic episodes and continued surveillance to protect oneself; negative social attitudes and thoughts that are introjected, that is, internalized LGBTIphobia; and the choice of whether or not to veil their sexual orientation, requiring an effort to repress and hide their identity, or to reveal it in order to face the daily conflicts of space and legitimacy.

The term "sexual minorities" or "sexual and gender minorities" involves those individuals who are socially less favored, whose sexual orientation, gender identity and reproductive/sexual practices are considered outside the standards of cultural, social and physiological normality (Silva & Costa, 2020). The Minority Stress of the LGBTQIA+ public needs to be understood from the concept of social vulnerability, since this alludes to social and cultural dynamics in interaction with individual aspects in the production of conditions of fragility and danger (Borret et al., 2021).

In the field of health, the concept of vulnerability intends to analyze how the interrelationships in the individual, collective and institutional contexts are related to the health and illness process (Oviedo & Czeresnia, 2015). This term began to be used in the 1980s when studies on the HIV/AIDS epidemic emerged, however, initially, the concepts used were those of risk groups and behaviors (Parker, 2019). Such use of these terms brought negative consequences for the LGBTQIA+ community, such as stigmatization, blame and isolation of the group that had specific characteristics (gays, transvestites, injecting substance users and sex workers), and those who were not framed in these aspects were protected (Guimarães, 2018).

The LGBTQIA+ body suffers the impacts of power relations and knowledge that are socially produced, conditioning it through its norms, behaviors that are accepted or desired, a policy that dictates those that should exist or be erased from spaces based on heteronormativity (Ribeiro et al., 2019). In the study by Santos et al. (2020) carried out at the Public University of Northeast Brazil, with 60 university students from health courses, the data obtained revealed worse mental health indicators for non-heterosexual students (35%), specifically in relation to the female public (55%). Women had more mental health impairments, while male individuals showed a rate of prejudice in relation to the sexual diversity of others or internalized homophobia, hiding their sexuality from themselves and others.

The health of homoaffective students in a study carried out by Pineda-Roa and Navarro-Segura (2019) on stressful episodes in the life of the Colombian LGBT population, reported that 2 out of 3 participants perceived some level of stress because of their sexual orientation. For men, stress was associated with problems with the police and being physically assaulted in an incident or attack. Young adults between the ages of 18 and 29 experienced higher levels of stressful events than adults over 30 years of age.

Miranda et al. (2021), in a study carried out in the state of Alagoas, detected that among the public that presented the highest average of anxiety were lesbians, followed by bisexuals and asexuals who had lower rates. In addition, one of the conditioning factors for anxiety that stood out for bisexuals, lesbians and asexuals was the variable "family", presenting a higher harmful degree, unlike gay men who highlighted "financial" as a factor that is harmful to mental health.

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Oliveira and Vedana (2020) in their research on posts that referred to suicide, depression, and population in blogs on the Tumblr platform, identified 14 blogs, with 916 posts, involving content of intense suffering, self-destructive behavior, emotional vulnerability, rejection, and self-deprecation. These data can reveal how much social networks are used today as mechanisms for symbolizing the anguish of the LGBT population. Furthermore, Torres et al. (2021) showed, in a sample of 976 participants, that the LGBTQIA+ population had a higher prevalence of medical diagnosis of depression compared to participants in the National health Survey (24.8% vs. 10.2%) and regarding lifestyle, most LGBTQIA+ participants indicated weekly alcohol consumption (82.7%), in which 20.9% were smokers.

In view of the above, this research aimed to verify the relationship between internalized LGBTQIAphobia, sexuality disclosure, experiences of stigma and prejudice with stress factors, anxiety and depression in a private institution, located in the city of Cajazeiras – PB. It is believed that analyzing these factors allows understanding the prevalent symptomatology in the LGBTQIA+ population compared to heterosexual individuals, considering the social factors involved in health-disease processes. In addition, it is expected that there will be contributions to public health professionals, psychologists and public policy makers to broaden their perspectives and interventions on the health demands of the LGBTQIA+ population.

2 METHOD

2.1 Participants

Participated in this study 110 university students from Centro Universitário Santa Maria - UNIFSM, located in the municipality of Cajazeiras, Paraíba hinterland. 70% (n = 77) identified themselves as cis-women, 31% (n = 31) identified themselves as cis-men and 1.8% (n = 2) considered themselves non-binary, aged 18 and over (M = 22.75; SD = 6.12). As for sexual orientation, 70% (n = 77) declared themselves to be heterosexual, while 30% (n = 33) declared themselves to belong to the LGBTQIA+ population (bisexuals, n = 16; lesbians, n = 4; homosexual, n = 15). Most participants are brown people, 47.3% (n = 52) and white, 45.5% (n = 50). Black people represented 6.4% (n = 7) and there was one participant who declared himself to be indigenous. Family income declared by most participants ranged from 1 to 5 minimum wages (91.8%; n = 101).

2.2 Data Collection Procedures

Data collection was carried out using a form previously created in Google Forms, applied to students in real time upon invitation made in the classroom and with authorization from teachers. The form included the sociodemographic questionnaire, the Minority Stress Assessment Protocol and the Depression, Anxiety and Stress Scale.

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2.3 Data Analysis Procedures

Data were analyzed using the *Statistical Package for Social Sciences (SPSS) software,* version 27. Descriptive statistics were performed to characterize the sample. To analyze the constructs between the two groups of LGBTQIA+ and heterosexual people, Student's t tests were performed for independent samples, to assess the extent to which the levels of stress, anxiety and depression, prejudice against sexual and gender diversity were different. In addition, Pearson correlation analyzes was performed to investigate the relationship between stress, anxiety, depression, prejudice, internalized LGBTQIAphobia, stigma and sexuality disclosure.

2.4 Ethical Procedures

This is part of a larger postgraduate project, master's degree, that was conducted after approval by the Research Ethics Committee of the State University of Paraíba – Campus Campina Grande (CAAE: 65449922.0.0000.5187). All steps were duly completed in an ethically and methodologically appropriate manner, considering the Regulatory Guidelines and Norms for Research Involving Human Beings (Conselho Nacional de Saúde, 2012).

2.5 Instruments

Sociodemographic questionnaire. This instrument aims to highlight sociodemographic information, involving aspects related to age, gender identity, sexual orientation, color/ethnicity, marital status, family income, religion etc.

Minority Stress Assessment Protocol (PEM-LGB-BR; Costa et al., 2020). This protocol contains three scales (Internalized Homonegativity Scale; Sexuality Disclosure Scale; Stigma Experience Scale) that were adapted for the Brazilian context, aiming to assess Minority Stress in LGBs people.

Internalized Homonegativity Scale. It contains 7 items, whose response options vary in terms of agreement 1 (“I totally disagree”) to 7 (“I totally agree). It evaluates the internalized homonegativity that concerns dissatisfaction with being homosexual arising from the reaction to social prejudice around homosexuality.

Sexuality Disclosure Scale contains 4 items and assesses the level of sexuality disclosure as they “come out of the closet” to heterosexual friends, family members, co-workers, gay friends or LGBT friends. Items are rated on a four-point scale: 1 (Did not disclose); 2 (Revealed to few); 3 (I revealed it to many); 4 (Revealed to all).

Experiences of Stigma Scale contains 7 items and analyzes the experiences of stigma, asking individuals about previous experiences of abuse, violence and discrimination caused by sexual orientation. Response options range from 0 (never) to 3 (three or more times).

Scale of Prejudice Against Sexual and Gender Diversity (Costa et al., 2015). This scale contains 16 items and assesses the level of prejudice against lesbians, *gays*, transsexuals and gender nonconformity. Items are rated on a five-point scale ranging from 1 (completely disagree) to 5 (completely agree).

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Depression, Anxiety and Stress Scale or DASS-21 (Patias et al., 2016). It has 21 items and asks the individual in response to mark the level at which a given situation applied to him in the last week. Answers range from 0 to 3, where 0 equals “did not apply to me at all” and 3 equals “applied to me a lot or most of the time”.

3 RESULTS AND DISCUSSION

The results of Student's T tests demonstrated that LGBTQIA+ people (M = 1.56; SD = 0.78) had significantly higher levels of stress than heterosexual people (M = 1.21; 0.67; t (108) = -2.37; $p < 0.05$; Cohen's d = 0.70). Regarding depression levels, LGBTQIA+ individuals (M = 1.44; SD = 0.86) had significantly higher levels than heterosexual people (M = 0.97; SD = 0.74; t (108) = -2.95; $p < 0.05$; Cohen's d = 0.78). Anxiety levels were statistically higher for the LGBTQIA+ group (M = 1.13; SD = 0.76) than heterosexual people (M = 0.69; SD = 0.58; t (48.7) = -2.91; $p < 0.05$; Cohen's D = 0.64). Regarding levels of prejudice against sexual and gender diversity, heterosexual people (M = 1.48; SD = 0.73) showed higher levels than LGBTQIA+ people (M = 1.13; SD = 0.21; t (99.7) = 3.78; $p < 0.05$; Cohen's d = 0.62).

Table 1: Comparison between the Constructs by group composed of heterosexuals and LGBTQIA+ people.

Constructs	Groups	N	Mean	SD	t	p	Cohen's d
Stress	Heterosexual	77	1,22	,67	-2,37	0,02	0,70
	LGBTQIA+	33	1,56	,79			
Depression	Heterosexual	77	,97	,74	-2.95	0,00	0,78
	LGBTQIA+	33	1,45	,86			
Anxiety	Heterosexual	77	,70	,59	-2,91	0,00	0,64
	LGBTQIA+	33	1,13	,77			
Prejudice	Heterosexual	77	1,48	,73	3,78		0,62
	LGBTQIA+	33	1,14	,21		<,001	

Table 2: Correlation between the construct’s depression, anxiety, stress, prejudice, stigma experiences, sexuality disclosure, internalized LGBTQIphobia.

		Depression	Anxiety	Stress	Prejudice	Stigma Experiences	Sexuality disclosure	Internalized LGBTQIphobia
Depression	r	1						
	N	110						
Anxiety	r	,68**	1					
	N	110	110					
Stress	r	,71**	,82**	1				
	N	110	110	110				
Prejudice	r	-,24*						
	N	110						
Stigma Experiences	r			,37*		1		
	N			33		33		
Sexuality Revelation	r				-,37*		1	
	N				32		32	

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Internalized LGBTQIphobia	r				,41*		-,49**	1
	N				33		32	33

**. Correlation is significant at the 0.01 level v (2 tailed).
**. Correlation is significant at the 0.01 level v (2-tailed).

Significant and negative correlations were found between depression and prejudice (r = -0.24; p = 0.01) and between prejudice and sexuality disclosure (r = -0.37, p = 0.04). On the other hand, significant and positive correlations were identified between stress and stigma experiences (r = 0.37; p = 0.03), between prejudice and internalized LGBTQphobia (r = 0.41; p = 0.02) and between internalized LGBTQphobia and sexuality disclosure (r = - 0.49; p = 0.00).

The main objective of this study was to compare levels of stress, anxiety and depression in university students who were members of the LGBTQIA+ community and heterosexual. The results identified significant differences in the constructs investigated between the two groups, with LGBTQIA+ people, being a minority in the political sense, presenting higher scores for stress, anxiety, and depression. These data corroborate with studies developed in Brazil and internationally (Chinazzo et al., 2021; Souza et al., 2022; Urzúa et al., 2022).

Negative mental health conditions are commonly associated with socially marginalized groups, such as depressive symptoms, anxiety, substance use, suicidal ideation. Furthermore, such an outcome may be associated with the strengthening of conservatism, which tries to make invisible the struggle flags of social movements that are present in society and that have the purpose of combating the oppression that individuals of LGBTQIA+ community, black people, women, people with disabilities, indigenous people suffer (Souza, 2020).

In this context, when health services understand that respect for the social name and preparation to embrace sexual and gender diversity are necessary, the specific needs of the LGBTQIA+ population will be met, as well as programmatic vulnerability will be reduced (Lima et al., 2019). In the Unified Health System (SUS) it is essential that people with different needs need their care to be carried out differently, since one of the principles that govern this system is equity (Matta, 2007).

Regarding prejudice against sexual and gender diversity, LGBTQIA+ people are targets of psychological violence, such as humiliation, pressure to change their behavior, rejection and lack of social support related to the isolation of social interaction in the most diverse nuclei, including the family (Gomes et at., 2021). Therefore, these subjects, when reporting that they are experiencing anguish, reflect the lack of necessary support and are forced to fit into the parameters of heteronormativity, aiming at adapting to the system so that they can experience happiness and well-being (Linhares et al., 2021).

In addition, there is a significant and negative correlation between depression and prejudice, but it is noteworthy that the average scores of LGBTQIA+ participants were statistically higher. Such a correlation may have been negative between these two variables, since one of the linked limitations was the sample size of members of this community used for this research. Thus, one of the factors that may be associated with levels of depression in sexual minorities when compared to heterosexuals is suicidal behavior. The transsexual population, for example, has the highest prevalence rates of suicidal ideation and attempts with 67% and 35.5%

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respectively (Carvalho et al., 2019). This author points out that among the risk factors, the one that stood out the most was discrimination and regarding protective factors, social and family support were fundamental. Another fundamental aspect is religion, which for many works as a protective factor, but for LGBTQIA+ individuals it can operate as a risk factor, since many religious discourses disapprove of sexual relations with people of the same sex, perceiving them as sinful or "unnatural" (Silva & Barbosa, 2016).

In the qualitative mixed method study by Malta et al. (2020) carried out in the city of Rio de Janeiro, involving 50 participants who were part of sexual and gender minorities, found extremely high rates of generalized anxiety disorder (GAD) – 66%, major depressive episode (MDE) – 46% and post-traumatic stress disorder (PTSD) – 39%. Even so, low self-esteem and negligible social support were mentioned by a third of this same sample.

On the other hand, there was a significant and negative correlation between prejudice and sexuality disclosure, that is, the greater the prejudice that LGBTQIA+ individuals suffer, the lower the levels of sexuality disclosure. This information can demonstrate the social situation that LGBTQIA+ people face in not "coming out", not revealing their sexual and/or gender identity due to the fear they feel of being rejected by other people, especially by the family, which ends up creating expectations based on heteronormative roles. Consequently, intolerance can lead to the breaking of ties, refusal to provide support and violence (Nascimento & Scorsolini-Comin, 2022).

Minority stress is mainly associated with the stigmas they carry in their lives, as demonstrated by the positive correlation between these two constructs. Silva et al. (2021) concluded that transgender people are at increased risk of mental illness, particularly anxiety disorders. Anxiety symptoms interfere with the production of stressful conditions that affect their daily lives, such as exclusion related to gender identity and expression and the isolation of the population in the most diverse areas, health, education, work, politics.

Although minority stress initially developed in the context of sexual orientation, gender identity is also equally implicated. Thus, minority stress processes are understood along a distal to proximal continuum. Distal stressors refer to experiences and events external to the person (life events, chronic tension, everyday discrimination or microaggressions) while proximal stressors are those that are transmuted through socialization and experienced by the individual through internalized cognitive processes (internalized negative social attitudes, internalized homophobia and transphobia, expectations of rejection and discrimination, stigma, concealment of sexual and gender identity (Meyer, 2015).

Internalized LGBTQIAphobia is related to prejudice against sexual and gender diversity, as shown by the correlation between these two variables. This manifestation of internalized LGBTQIAphobia can happen in psychotherapy, making psychological care difficult and constituting one of the barriers to accessing mental health for this public. Many patients, for example, decide not to talk about their sexual orientation or gender identity for fear or insecurity of suffering prejudice and discrimination in these spaces, thus, an affirmative approach is necessary so that these subjects are welcomed and feel comfortable talking about their demands (Mussi & Malerbi, 2020).

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This affirmative approach to psychotherapy was first mentioned by psychologist Alan Malyon (1982) and concerns a body of specific psychological knowledge that questions the traditional wisdom that perceives homosexual desire and homosexual orientations to be pathological. This pathologization still persists in contemporary society, as can be seen in the study by Guimarães et al. (2020) who investigated the view of primary care professionals in the construction and maintenance of stigmas directed at this population. The analyzed discourses revealed that stigma is still present in the common sense of society, being enhanced and rationalized by contemporary Scientia Sexualis, reinforcing the production of psychiatric classifications and statistical analyzes that focus on the notion of groups and risk, producing a stereotyped generalization that involves members of the LGBTQIA population to alcohol abuse, psychological disorders and promiscuity.

In this way, prejudice can be understood as a social construction that precedes the constitution of the subject, since normative hetero and cis practices already exist and try to regulate human relationships. In this sense, LGBTQIA+ patients reported that they have already gone through discrimination, hostility, negative therapeutic experiences, highlighting veiled and subtle microaggressions. Such communication involves erroneous beliefs, prejudices and sexual stigmatization that may occur consciously or unconsciously.

Sousa and Aragão (2019) analyzed the discourse of professionals and users of a hospital in the city of Parnaíba-PI. It was noticed that both professionals and users are unaware of the existence of the National Comprehensive LGBT Policy. This policy aims to guarantee the rights of the LGBTQIA+ public. This lack of knowledge about the policy results in the reproduction of situations of prejudice in health devices that help these users who identify themselves as transgender people and hinders prevention and health promotion.

A significant and negative relationship was perceived between internalized LGBTQphobia and sexuality disclosure, that is, the internal prejudice that people in this community have affects them to the point of not being able to publicly express their sexuality. Most LGBT+ people do not have a support network full of friendships, family members and support from religious communities. This contributes to many becoming hypervigilant in relation to those people who will or will not support them in their sexual orientation and gender identity (Tomicic et al., 2021).

The factor of acceptance and respect for sexual and gender identity helps LGBTQIA+ people feel supported, proud of themselves and able to face and set limits in relation to the discrimination and prejudice they suffer daily (Figueira, 2020). In this way, the family occupies a prominent place within the support network for non-heterosexual people, since it has essential functions for the subject's development, among which biological ones stand out, such as the survival of the species, as well as psychological and social. Family support can be positively perceived by these people, as it allows them to present positive mood-related behaviors in which they contribute to a sense of well-being and psychosocial health among the people who are part of the family arrangement (Orcasita et al., 2020).

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4 CONCLUSION

Understanding the phenomena that revolve around the onset of psychological disorders prevalent in the LGBTQIA+ population is an essential task for health professionals. Recognition of the specific stressors that lead to illness and vulnerability in this population can guarantee equity, strengthen these subjects' ties to health services and promote public health policies that are more appropriate to the needs of this population.

Furthermore, inserting in this field the political, social and historical dimensions that include the processes of (de)pathologization is important to reframe the care processes that are denied to this layer of the population. The affirmative approach, in this sense, can be a factor that collaborates in the promotion of mental health since it recognizes sexual and gender difference as a manifestation of human experience and expression.

Universities are institutions that can include the responsibility of promoting mental health in the most diverse projects, events and curricular units in their agendas, allowing LGBTQIA+ people to produce their own narratives. In this way, it would provide visibility and reduce vulnerabilities. Specific programs aimed at the LGBTQIA+ population can be carried out in psychology school services to prevent and promote care, enabling these spaces, in addition to educational training, to contribute to guaranteeing the rights of this group.

It should be noted that this study had limitations regarding the type of sample used. Thus, future research may arise to fill in the gaps in this one. A larger sample may highlight more significant differences regarding intersectionality and other social markers of health. Even so, the data found could strengthen the information about research involving the symptomatology of this public.

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