

SOCIAL IDENTITIES AND MENTAL HEALTH

A whitepaper on a mixed-methods study undertaken by the Belongg Mental Health Collective on the mental health service related experiences of individuals, based on their identities and identity-related experiences.

BELONGG MENTAL HEALTH COLLECTIVE

brings inclusive mental health resources to people who face identity-linked discrimination and prejudice.



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1 EXECUTIVE SUMMARY

BACKGROUND

Mental health conditions such as major depressive disorder, anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder, affect hundreds of millions of people in the world. According to the World Health Organization (WHO), one in four people will be affected by mental health or neurological disorders in their lifetime (World Health Organization, 2001).

India faces significant levels of mental health illness with another WHO report suggesting that while approximately 7.5% of the 1.3 billion people in India are living with mental illnesses, there are only 4,000 experts to cater to them (World Health Organization, 2017).

The problem is more pronounced for people with marginalized identities in terms of gender, race, caste, disability, sexuality, and ethnicity. A wide range of qualitative and quantitative studies have conclusively shown that people who face discrimination due to their religion, sexuality, gender, or disability face more prominent episodes of depression, anxiety, or fear. Furthermore, people with overlapping marginalized identities face even more pronounced challenges.

When it comes to seeking care, research carried out in certain countries shows that individuals belonging to minority identities report less satisfaction, comfort with and acceptance of mental health services compared to members of non-marginalized identity groups. But this problem hadn't been studied in India rigorously and presented an important research gap.

Between 2020-2021, Belongg carried out two rounds of surveys and studies focused on Identity and Mental Health in India. While studies from the first round have been published previously, this report covers the second round of the study carried out in 2021.

The quantitative phase of the study included responses from 111 participants from across India. Most of the participants in the survey were individuals in the age group of 18-25, who identified as female, completed graduation or diploma and are currently employed (working for more than 35 hours per week). The survey was followed by in-depth interviews with 10 respondents who consented to being interviewed.

KEY FINDINGS

- While 59.46% of respondents reported facing identity-based discrimination, only 50% of them were using a mental health service at the time of taking the survey.
- The proportion of respondents who had not faced discrimination and who felt they never had to use a mental health service was almost twice that of those who had faced discrimination indicating the lower status of mental health among those who have experienced identity-based discrimination, among other things.
- Most of the respondents who had experienced identity-faced discrimination but hadn't used a mental healthcare service before cited affordability as the biggest barrier to seeking care.
- Most of the reasons cited by respondents who had experienced identity-based discrimination and stopped using a mental healthcare service, were related to the mental health professional while most of the respondents who hadn't faced discrimination stopped using services due to experiencing positive gains from therapy.
- Among respondents who have used mental healthcare services, those who had experienced discrimination rated the service they used and the professional who provided it significantly more poorly than those who had not experienced discrimination.
- Among respondents who had experienced identity-based discrimination, those who discussed the same in therapy rated the service and professional more positively than those who did not discuss their experiences with discrimination with their therapist.
- Qualitative responses pointed to people feeling invalidated in therapy rooms and hence giving up on therapy altogether because aspects of their identity or their lives were not deemed relevant or salient by the therapist. Such respondents rely on alternate safe spaces among peers for community healing.
- Therapeutic services were a source of stress for some minority respondents who were unsure about the professional's social and political leanings and therefore spent much energy carefully gauging them from their responses in the therapeutic setting or by meticulously concealing certain stigmatized parts of their identity in therapy.
- Respondents felt that the lack of a) personal lived experiences (of the identity that the clients belong to) and b) training in identity-linked mental health were two of the most significant challenges therapists faced in addressing the mental health needs of diverse help seekers.

The results point to the need to design and promote conversations, content, and resources addressing the problem of identity-based discrimination in Indian mental health and creating substantive solutions.

RECOMMENDATIONS

Based on the results from the study, Belongg recommends five high-level solutions.

1. Creating targeted knowledge resources, such as identity-specific mental health toolkits, for mental health professionals as well as mental health users.

Even though in recent years we have witnessed an increased awareness about the linkages between social identity and mental health, many respondents have noted a lack of existing resources for mental health users as well as mental health professionals that focus on intersectionality in mental health. This lack necessitates the creation of resources as well as training programmes that address unique mental health challenges caused due to identity-based experiences of discrimination.

2. Advocacy and programs to promote the inclusion of psychosocial studies in curriculums designed for psychology students.

While typical training in psychotherapy involves studying psychological aspects of an individual and the human brain, it often excludes the sociological understanding of mental health. This is crucial in countries such as India (where emic-based evidence suggests that socio-cultural factors such as poverty and majoritarian identity, emotional and physical violence, etc. play a significant role in the development of mental health issues among individuals). It is imperative that the training/s received by mental health professionals be oriented towards understanding the diversity that exists around us, and its impact on an individual's mental health.

3. Designing and promoting specific mental health care plans optimized for diverse marginalized groups

It is important that mental health care plans catering to members of specific marginalized communities such as the queer community are readily available for mental health professionals across the country. It is equally important for mental health professionals as well as mental health organizations/collectives to adapt their services to help the community members navigate identity-linked trauma and other mental health challenges.

Capacity building and training of members from marginalized communities on intersectional mental health and care

4. It should be highlighted that there is an urgent need to capacitate individuals from communities that have faced structural oppression for generations. Training modules on community mental health should be made readily available to members of the marginalized community to aid the creation of ecosystems of care. Simultaneously mental health academic and training institutes should emphasize scholarship programmes for course candidates from marginalized communities.

5. Greater funding, innovation, and visibility for intersectional innovation in the mental health sector

Mental health professionals, researchers as well as organizations need to make a conscious effort to promote and create avenues for innovations catering to the intersectional needs of the individuals who face identity-linked discrimination. Such innovation would help create a nationwide momentum towards intersectional inclusion in the mental health sector. Funders need to support this intersectional agenda through dedicated funds and programs focused on intersectional mental health.

2 BACKGROUND OF THE STUDY

“A system cannot fail those it was never meant to protect.”

-W. E. B. Du Bois

Taking note of the different identity-related experiences that individuals have and the demonstrated link between these experiences and mental health, Belongg undertook a study on ‘Social Identities and Mental Health’. The purpose of the study was to fill the vacuum of knowledge about the experiences of mental health service users in India who belong to different social groups, and the unique challenges they face in accessing and using mental health services to cope with the impact of identity-based discrimination. The competence of mental health professionals in the country when working with service users with minority or stigmatized identities was also studied.

The experiences of users of mental health services were documented by employing quantitative questions as well as through in-depth qualitative interviews. The study findings are crucial to the evaluation of the accessibility of mental health services to persons with stigmatized identities in the country and also provide some insight into how professionals presently fail or succeed in meeting the unique demands of these service users

A total of 111 participants participated in the quantitative phase of the study. The qualitative phase of the study included in-depth interviews with 10 participants purposively selected from a group of 66 who had consented to be contacted for an interview.

Both the quantitative data as well as qualitative data pointed out that a greater proportion of individuals who have faced identity-based discrimination seek mental health services as compared to individuals who have not faced identity-based discrimination and generally, individuals who have faced discrimination fare poorly when they use a mental health service, as determined by their dropout rates and evaluation scores.

Participants of the study had faced different forms of discrimination, both overt and covert. It was underlined that discrimination of any kind and nature had an impact on the mental health of participants as evidenced in the qualitative data. Among the participants who have faced discrimination, few seek mental health services. A few participants perceived mental health service settings as not being suitable for discussions around ‘experiences of discrimination’ but rather oriented to marked ‘psychological’ symptoms.

Respondents shared that negative experiences with one's MHP/s in the past have contributed to a change in attitude/s towards mental health services. A few participants reported changing their search strategy when it comes to finding an MHP to include reliable sources of information like friends instead of searching online, and they generally needed to expend a lot of effort into finding a suitable MHP. While services may be accessed, they are, it seems, not readily accessible for people with certain minority identities.

Moreover, the quantitative data revealed an association between the participant's decision to disclose their experiences with discrimination to the MHP and their perception of the MHP's competence. In-depth interviews revealed that they do this through examining the MHP's professional title, as well as through judging the first few sessions and the MHP's professionalism, ability to create a safe space for discussions, etc.

After taking into account the high prevalence of exposure to discrimination, the significant impact that this exposure has on their mental health and the less than ideal experiences that individuals with minority identities have in mental health service settings, Belongg recommends future research to uncover more information about the mental health service experiences of persons who face discrimination to inform therapeutic practices. There is a clear need for MHPs to expand their competence by engaging more closely with the social realities of different groups in society.

THE MENTAL HEALTH CHALLENGE



Source: Dhruvi Acharya

The term mental health encapsulates a wide variety of conditions, issues and contexts. While illness represents individual suffering, disease implies structural and functional abnormalities (Boyd, 2000). Even though the difference between the two has been blurred constantly by experts, especially medical professionals, doing so can be quite harmful. The heterogeneity of the experience, disparity of contexts, and diversity of people make the task of employing a single framework difficult (Jacob, 2016). This distinction is quite important in our efforts to understand mental health, especially in the context of India.

Mental health conditions such as major depressive disorder, anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder, affect millions of people in the world. According to the World Health Organization (WHO), one in four people will be affected by mental health or neurological disorders in their lifetime (World Health Organization, 2001). Despite the high prevalence rates, mental illness is still seen as taboo in low and middle-income countries such as India, with governments and societies both continuing to accord relatively low levels of importance to addressing such challenges and mental health a stature as compared to the physical health of their people.

To tackle the stigma associated with mental health challenges, former Director-General of WHO, Dr. Gro Harlem Brundtland, said, "mental illness is not a personal failure. In fact, if there is a failure, it is to be found in the way we have responded to people with mental and brain disorders." (World Health Organization, 2001).

However, the tide is slowly changing with several non-governmental organizations and global organizations now placing more emphasis on the mental health of their employees and stakeholders. But there is still a long way to go to fully address this issue, including the need to invest more in making this acceptable, making it easier to access support services, and also creating better infrastructure. Another WHO report suggests that while approximately 7.5% of the 1.3 billion people in India are living with mental illnesses, there are only 4,000 experts to cater to them (World Health Organization, 2017). Moreover, the prevalence rate could be much higher, as suggested by the findings of a countrywide 2015-2016 study by India's National Institute of Mental Health & Neurosciences (NIMHANS) (Murthy, 2017). It revealed that nearly 150 million Indians needed active intervention while fewer than 30 million were getting it. Furthermore, poor accessibility to these services makes them expensive, thereby reducing access further. Nearly 35% of India's population is between the ages of 15 and 34 years, according to the government's statistics. And suicide was the leading cause of death among young people – aged 15 to 39 – in 2016, according to Lancet Global Health Study (Lancet, 2017).

In the following sections, literature on identity-based discrimination and its link to the mental health of minorities is explored. A vast majority of these studies come from the West and focus on sexual and ethnic minorities, mostly Black and Hispanic communities. Studies on their experiences while using mental health services were fewer and studied categorical rather than experiential variables. These were reviewed alongside studies on the characteristics of services presently available to minorities and recommendations for improved services. The section closes with a recall of the findings of our previous survey titled 'Belongg Mental Health Survey 2020'.

MENTAL HEALTH AND IDENTITY-BASED DISCRIMINATION

Identity-based discrimination which may be defined as the unfair or differential treatment of an individual due to their membership in a certain social group exacerbates mental health issues for people significantly. A mix of qualitative and quantitative studies has shown that people who face discrimination due to their religion, sexuality, gender, or disability face greater mental health challenges than their counterparts belonging to majority social groups (Drabish & Theeke, 2022; Link & Phelan, 2001; Wandrekar & Nigudkar, 2020). As an example, the Human Rights Campaign Foundation found in a 2016-2017 survey that 28% of LGBTQ youth — including 40% of transgender youth — had felt depressed most or all of the time during the previous 30 days, compared to only 12% of non-LGBTQ youth (Human Rights Campaign, 2018).

With minority status comes the scope of internalizing stigma, and an inability to perceive social-psychological resources, in the rare case that they are available, which contributes to poor mental health (Lehavot & Simoni, 2011). When sexual minority identity intersects with another minority identity, for instance having a mental health diagnosis such as borderline personality disorder, the individual who faces multifold discrimination is at greater risk of experiencing depressive symptoms (Chang, Kellerman, Fehling, Feinstein & Selby, 2021). Hence, at any point, an individual is experiencing threats to their mental health from various sources which target them due to their many identities or they are protected by the same.

Not just sexual minorities, but the ethnic minorities in the Western world also suffer a similar fate (Vines et al., 2018; William, Neighbors & Jackson, 2003). Cokley et al.'s (2011) study found that students with minority status reported more discrimination and lower mental health than students belonging to ethnic majorities. This study also established the mediating role of discrimination in the relationship between ethnic identity and mental health. Taken together, when racial/ethnic and sexual minority status is investigated, studies have found that existing as "minorities within minorities" puts Black sexual minorities at increased risk of oppression and discrimination thereby increasing the risk of psychopathology (Greene, 1994, p. 248). More recently, Calabrese and colleagues (2015) studied Black sexual minority women who are triply marginalized in society and found that they experienced more discrimination and reported more depressive symptoms and poorer social wellbeing as compared to their male counterparts and White sexual minority women, indicating that the more marginalized or stigmatized group an individual belongs to, the more complicated is their experience of mental health.

Such a positive correlation between identity-based discrimination and mental illness has been documented in minority individuals of all age groups ranging from the lower to the higher end. Children and adolescents who face discrimination are at greater risk for common mental disorders and when the child or adolescent has experienced discrimination, problem behaviours are also common (Coker et al., 2009; Szalacha et al., 2003; Tobler, Maldonado-Molina, Staras, O'Mara, Livingston & Komro, 2012). Not only their personal experiences with discrimination but the discrimination that their parents face too has been found to affect adolescent mental health, providing evidence for the linked lives hypothesis (Park, Du, Wang, Williams & Alegria, 2018). On the other end, older adults too face racial/ethnic discrimination and discrimination based on their sexual identities which are associated with their poor mental health status (Fredriksen-Goldsen, Kim, Barkan, Muraco & Holy-Ellis, 2013; Jang, Chiroboga, Kim & Rhew, 2010; Kim & Fredriksen-Goldsen, 2017). Among all the age groups, however, adolescents and

young adults seem to be at greater risk of adverse mental health outcomes according to Vines et al.'s (2018) review of 171 journal articles.

At certain points in history, specific identities come under mass attack. The COVID-19 pandemic is one such incident wherein misinformation about the virus and uncontrolled aggression has led to Asians, specifically Chinese individuals, facing widespread discrimination, virtually and in person. There is an increasing number of cases of racial and ethnic discrimination targeting certain communities, increasing mental health challenges for them (Lee & Waters; 2021; Zhou, Banawa & Oh, 2021). Not just Asians but other minority communities who have always faced health inequalities like African Americans have suffered disproportionate losses at the hands of the so-called “great equalizer” (Johnson, 2020; Stafford, Hoyer & Morrison, 2020). In India too, the pandemic brought with it a milieu of conditions that posed challenges to the mental health of women, migrant labourers, sexual minorities and those with a history of mental illness (Joshim, 2021). The increase in caste-based discrimination is clearly illustrated in Kisana and Shah's (2021) study that captured the experiences of sanitation workers (who are typically members of marginalized caste groups) whose employers have manipulated the pandemic to discriminate against them further and even justify practicing untouchability.

THE INDIAN CONTEXT

CASTE

Of all the identities in the Indian context, caste identity has been a dominant factor in the discourse of social exclusion. The caste system is a form of social stratification that divides people into rigid hierarchical groups based on their birth. While there is ample evidence of caste-based discrimination and violence, social entitlements, and intergenerational oppression - there is scarcely any academic inquiry into the psychological impact of caste. A few scholars have argued that psychiatry and psychology in India are largely based on western constructs that overlook cultural identities, especially caste, and center it in their work (Jadhav, 2014; Jiloha, 2010; Pal; 2015, 2020).

Indian scholar, Pal (2015), drawing from vast empirical research on caste violence, social exclusion and mental health found that violence, big and small, results in the reiteration of the status of lower-caste groups as inferior. Mental health challenges in these groups are impacted by a confluence of distress following discrimination, the cut down of social ties, restricted mobility and social injustice, thereby demanding complex, multi-dimensional interventions.

Pal (2015) recommends using interventions that promote resilience, increase the lower-caste group's sense of belonging in the larger society, and improve communication between different communities. As is readily evident, these solutions are starkly different from conventional mental health interventions that typically take an individualistic rather than a social or group approach to therapy. There is also an increasing understanding of the lack of representation of therapists from lower caste groups which proportionally affects the therapy-seeking population from such groups and also obliterates contextual inputs in the making and framing of mental health services in India (Sawariya, 2021).

Later, Pal (2020), argued that the psychological impact of caste can be simplified into two forms - aggression and withdrawal. Being constantly subjected to discriminatory treatment, denial of opportunities, and restrictions in interpersonal relations undermine their sense of dignity which fuels alienation and trauma starting from a young age. Caste violence permeates fear and trauma not just in the minds of the victim but the entire community (Pal, 2020). This is further exacerbated by a lack of access to mental healthcare owing to their socio-economic background.

OTHER IDENTITIES

Similarly, specific religious, gender, ethnic, disability and other identities are also related to discrimination and oppression, and consequently, poor mental health in India. A 2017 WHO report on depression ranked India alongside countries where the burden of depression is 50% higher for females than males (World Health Organization, 2017). Needless to say, religious minorities in India are socially excluded and marginalized to a great extent. A large population-level analysis of mental health found that Scheduled Caste and Muslim individuals are less mentally healthy as compared to upper caste Hindus, a difference that was not explained by class differences (Gupta & Coffey, 2020). This study highlights the need for addressing the effects of discrimination instead of blindly distributing culturally-irrelevant mental healthcare services. When a minority religious identity intersects with other identities like a minority sexual identity, the mental health challenges the individual faces become more profound (Askari & Doolittle, 2022).

Violence from the past too follows marginalized social groups like a ghost. Indians who migrated from Pakistan during the partition feel alienated, with no sense of belonging and experiencing intergenerational trauma to this day (Kalra & Zysk, 2020).



Partition of India, 1947; Source: Wikimedia Commons

Given the vast evidence for the link between identity-based discrimination and mental health, and the individual and economic burden that it constitutes, this has to be explored further in the Indian context and its repercussions for mental health service providers and users must be examined (Elias & Paradies, 2016; Gordon, 2016; Spencer et al., 2010).

USE OF MENTAL HEALTH SERVICES AND IDENTITY-BASED DISCRIMINATION

SERVICE UTILIZATION

Whether or not mental health services are available to the masses depends, not just on the country's economy and other such macro-factors but also on individual-level factors like the MHP's (MHP's) knowledge of the factors affecting a person's mental health, and their awareness of the resources available to help certain individuals (Stiffman et al., 2001). Only then are they likely to assess their problems accurately and provide services (Stiffman et al., 2001). Even when mental health services are available, studies have found that (ethnic) minority groups who are discriminated against, underutilize them (Evans & Sheu, 2019; Jimenez, Cook, Bartels & Alegria, 2012; Lasser, Himmelstein, Woolhandler, McCormick & Bor, 2002). When members of minority groups have a mental health diagnosis, this problem intensifies as they face double stigma (stigma against their cultural group and mental illness) which further prevents them from utilizing services (Barefoot et al., 2015; Gary, 2005). No studies on service utilization, specifically as it relates to minorities, were found.

India's large mental health treatment gap needs no formal introduction but is instead a fact that many of us have come to terms with within a personal capacity. So such user and provider factors exponentially compound this problem making services virtually impossible to imagine for the country's minorities.

SERVICE CHARACTERISTICS

Not individual variables like those mentioned above, but service provider variables, account for most of the differences in mental health help-seeking behaviour (Stiffman et al., 2001). In the US, a vast majority of substance use treatment programs were found to lack specialized services for queer individuals (Cochran et al., 2007). Furthermore, MHP were found to lack the necessary training needed to treat sexual minorities (Eliason & Hughes, 2004). Such studies about the characteristics of services as they specifically relate to minority identities are few and most of them conclude that specialized training and services to address minority service needs are lacking.

EVALUATION OF SERVICES

User or client evaluation of services is extremely important as their satisfaction is associated with treatment outcomes (Betancourt, Green, Carillo & Ananeh-Firempong, 2003; Horvath & Bedi, 2002), their quality of life following treatment (Walker, Ristvedt & Haughey, 2003) as well as their future help-seeking behavior (Sun et al., 2000) i.e. their likelihood to seek treatment in the future when facing mental health challenges. Individuals belonging to minority groups report less satisfaction with mental health services and perceive less comfort and acceptance than members of majority groups. For example, Avery and colleagues (2001) found that lesbian and bisexual female users of services were more likely to report dissatisfaction with services than heterosexual women.

Most important to note is that (racial/ethnic) minorities felt that their experiences related to their identity were more important than did majority (White) clients and consequently reported more satisfaction with a mental health service when these elements were included in their care (Meyer & Zane, 2013). Not only acknowledging the user's identity but also acknowledging the differences between the identity of the mental health service user and the provider is also extremely helpful (Harley, Jolivet, McCormick & Tice, 2002). When the stage is opened for discussion about their identity, the minority individual comes to trust the treatment process (Cardemil & Battle, 2003). This is another reason for MHPs to improve their knowledge and cultural competence.

In addition to service underutilization and dissatisfaction, or perhaps as a consequence of this, minority individuals also experience less positive treatment outcomes (Chambers et al., 1998). When issues related to their identity, which they perceived to be more important than majority group members, weren't adequately addressed in the mental health service, minority service users reported less satisfaction with the treatment (Meyer & Zane, 2014). Hence, identity-related experiences are not to be pushed under the carpet to avoid discomfort but must be addressed deliberately and sensitively. In a similar vein, for racial/ethnic minorities to report perceived treatment outcomes, it was found that their racial match with the MHP as well as the professional's knowledge of prejudice and discrimination was important (Meyer et al., 2013).

Unsurprisingly, belonging to multiple minority groups makes the person less likely to evaluate mental health services positively. Persons with mental illness who have faced discrimination on the grounds of more than one of their identities, report less satisfaction with mental health services than those who are discriminated against based on one identity (Thompson, Noel & Campbell, 2004).

BELONGG IDENTITY & MENTAL HEALTH SURVEY 2020

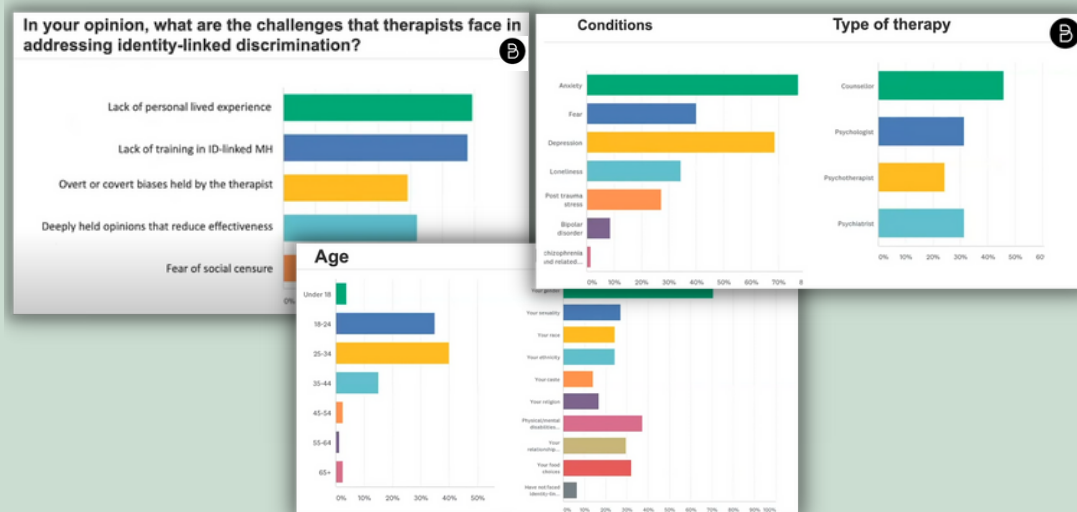


Figure: An illustration of the interim findings from the 'Identity & Mental Health Survey' conducted by Belongg in 2020

In May 2020, Belongg conducted a preliminary survey that revealed information about therapy seeking, use and satisfaction with respect to the identities of service users in India.

Some of the key findings from the survey include the following:

- The language of mental health is still largely alien to a majority of people. About 62% of the respondents do not find therapy in India affordable.
- About 31% of our respondents reported facing identity-based discrimination but have either not sought help, or have not thought about it.
- 55% of the respondents who sought help reported facing identity-based discrimination while being in therapy with varying frequencies,
- About 87% of respondents said that India lacks therapists who specialize in identity-linked mental health issues.
- Most respondents said that a) the lack of personal lived experiences (of the identity that the clients belong to) and b) lack of training in identity-linked mental health were two of the significant challenges therapists faced in addressing mental health.
- Most qualitative responses tell us of people feeling invalidated in therapy rooms and hence giving up on therapy altogether. They rely on alternate safe spaces among peers for community healing.

- As per our survey results, 60 % of the respondents noted that therapists in India lack training in culturally competent inclusive therapy practices. This leads to clients experiencing therapy that is either unaccommodating or fails to center their identities as causes of their unique mental health challenges.

The results pointed to the need to design and promote conversations, content, and resources addressing the problem of identity-based discrimination in Indian mental health & creating substantive solutions.

3 METHOD OF INVESTIGATION

The Belongg Intersectional Mental Health Report 2022 was initially undertaken to complement the above-mentioned survey findings. The primary objectives of the study include ascertaining social identity-related experiences of individuals and the experience of mental health service users vis-à-vis their identity and characteristics of the mental health service.

GOALS OF THE STUDY

Phase 1: Quantitative enquiry using online survey methodology to capture the characteristics of users, their mental health service providers and their evaluation of the same.

- To study identity-related experiences, specifically, discrimination, faced by individuals.
- Assess the experience of people who have sought mental health services to deal with identity-based discrimination and those who haven't
- Assess the characteristics of these services and individual evaluations of them.

Phase 2: Qualitative interviews to probe further into the experiences of mental health service users vis-à-vis their identities to develop descriptions and capture mediating factors

- Capture their experiences with accessing mental health services as well as their experience of therapeutic interventions as it relates to their identity
- To study and assess the impact of identity-based discrimination on the mental health of people with these marginalized identities

The following research questions will guide and facilitate the research study.

RESEARCH QUESTION

What is the experience of individuals who have used a mental health service(s) to address challenges caused by identity-based discrimination?

- 1.What is the nature of identity-based discrimination that they have faced?
- 2.What is their history of mental health service usage and the reasons for it?
- 3.What are the characteristics of the mental health services that were accessed?

4. What is their experience, specifically the level of satisfaction and challenges they face, when using the service?

HYPOTHESES

Based on the review of literature and findings from Belongg's 2021 survey, the following hypotheses were drawn.

Hypothesis 1: Individuals with minority identities are more likely to report having faced discrimination than others.

Hypothesis 2: Individuals who have experienced identity-based discrimination are more likely to discontinue a mental health service due to service/MHP-related factors.

Hypothesis 3: Individuals who have experienced identity-based discrimination have more mental health needs or use mental health services more than individuals who haven't.

Hypothesis 4: Mental health service users who have faced identity-based discrimination have less positive experiences in mental health service settings as compared to service users who haven't faced identity-based discrimination (evaluation of the quality of service, assistance received, ability to disclose experiences to MHP and their likelihood to recommend the service)

Hypothesis 5: Service users who have faced identity-based discrimination evaluate their MHPs less positively than service users who have not experienced identity-based discrimination (level of satisfaction with MHP and evaluation of their ability to address their concerns).

Hypothesis 6: MHPs with specializations are rated more positively than MHPs who do not, by service users who have faced identity-based discrimination.

Hypothesis 7: The likelihood of the service user who has experienced identity-based discrimination disclosing their identity-related experiences to the MHP is related to their evaluation of their ability to address their concerns.

DESIGN

When studying the interplay between identity and mental health service use, a variety of factors need to be addressed before the researcher can immerse themselves in individual experiences. These factors include but are not limited to, the various identities of the person and demographic variables, the characteristics of the services they use and their self-reported discrimination, level of satisfaction in therapy, etc.

Such information can be collected via quantitative surveys before elucidating the findings using qualitative interviews. The interviews can later explain quantitative findings by revealing more information. Hence, the main purpose of this study i.e. to shed light on the junction of identity-based discrimination, mental health and service use, is best answered by using both qualitative and quantitative methods.

This study used a sequential explanatory model, a mixed-methods approach. The purpose for using the mixed method approach here is multifold. It is to complement and elaborate on the findings of the first phase using the second, to provide a complete picture of the variables under study and to overcome the weakness of the two phases by applying both and filling gaps in knowledge (Greene, Valerie, Caracelli & Graham, 1989). The quantitative phase included a survey that was circulated online, following which participants were recruited for the second phase of the study - a qualitative interview, based on their expressed willingness to participate. The interviews served to illustrate and interpret the quantitative results.

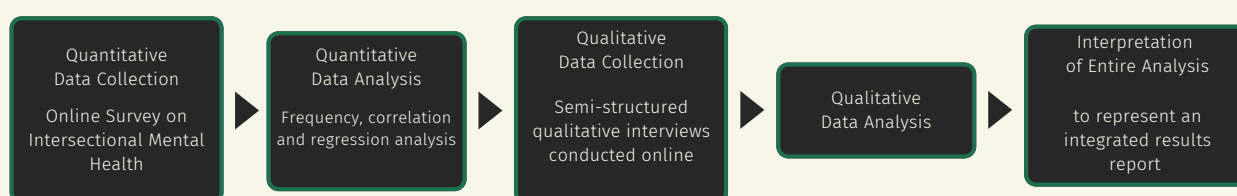


Figure 1: Visual Model of Procedures

The study used a survey form to collect responses in the quantitative phase, and a semi-structured questionnaire was utilized for respondents of the survey who agreed to participate in the qualitative interviews. The questions in both the survey and the interview focused on social identity and mental health, experiences with mental health care vis-a-vis identity(s), and possible solutions to make mental health care accessible for all.

SAMPLING

Participants for the quantitative phase were recruited using non-probability convenience sampling techniques. The survey was circulated online. Following this, participants were selected for the qualitative interview phase using the purposive sampling technique based on their unique survey responses and demographic characteristics to develop an understanding of the quantitative findings. The quantitative phase included 111 participants. Some of these participants consented to be interviewed in the second phase of the study and

were contacted via email. Of these, 10 participants responded and were included in the qualitative phase.

PROCEDURE

First, participants filled out an online survey (see Appendix A) that they accessed via social media platforms, their university website, etc. The questions of the survey pertained to their identities, their personal experiences with mental health service use, specifically therapy and their perceptions of therapist competency and overall satisfaction with the services available. Second, the quantitative responses were analyzed using statistical tests of significance, correlation and variation.

The final question of the survey asked participants about their willingness to participate in a remote interview. Participants who consented to this were selectively contacted, based on their responses, for the second phase of the study. In the third step, the qualitative interview phase, semi-structured interviews about their awareness of their identity, the impact of discrimination on their mental health, their experience and challenges in finding appropriate care, were conducted (see Appendix C). The semi-structured interview method uses an interview guide. Questions that aren't included in the guide may be raised if the participant reveals new information that the researcher wishes to explore.

First, introductory emails were sent to the selected participants. The emails closed with a request to the participant to choose a time that is most convenient to them, when they are free, and in an environment where they can talk comfortably in, for the interview. A consent form was sent to them after this (Appendix B). Cohn and Larson (2007) recommend the use of more than one mode of receiving consent. It has been found that participants too, prefer to have more than just verbal consent (Lawton et al., 2017). Therefore, during the call too, consent was received, using the verbal mode. Interviews lasted between twenty to fifty minutes and were carried out via Zoom. Audio recordings of the interview were documented after receiving the participant's consent for transcription and analysis. These files were stored electronically and protected. Participant names were abandoned and numbers were assigned to their data instead.

Identity-related experiences can be sensitive to discuss, especially if the identity in question is commonly subject to discrimination. In this case, overcoming the methodological issues related to remote audio interviews like establishing rapport, developing an alliance with the participant and communicating non-verbally becomes all the more crucial (Mealer & Jones, 2014).

In this study, we ensured that the calls were set for a time that was most convenient to the participant and during the interview, relayed compassion and active listening (Mealer et al., 2014). Despite the shortcomings of this mode of interview, the distance that it creates between the participant and the researcher can remove the perception of judgment thereby giving the participant the space to engage more deeply in their reality than they would if visual cues were present in which case the researcher's reactions and the differences between the researcher and the participant would affect data collection (Mealer et al., 2014; Ward, Gott & Hoare, 2015).

Finally, the qualitative interviews were analyzed using the thematic analysis method that involves reading through a data set i.e. transcripts from the qualitative interviews and identifying patterns in meaning across the data (Bryman, 2016). To capture the lived experiences of participants, and as there isn't a large body of culturally relevant theories to draw from, inductive coding was used. The results of the analysis are discussed in the following section.

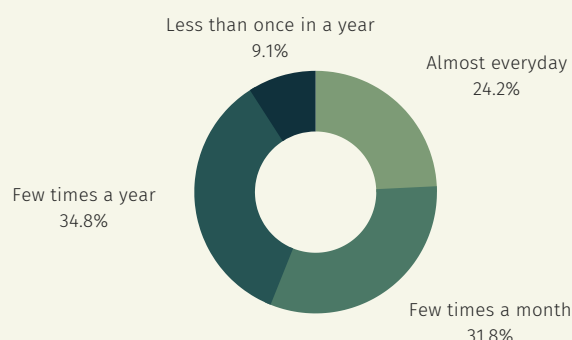
4 RESULTS

SAMPLE

The quantitative phase of the study included responses from 111 participants from across India. Most of the participants in the survey were individuals in the age group of 18-25, who identified as female, had completed graduation or diploma and were employed (working for more than 35 hours per week). Their responses to the survey were explored in the qualitative phase of the study in which 10 consenting participants were interviewed. In the following sections, quantitative findings and interview data to substantiate and elaborate on the same can be found.

EXPERIENCES WITH DISCRIMINATION

59.46% of respondents reported that they had faced discrimination. Among these respondents 24.2% reported facing discrimination almost every day, 31.8% face discrimination a few times a month, 34.8% face discrimination a few times a year and 9.1% face discrimination less than once in a year.



Graph 1: Frequency of discrimination experiences

Gender

It is worth noting that a majority of the respondents reported facing discrimination due to their gender identity (59%), followed by appearance (45.45%) and sexuality (30.3%) along with other identities.

A respondent said:

“Misgendering is almost an everyday occurrence in my life, starting from consistently being referred to using the wrong pronouns and feminine terms to having to hide my gender identity. This constant worry of gauging when and whom to disclose my gender and sexual identity to is an extremely tiring and dreadful exercise.”

In the qualitative interviews participants who identified as women discussed their experiences with harassment, and sexism at the workplace and universities, as well as, the everyday enforcement of gender norms onto them. Interviewee S3 described how her peers’ comments led to her doubting her gender identity and the confusion that followed.

“Why are you comparing me with a man just because of my haircut or my attire? Okay. I am more comfortable with T-shirts. I am more active in sports attire. These kinds of things are always happening. This gave me a kind of depression when I was in class eleventh and twelfth...I felt “You are not good as a woman, as a human even”. I questioned my identity, my gender, and myself. I questioned myself a lot” (S3)

Appearance

As an identity, ‘appearance’ meant different things for different participants. The subjective meanings of the same were explored in the qualitative phase. It is worth noting that individuals who reported race (especially individuals from the North East) as a criterion for discrimination also reported appearance as one of the identities that they faced discrimination based on.



Source: Apart, yet closer than ever, Bonnie Brown.

Interviewee A2, when discussing their experiences as a north-eastern Indian living in central North India said,

“You just walk on the streets and people just come walking behind you and whisper “corona”. It was so funny in one sense but also infuriating because it was a pandemic. Globally there are people with Mongolian features anywhere and everywhere. That projection of this anti-Chineseness has always been there but it kind of became overt in this period. For example one of my friends was spat on and one of my juniors was slapped on the road. So a lot of overt violence...The fact that all this happened within a closed student settlement area where you’d expect yourself to feel safer...”

Interviewee S2 described her experience being fat-shamed as a woman -

“For a large part of my life, I believed that I was fat because that’s how I was made to feel...I think the discrimination I faced because of my gender and fat-shaming went hand in hand. I was made to feel insecure about my body at home as well as in college.”

Employment Status

Respondents who were employed reported their income and those who weren't (unemployed adults and students) reported their family income. No significant difference was found between the number of respondents belonging to different family income groups who have faced discrimination. No such difference was found between respondents belonging to different individual income groups either.

When comparing respondents belonging to a family income group (i.e. unemployed persons) with respondents belonging to the equivalent individual income group (i.e. employed persons), the difference between the proportion of respondents with an individual income of Rs. 1,50,000 to 2,00,000 ($n = 2$) and respondents with a family income of Rs. 1,50,000-2,00,000 ($n = 7$) who have faced discrimination was found to be significant ($z = 2.23664$, $p = .01778$ at $p < .05$). (Note: The two samples are extremely small and results are therefore prone to type I error).

Those unemployed persons whose families earn a lower or higher income than Rs. 1,50,00 to 2,00,000 face discrimination to the same extent as their employed counterparts. When students ($n = 2$) are removed from this unemployed group, we find that the group does not differ significantly from respondents who are working and earning between 1,50,000 and 2 lakhs per month. This points to the possibility that within the workplace, and outside it, an equal number of adults face discrimination. Interviewee A3 said,

"It was all about numbers. I remember having a couple of horrible days in the office. I was looking for counsellors and I saw one counsellor online when I was in the office. I saw them upstairs (online). The session was very overwhelming so I broke down then. I went downstairs to the office and cried. I remember crying because my boss knew that I did see counsellors but anyways...It was quite terrible." (A3)

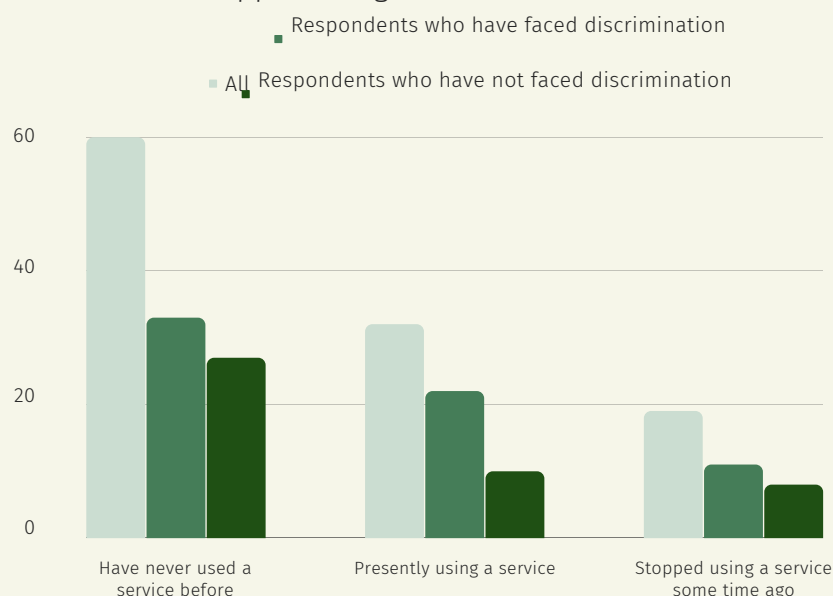
Interviewee A4 spoke about workplaces only paying lip service to the accommodation of persons with diagnosed mental disorders and about how symptoms that aren't advantageous or easily understood are perceived as a burden on the company's productivity.

"No one says, 'your mental illness is too much for us, leave. It is always done in a very subtle way. There will be times when people will reduce your workload, give it to someone else and give you menial tasks to do and eventually it is hard for you and your seniors to justify your position there. Then, you don't match their productivity standards.'" (A4)

No significant difference was found between the proportion of people belonging to different gender groups, income groups and employment groups facing discrimination. Hence, hypothesis 1 is rejected.

SEEKING HELP

Out of the 111 respondents, 54.05% reported having never used a mental health service in the past. 28.83% of the respondents were using a service at the time of filling out the survey and 17.12% had stopped using a mental health service some time ago.



Graph 2: Mental Health Service use Status

HAVE NEVER USED A SERVICE BEFORE

When it came to the reasons for them not having used a mental health service before, the respondents who have faced discrimination and those who haven't endorsed different reasons at different frequencies. A significantly higher proportion of respondents who have faced discrimination cited 'lack of support from family and friends' as a reason for not using a mental health service as compared to respondents who have not faced discrimination ($z = 2.7482$, $p = .00596$ at $p < .05$).

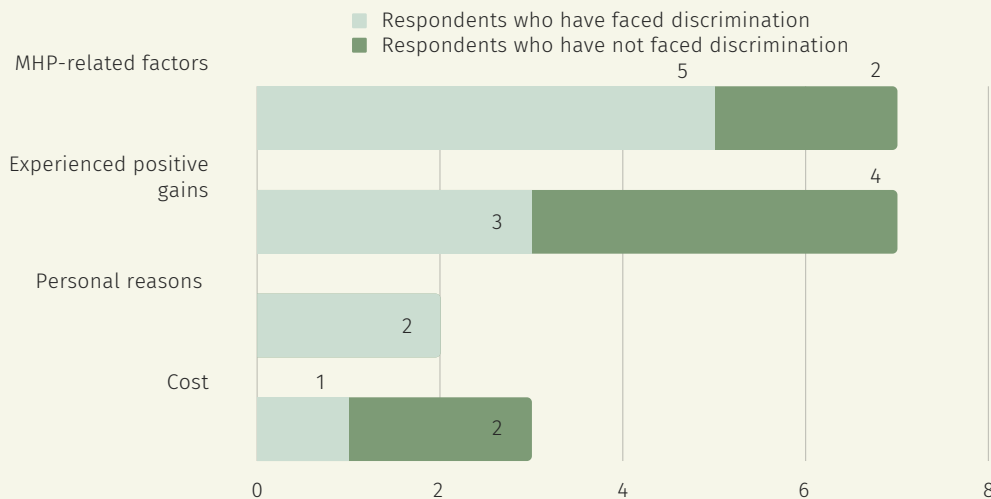
This finding is worth exploring in the future as it may indicate that persons belonging to certain identity groups hold more stigma against mainstream mental health services than others.

An interviewee (S1) shared the following thoughts on the need for de-stigmatization programs designed specifically for minority groups-

"General mental health modules to de-stigmatize (mental health) may not work for certain communities as much as it would for some other communities. Access to mental health is a privilege. Ultimately it comes down to middle and higher class people interacting with other therapists who are from a similar background, so yeah, making it also more accessible in terms of psychoeducation also might help."

STOPPED USING A SERVICE SOME TIME AGO

The survey was also filled by persons who had stopped using a mental health service recently. The difference between the proportion of respondents who had experienced identity-based discrimination ($n_1 = 11$) and those who hadn't ($n_2 = 8$) who had discontinued a mental health service was not significant ($t = 0.88277$, $p = .389672$ at $p < .05$). These respondents provided their reason(s) for discontinuing the service and they are as shown in the graph.



Graph 3: Reasons for Discontinuing Service

Through the above graph, it can be observed that the reason for discontinuing a service that was most cited by respondents who have faced discrimination is MHP-related factors. This difference however was not significant ($t = -0.98617$, $p = .337876$ at $p < .05$). Hence, no evidence to support hypothesis 2 was found. The hypothesis is rejected but the small size of the subgroup of respondents who have discontinued a service ($n=19$) is to be noted.

In the qualitative phase, multiple reasons for discontinuing services were outlined by the interviewees, many of whom had to consult upwards of two mental health professionals before settling for one in the present.

"I was mistreated by a psychologist initially. Even though she was a woman she told me that I am not a 'good woman' because I am an extrovert and my presence was hurting others. Because of her inconsiderate behaviour, I was in trauma for three months." (S3 who identifies as queer)

"I was 19. I am completely clueless and in the middle of a completely bad breakdown. So we went to this guy. He, in the name of therapy, would ask strange questions...just very very basic things like "Do you pray every day?". I was like why is this relevant, why are you making these assumptions about me, whether I have these faiths at all. Even though I was in this haze of medication and having cried all night, feeling sad and suicidal...I realized I was in the worst possible place and I communicated that to my parents. That was my first experience with mental health care and I was so put off by it" (A4)

"I went to see a family therapist. That was terrible. She was biased from the beginning and her method of providing therapy was just terrible! I mean, I felt like there was no approach to her method...I don't think any professional is supposed to be shouting at you and saying "stop doing this". I remember the last session, I came out crying...That's why I took a pause to make sure...to see which therapist I can find" (A1)

Interviews were rampant with such stories. Confidentiality was broken, the MHP behaved unprofessionally, passed judgements about the service user's behaviour and enforced spiritual teachings during the sessions. What resulted was a change in the individual's attitude towards mental health services as a whole and when they sought services in the future, they felt immense pressure to find the right MHP and experienced little hope in this regard.

During the sessions, individuals were vigilant and careful at first "testing the waters" (A5 and S1) in the first few sessions, withholding information till they ascertain that the MHP is reliable and competent. The economic, as well as time and psychological costs of such anticipation, are easy to imagine. MHPs can reduce such costs by making explicit, their competencies and their limits.

On the other hand, the primary reason for respondents who have not faced discrimination to discontinue mental health service was found to be the positive gains they had achieved through using a mental health service.

Presently using a service

It is worth noting that 68.75% of the respondents who had reported facing discrimination were using a service during the time of the research study and around 57.89% of the respondents who reported facing discrimination had stopped using a service some time ago. This difference between the respondents belonging to the two groups who are presently using a service ($n_1 = 24$ and $n_2 = 8$) was found to be significant ($z = 2.1224$, $p = .034$ at $p < .05$) thereby confirming hypothesis 3.

Below are a few statements from the interviewees about the impact of discrimination on their mental health

"It is really anxiety-inducing at one point, because I mean my caste cannot be erased, so obviously I sometimes worry about what if I get discriminated during an interview process or after getting in, and what if I'm harassed or discriminated because of that, at work or anywhere else, because probably like second-hand trauma, I don't know if that's a trauma. And then yeah sometimes I just don't really find that much hope in the world." (S1)

"I always feel the need to work out. When I was in college I would be very conscious of my body and the way my body is being perceived by others." (S2, appearance-based discrimination)

"I would think that I am not a good enough woman or a good enough human. It underwent quite a prolonged period of depression because of these experiences." (S3, gender and sexuality-based discrimination)

"I had buried it down (the memory of when they were harassed during Holi celebrations). After hearing about the way that girls on campus were treated during the college tech fest, everything came crashing down. I cried and stayed in bed for two days and eventually used assignments to distract myself" (A5, gender-based discrimination)

"I usually end up thinking maybe I am not good enough because I am young" and "I feel vulnerable. I constantly need validation and I can't make decisions on my own" (A1, gender-based discrimination). A1's experiences with discrimination also affected their productivity at work.

When compared based on gender identities, men (12 out of 40) and women (35 out of 66) differ greatly in their help-seeking behavior ($z = -2.3136$, $p = .02088$ at $p < .05$) with a significantly greater proportion of respondents who identify as female seeking mental health services.

Students differed greatly from unemployed persons in their help-seeking behavior with a significantly larger proportion of students seeking services as compared to unemployed persons ($z = 2.1626$, $p = .03078$ at $p < .05$). The difference between students and employed persons, however, was not significant, indicating that through on-campus services that are often free-of-cost and/or by using their family's income, students are likely able to use services to the same extent that employed persons do. This points to the importance of free on-campus mental health services. Students are a vulnerable population and a lack of on-campus services can reduce their help-seeking status to that of unemployed persons. When A5 was a student in the 7th grade, they met with the school counsellor who was "old-fashioned" and "backwards" and had failed to maintain confidentiality, revealing information about the sessions to A5's family.

An interviewee (S4) who had previously accessed (pro-bono) mental health services in their school as well as college said,

“Thanks to my earlier experiences with counsellors, I have made my expectations quite clear with my current therapist from the first day- what I needed help with. That has served me well.”

A significantly lower proportion of survey respondents with a family income of Rs. 0 - 50,000 used mental health services compared to respondents with an individual income in the same category ($z = -2.1$, $p = .03572$ at $< .05$). This points to a difference in the accessibility of services to employed and unemployed persons. In a similar vein, 30% of the respondents who have never accessed mental health services haven't done so because of the high costs of the services. The need for affordable mental healthcare is abundantly clear. Not only does psychological knowledge and academia centre the upper-class and caste individual, so does psychological practice.

CHARACTERISTICS OF THE SERVICES USED



Graph 4: Word cloud of the identity/identities that professionals who respondents have seen are trained/experienced enough to work with

Specialization indicates the visibility or accessibility of resources that MHPs have been able to tap onto to better cater to certain marginalized groups. A majority of the MHPs that the respondents had consulted did not have any specialization. Among those with specializations, 53.06% of the professionals work in an organization and 69.23% of these organizations specifically cater to certain minority groups. There seem to be more resources or training made available on mental health work with queer individuals compared to work with other identities.

An interviewee who has experienced caste-based violence (S1) said,

“After my not-so-good experience with a therapist, I realized that it’s time I started looking for an anti-caste queer-affirmative therapist in particular. No matter how long it takes.”

An interviewee who had experienced racial discrimination (A2) said

“The problem with people who face racial discrimination from people from the mainland is that they do not want a therapist from the mainland to treat them. Simply going out on the street itself gives them trauma so I cannot imagine anyone from the northeast can see a therapist from the mainland. No matter how comfortable the therapist can make the room to be or the conversation to be, I don’t think they can help”

Furthermore, interviewee A2 currently sees an MHP from mainland India over the telephone and has never met them. A2 is aware that the MHP is from mainland India but the MHP does not know that A2 is from northeast India. Even though the service has helped A2, she stated that if she had to meet the MHP in person, when he’d realize that A2 belonged to northeast India, she would not feel comfortable. This indicates that training MHPs must go beyond focusing on their competence to support individuals from majority groups living in urban areas. It is important for psychological and psychiatric curricula to expand and address the needs of individuals with different identities.

Assessment of Services

When comparing the scores they provided across six evaluation criteria (overall quality, assistance received, satisfaction with the professional, helpfulness of the service, professional’s ability to address their concerns and whether they’ll recommend the service to others), we find a significant difference between the scores provided by respondents who have experienced discrimination and respondents who haven’t ($t = -2.77323$, $p = .002949$ at $p < 0.5$).

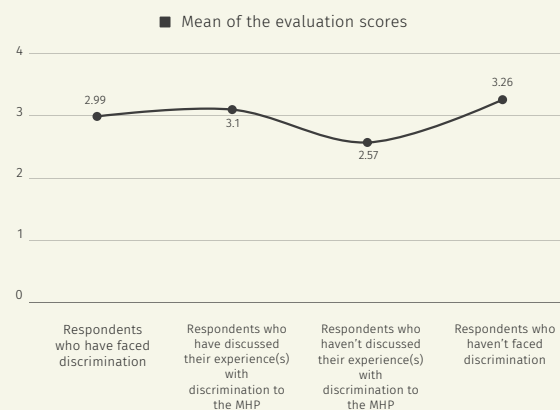
When testing hypothesis 4, the following results were arrived at. It was found that users who had not faced discrimination rated their experiences more positively ($M2 = 3.23$) than users who had faced discrimination ($M1=2.99$) ($t = -1.6589$, $p = 0.9924$ at $p < .10$). Hence, hypothesis 4 is accepted and it can be said that the results of this survey indicate, with some certainty, that those service users who have faced identity-based discrimination rate their service experience less positively than service users who have no history of identity-based discrimination.

When testing hypothesis 5, it was found that respondents who hadn’t faced discrimination evaluated the ability of the professional to address their concerns and the help they received from the service more positively and reported being more satisfied with the professional than respondents who had faced identity-based discrimination ($t = -2.06659$, $p = .040515$ at $p < .05$). Hypothesis 5 is accepted and it is concluded that the study’s results indicate that service users who have faced identity-based discrimination in the past rate their MHPs less positively than service users who haven’t faced discrimination do.

When taken together, it is found that respondents who haven't faced discrimination gave higher scores along the six criteria than did respondents who have faced discrimination ($t = -2.85067$, $p = .004664$ at $p < .05$). A significantly larger proportion of respondents who have not faced discrimination ($M2 = 3.26$) rated their experiences while using the service and the MHP, more positively as compared to respondents who have faced discrimination ($M1 = 2.99$).

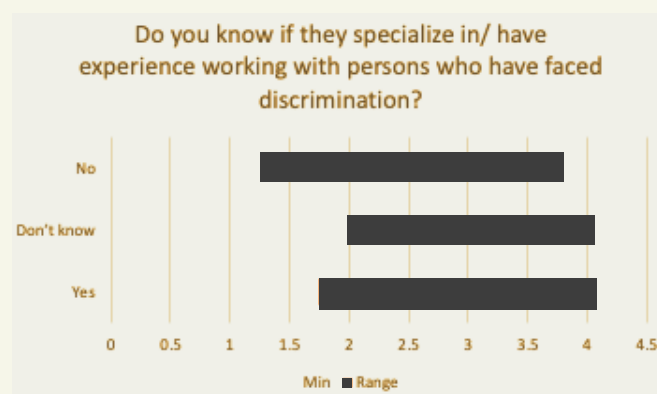
On the other hand, when comparing the overall evaluation scores provided by respondents who have faced discrimination and disclosed this to their MHP and those who haven't, no significant difference is found indicating that users who disclose their experience with identity-based discrimination perceive the service to be only as useful as those who didn't disclose this information ($t = -0.14347$, $p = .886069$ at $p < .05$).

The graph below represents the average of the evaluation scores (1 to 4) of those who faced discrimination and those who haven't.



Graph 5: Evaluation scores of services and the frequency of discrimination experiences

The following graph represents the evaluation scores of respondents and the MHP's specialization in/ experience working with persons who have faced discrimination. A significant difference was found between the scores awarded to professionals who are trained to work with specific marginalized identities or those with experience in doing the same and professionals who do not have such training or experience ($z = 3.048116$, $p = .002303$ at $p < .05$). Hence, hypothesis 6 is accepted.



Graph 6: Evaluation scores of services and the specialization/experience of the MHP

Closely related to this is another finding that the title of the professional (i.e. their qualification) was found to have an effect on the service user's rating of their ability to address their concerns ($f\text{-ratio} = 3.59031$, $p = .01301$ at $p < .05$). Furthermore, the difference between the evaluation scores provided to psychologists was significantly higher than that provided to psychotherapists ($p = .02011$). All of this points to the importance of training in the delivery of mental health services.

From carrying out the Pearson's correlation test, it was found that the two variables, i.e. the respondent's disclosure about their experiences with discrimination and their perception of the MHP's ability to address their concerns are positively correlated but only weakly ($r(31) = 0.2567$, $p = .1493$). Hence, there is some evidence of the two being related and hypothesis 7 is accepted. Whether the disclosure follows the perception of competence or if competence is perceived following the professional's response to the client's disclosure about their experiences with discrimination is worth exploring. The qualitative interviews provided some insight into this wherein interviewees stated that they gauge the professional's abilities and limits before disclosing more information.

RECOMMENDATIONS FOR MHPs

To improve their competence in working with persons with minority identities, MHPs could adopt certain suggestions made by the interviewees in this study.

Interviewee A4 suggested -

"I think the best way (to become competent) is to seek workshops and training... There is no dearth of information, you need to be someone who is willing to say "I have a knowledge gap and I am willing to learn". Network with therapists working with queer clients and they can share experiences and information. Add a small memento, maybe subtly add a small rainbow flag in your room that tells the person "Hey! I'm safe to talk to". But as of now, I need a therapist from the community for me to just feel at ease".

Interviewee S1 pointed toward the need for empathy, patience and clarity in therapeutic settings-

"Two of my previous therapists took the context into account very seriously, which I think was very helpful in that setting. For me, context matters a lot, plus listening, and then at least trying to be empathetic, and if they don't know anything they should probably state it so that it helps foster a clear understanding of what each other knows or doesn't know, so that we can work around it or not."

Talking about campus counsellors, interviewee A5 stated that very often, students spend the first two sessions “testing the waters” as they do not know what the limits of campus counselling are. University websites must also clearly state what services their counsellors are capable of offering and what they can’t. A5 suggested

“They should introduce themselves to students and make themselves visible”

While some interviewees suggested that MHPs become more socially aware, move away from scientific and individualistic conceptualizations of the client’s problem, and attend workshops and training to become competent to support individuals with marginalized identities, other interviewees believe that no amount of training can compensate for the therapist’s identity or their individual experiences, which are different from their own. Hence, a need for both specialized training as well as for MHP-to-service-user-matching is noted.

5 DISCUSSION

The quantitative phase of this study included responses from 111 participants out of which 66 had faced identity-based discrimination. The qualitative phase of the study included in-depth interviews with 10 participants from this group of 66 who had consented to be contacted for an online interview (via Zoom Audio). The results from the quantitative phase of this study were built upon, using data from the qualitative phase. This study pointed out that a greater proportion of individuals who have faced identity-based discrimination seek mental health services as compared to individuals who have not faced identity-based discrimination who seek mental health services and generally, individuals who have faced discrimination fare poorly or are less satisfied when they use mental health services, as determined by their dropout rates and evaluation scores.

In this sample, it was found that discrimination often begins at home. It is also common in educational institutions and the workplace. Participants of the study reported facing different forms of discrimination, overt and covert, and micro and macro aggressions. While some of the participants who have faced identity-based discrimination reported disclosing this to their MHP, others did not as they believed it was too trivial to discuss or because they believed the MHP would not understand. It was observed that discrimination of any kind and nature had an impact on the mental health of participants as evidenced in the qualitative data. Despite this, among the participants who have faced discrimination, only a few sought mental health services.

While searching for mental health services suitable to them, it was found that the strategy for finding a suitable MHP was based on their past experiences. Past negative experiences with mental health services contributed to a change in attitude towards mental health services. Having had one or more poor experiences in the past, participants reported that they changed their search strategy to include reliable sources of information such as friends instead of searching online and they generally expended a lot of effort on finding a suitable MHP. Since MHPs with identity-specific specializations (such as queer, caste and disability affirmative practices among others) are rated more positively than MHPs working without such lenses, it can be said that the need for such specializations is much more pronounced among those affected by identity-linked discrimination. These specializations play an important role in an individual accessing or continuing to access mental health services.

Once they have found a suitable MHP, participants have unique experiences in the therapy setting that is determined by MHP as well as participant-related factors. For example, the service user's level of disclosure and decision about what to disclose were found to be contingent on their perception of the MHP's competence. The quantitative

data revealed an association between the participant's decision to disclose their experiences with discrimination to the MHP and their perception of their competence. They do this through examining the MHP's professional title, as well as through judging the first few sessions and the MHP's professionalism, ability to create a safe space for discussions, etc.

Both qualitative, as well as quantitative data, indicate that service users who have faced identity-based discrimination rate their service experience less positively than service users who have no history of identity-based discrimination. Taking into account the high prevalence rate of exposure to discrimination, the significant impact of this exposure on mental health and the sub-optimal experiences of individuals with minority identities in mental health service settings, the need for efforts to improve the cultural competence/humility of MHPs and to make them more intersectional in their practice, cannot be denied.

To summarize, the findings of the study underlined a close relationship between social identities and an individual's access to mental health services and their experiences in therapeutic settings. The study revealed the following relationships:

- A positive relationship between a lack of identity-affirming experiences in their previous encounters with MHPs and their discomfort in accessing mental health services.
- A positive relationship between the likelihood of mental health users disclosing their identity-linked experiences in the session and their assessment of the MHP's competence.
- A positive relationship between the capacity of an MHP to address identity-related issues and the user's assessment of the mental health services.

LIMITATIONS

The findings of the study are best read keeping the following in mind:

- Given that the survey was circulated certain populations are not represented in this study, owing to the country's digital divide which is not just wide but also gendered (Seth, 2022).
- Audio-only interviews restricted our ability to assess interview conditions such as the respondents' body language, facial expressions and other nonverbal cues. As this has implications for rapport and trust building, the audio-only condition likely reduced the quality or depth of the interviews.

- For the purpose of collecting survey responses using the quantitative method, social categories are assumed to be fixed in this study, although in reality they are often fluid, dynamic and become salient in relation to the context.

RECOMMENDATIONS

1. Enriching the knowledge base of identity and mental health through the creation of intersectional training modules, toolkits, handbooks for mental health service users, etc.

Respondents noted that despite increasing awareness about the linkages between social identity and mental health, resources about the same have remained scarce, especially in the Indian context. There is hence a need for resources that address the unique mental health challenges caused due to identity-based discrimination and other identity-related experiences

2. Inclusion of psycho-social studies in curriculums designed for psychology students.

Typical training in psychotherapy involves studying individuals as monoliths whose experiences are universal and only vary insofar as their parents do. The social roots of well-being are rarely considered and are often entirely overlooked by the biomedically oriented psychology and psychiatry communities. It is imperative that training received by mental health professionals be oriented towards understanding the social experiences that shape mental health and service-related experiences and behaviour.

3. Designing and using customized mental health care plans while engaging with diverse marginalized groups

It is important that mental health care plans catering to members of specific marginalized communities such as the queer community are readily available for mental health professionals across the country. It is equally important for mental health professionals as well as mental health organizations/collectives to adapt their services to help the community members navigate identity-linked trauma and other mental health challenges.

4. Capacitating individual/s from marginalized communities

It should be highlighted that there is an urgent need to capacitate individuals from communities that have faced structural oppression for generations. Training modules on community mental health should be made readily available to members of the marginalized community to aid the creation of ecosystems of care. Simultaneously mental health academic and training institutes should emphasize scholarship programmes for course candidates from marginalized communities.

Collectivize voices advocating for intersectional innovation in the mental health sector

5.

Mental health professionals, researchers as well as organisations need to make a conscious effort to promote and create avenues for innovations catering to the intersectional needs of the individuals who face identity-linked discrimination. Such innovation would help create a nationwide momentum towards intersectional inclusion in the mental health sector.

6 REFERENCES

- Askari, A. S., & Doolittle, B. (2022). Affirming, intersectional spaces & positive religious coping: evidence-based strategies to improve the mental health of LGBTQ-identifying Muslims. *Theology & Sexuality*, 1-10.
- Avery, A. M., Hellman, R. E., & Sudderth, L. K. (2001). Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health*, 91(6), 990.
- Barefoot, K. N., Smalley, K. B. & Warren, J. C. (2015) Psychological distress and perceived barriers to care for rural lesbians. *Journal of Gay & Lesbian Mental Health* 19, 347–369.
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*.
- Boyd, K. M. (2000). Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts. *Medical humanities*, 26(1), 9–17. <https://doi.org/10.1136/mh.26.1.9>
- Bryman, A. (2016). *Social research methods*. (5th ed.). Oxford. UK: Oxford University Press.
- Calabrese, S. K., Meyer, I. H., Overstreet, N. M., Haile, R., & Hansen, N. B. (2015). Exploring Discrimination and Mental Health Disparities Faced By Black Sexual Minority Women Using a Minority Stress Framework. *Psychology of women quarterly*, 39(3), 287–304.
- Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice*, 34(3), 278.
- Chambers, E. D., Siegel, C., Haugland, G., Aponte, C., Bank, R., Blackshear, R., et al. (1998). *Cultural competence performance measures for managed behavioral healthcare programs*. Washington, DC: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Chang, C. J., Kellerman, J. K., Fehling, K. B., Feinstein, B. A., & Selby, E. A. (2021). The roles of discrimination and social support in the associations between outness and mental health outcomes among sexual minorities. *American Journal of Orthopsychiatry*.
- Cochran, B., Peavy, K. & Robohm, J. (2007) Do specialized services exist for LGBT individuals seeking treatment for substance misuse? a study of available treatment programs. *Substance Use & Misuse*, 42, 161–176.
- Cohn, E., & Larson, E. (2007). Improving participant comprehension in the informed consent process. *Journal of nursing scholarship*, 39(3), 273–280.
- Coker, T. R., Elliott, M. N., Kanouse, D. E., Grunbaum, J. A., Schwebel, D. C., Gilliland, M. J., Tortolero, S., Peskin, M. & Schuster, M. A. (2009). Perceived racial/ethnic discrimination among fifth-grade students and its association with mental health. *American journal of public health*, 99(5), 878–884.

- Cokley, K., Hall-Clark, B., & Hicks, D. (2011). Ethnic minority-majority status and mental health: The mediating role of perceived discrimination. *Journal of Mental Health Counseling*, 33(3), 243-263.
- Crawford, K., Fisher, W. H., & McDermeit, M. (1998). Racial/ethnic disparities in admissions to public and private psychiatric inpatient settings: The effect of managed care. *Administration and Policy in Mental Health*, 26, 101-109.
- Crocker J, Major B, Steele C. Social stigma. In: Gilbert D, Fiske ST, Lindzey G, editors. (1998). *The handbook of social psychology*. 4. Boston: McGraw-Hill. . pp. 504-553.
- Elias, A., & Paradies, Y. (2016). Estimating the mental health costs of racial discrimination. *BMC public health*, 16(1), 1-13.
- Eliason MJ & Hughes T (2004) Treatment counselor's attitudes about lesbian, gay, bisexual, and transgendered clients: urban vs. rural settings. *Substance Use & Misuse*, 39, 625-644.
- Evans, N. T., & Sheu, J. J. (2019). The relationships between perceived discrimination and utilization of mental health services among African Americans and Caribbean Blacks. *Journal of Immigrant and Minority Health*, 21(6), 1241-1247.
- Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American journal of public health*, 103(10), 1802-1809.
- Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in mental health nursing*, 26(10), 979-999.
- Gordon, D. (2016). Discrimination can be harmful to your mental health. *UCLA Newsroom*. January, 13.
- Greene, B. (1994). Ethnic-minority lesbians and gay men: mental health and treatment issues. *Journal of Consulting and Clinical Psychology*, 62(2), 243.
- Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational evaluation and policy analysis*, 11(3), 255-274.
- Harley, D. A., Jolivet, K., McCormick, K., & Tice, K. (2002). Race, class, and gender: A constellation of positionalities with implications for counseling. *Journal of Multicultural Counseling and Development*, 30(4), 216-238.
- Horvath, A. & Bedi, R. (2002). *The Alliance*. In: Norcross JC, editor. *Psychotherapy relationships that work: Therapist contributions and responsiveness to clients*. New York, NY: Oxford University Press. pp. 37-69
- Human Rights Campaign. (2018). *LGBTQ Youth Report*. Human Rights Campaign.
- Jacob, K. S. (2016). Mental Health Legislation: Contradictory Paradigms, Uneasy Compromise. *Economic and Political Weekly*, 51(50), 22-24.
- Jadhav, S. (2014). Caste, stigma, and mental well-being. Advanced Study Institute, Division of Transcultural Psychiatry, McGill University, Montreal, Canada. Retrieved on April 21, 2021.

- Jang, Y., Chiriboga, D. A., Kim, G., & Rhew, S. (2010). Perceived Discrimination in Older Korean Americans. *Asian American journal of psychology*, 1(2), 129–135.
- Jiloha, R. (2010). Deprivation, discrimination, human rights violation, and mental health of the deprived. *Indian Journal of Psychiatry*, 52(3), 207.
- Jimenez, D. E., Cook, B., Bartels, S. J., & Alegría, M. (2013). Disparities in mental health service use of racial and ethnic minority elderly adults. *Journal of the American Geriatrics Society*, 61(1), 18-25.
- Johnson, M. (2020, March 31). Andrew Cuomo on coronavirus fight: “You don’t win playing catch-up.” *The Hill*. Retrieved from <https://thehill.com>
- Kim, H. J., & Fredriksen-Goldsen, K. I. (2017). Disparities in mental health quality of life between Hispanic and non-Hispanic White LGB midlife and older adults and the influence of lifetime discrimination, social connectedness, socioeconomic status, and perceived stress. *Research on Aging*, 39(9), 991-1012.
- Kisana, R., & Shah, N. (2021). ‘No one understands what we go through’: self-identification of health risks by women sanitation workers in Pune, India during the COVID-19 pandemic. *Gender & Development*, 29(1), 35-54.
- Lasser, K. E., Himmelstein, D. U., Woolhandler, S. J., McCormick, D., & Bor, D. H. (2002). Do minorities in the United States receive fewer mental health services than whites?. *International Journal of Health Services*, 32(3), 567-578.
- Lawton, J., Hallowell, N., Snowdon, C., Norman, J. E., Carruthers, K., & Denison, F. C. (2017). Written versus verbal consent: a qualitative study of stakeholder views of consent procedures used at the time of recruitment into a peripartum trial conducted in an emergency setting. *BMC Medical Ethics*, 18(1), 1-13.
- Lee, S., & Waters, S. F. (2021). Asians and Asian Americans’ experiences of racial discrimination during the COVID-19 pandemic: Impacts on health outcomes and the buffering role of social support. *Stigma and Health*, 6(1), 70–78
- Lehavot, K., & Simoni, J. M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology*, 79(2), 159–170.
- Link, B. & Phelan, J. (2001) Conceptualizing stigma. *Annual Review of Sociology*. 27. 363–385.
- Mealer, M., & Jones, R. (2014). Methodological and ethical issues related to qualitative telephone interviews on sensitive topics. *Nurse Researcher*, 21(4), 32–37. <https://doi.org/10.7748/nr2014.03.21.4.32.e12>
- Meyer, O. L., & Zane, N. (2013). The Influence of Race and Ethnicity in Client’s Experiences of Mental Health Treatment. *Journal of community psychology*, 41(7), 884–901.

- National Institute of Mental Health and Neuro Sciences. (2016). National Mental Health Survey of India, 2015-16: Prevalence, Pattern, and Outcomes. National Institute of Mental Health and Neuro Sciences.
- Pal, G. C. (2015). Social Exclusion and Mental Health: the Unexplored Aftermath of Caste-based Discrimination and Violence. *Psychology and Developing Societies*, 27(2), 189–213.
- Pal, G. C. (2020). Caste and Consequences: Looking through the Lens of Violence. *CASTE: A Global Journal on Social Exclusion*, 1, 95-110.
- Park, I. J. K., Du, H., Wang, L., Williams, D. R., & Alegría, M. (2018). Racial/Ethnic Discrimination and Mental Health in Mexican-Origin Youths and Their Parents: Testing the “Linked Lives” Hypothesis. *Journal of Adolescent Health*, 62(4), 480–487.
- Sawariya, M. (2021). Caste and Counselling Psychology in India: Dalit Perspectives in Theory and Practice. *A Global Journal on Social Exclusion*, 2(1), 189-201.
<https://doi.org/10.26812/caste.v2i1.226>
- Seth, A. (2022, January 23). The gendered digital divide. *The Times of India*. Retrieved from <https://timesofindia.indiatimes.com/blogs/nonpartisan-perspectives/the-gendered-digital-divide/>
- Spencer, M. S., Chen, J., Gee, G. C., Fabian, C. G., & Takeuchi, D. T. (2010). Discrimination and mental health-related service use in a national study of Asian Americans. *American Journal of Public Health*, 100(12), 2410-2417.
- Stafford, K., Hoyer, M., & Morrison, A. (2020, April 18). Racial toll of virus grows even starker as more data emerges. *Associated Press*.
- Stiffman, A. R., Striley, C., Horvath, V. E., Hadley-Ives, E., Polgar, M., Elze, D., & Pescarino, R. (2001). Organizational context and provider perception as determinants of mental health service use. *The Journal of Behavioral Health Services & Research*, 28(2), 188-204.
- Sun, B.C., Adams, J., Orav, E.J., Rucker, D.W., Brennan, T.A., & Burstin, H.R. (2000). Determinants of patient satisfaction and willingness to return with emergency care. *Annals Emergency Medicine*, 35(5), 426-434.
- Szalacha, L. A., Erkut, S., Coll, C. G., Alarcón, O., Fields, J. P., & Cedar, I. (2003). Discrimination and Puerto Rican children’s and adolescents’ mental health. *Cultural Diversity and Ethnic Minority Psychology*, 9(2), 141–155.
- The Lancet. (2017). Global Burden of Disease 2016. *The Lancet*.
- Thompson, V. L. S., Noel, J. G., & Campbell, J. (2004). Stigmatization, discrimination, and mental health: The impact of multiple identity status. *American Journal of Orthopsychiatry*, 74(4), 529-544.

- Tobler, A. L., Maldonado-Molina, M. M., Staras, S. A., O'Mara, R. J., Livingston, M. D., & Komro, K. A. (2013). Perceived racial/ethnic discrimination, problem behaviors, and mental health among minority urban youth. *Ethnicity & Health*, 18(4), 337-349.
- Vines, A. I., Ward, J. B., Cordoba, E., & Black, K. Z. (2017). Perceived Racial/Ethnic Discrimination and Mental Health: a Review and Future Directions for Social Epidemiology. *Current epidemiology reports*, 4(2), 156–165.
- Walker, M.S., Ristvedt, S.L., & Haughey, B.H. (2003). Patient care in multidisciplinary cancer clinics: Does attention to psychosocial needs predict patient satisfaction? *Psycho-Oncology*, 12(3), 291-300.
- Wandrekar, J. R., & Nigudkar, A. S. (2020). What do we know about LGBTQIA+ mental health in India? A review of research from 2009 to 2019. *Journal of Psychosexual Health*, 2(1), 26-36.
- Ward, K., Gott M., & Hoare, K. (2015) Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing* 71(12), 2775–2785.
<https://doi.org/10.1111/jan.12748>
- Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American journal of public health*, 93(2), 200-208.
- World Health Organization (Ed.). (2001). *The World Health Report 2001: Mental Health: New Understanding, New Hope*. World Health Organization.
- World Health Organization. (2017). *Mental Health Atlas 2017*. World Health Organization.
- Zhou, S., Banawa, R., & Oh, H. (2021). Stop Asian Hate: The Mental Health Impact of Racial Discrimination Among Asian Pacific Islander Young and Emerging Adults during COVID-19. *Health Services Research*, 56, 8-9.

APPENDIX A

ONLINE SURVEY CIRCULATED FOR QUANTITATIVE DATA COLLECTION

PERSONAL INFORMATION

1. Preferred Name (Text)
2. Gender (Text)
3. Age (Text)
4. Email ID (Text)
5. Highest Education Completed (Dropdown)
 - a. Did not complete Senior Secondary School
 - b. Completed Senior Secondary School
 - c. Completed Graduation or Diploma
 - d. Completed Post-Graduation or above
6. Employment Status (Dropdown)
 - a. Employed, 35+ hrs/wk
 - b. Employed, 0-34 hrs/wk
 - c. Unemployed due to COVID-19
 - d. Unemployed (other reason)
 - e. Still Studying
7. Family income (INR per month)
8. 0-50000
9. 50000-100000
10. 100000- 150000
11. 150000- 200000
12. Above 2 lakhs

EXPERIENCES RELATED TO IDENTITY

1. Have you been discriminated against? (Being unfairly treated for who you are. People fearing/avoiding/disrespecting you, calling you names, denying a promotion or a job, refusing to let you buy/rent a house, denying you a bank loan and other services, etc. because of your identity) (Yes/No)

2. How often do you face such treatment from others?

- a. Almost every day
- b. A few times a month
- c. A few times a year
- d. Less than once a year
- e. Never

3. Which of these have you ever faced discrimination due to?

- a. Age
- b. Gender identity
- c. Sexuality
- d. Race (eg. ill-treatment of People from the North East)
- e. Ethnicity (eg. ill-treatment of People from South India in North India)
- f. Caste
- g. Religion
- h. Appearance
- i. Language
- j. Physical disabilities
- k. Mental disabilities
- l. Relationship status
- m. Political affiliation/s
- n. Other: (Text)
- o. Have not faced discrimination

4. Can you describe an incident where you were discriminated against? (Text)

You and Mental Health

The following statement will assess your experience with the use of professional therapeutic settings (with counsellors, medically certified clinical psychologists, psychiatrists, and psychoanalysts among others).

Seeking Mental Health Services

1. What is your mental health service use status?
 - a. Presently using a service
 - b. Stopped using a service some time ago
 - c. Have never used a service
2. If you are using a service or have used one before, Have you used them to better deal with experiences of discrimination? (Yes/No)
3. If yes, can you share the conditions/events that led up to you deciding to seek therapy? (Text)
4. If you have never used a mental health service, what were the reasons
 - a. Due to the availability of alternate spaces of comfort
 - b. Due to cost of the sessions
 - c. Due to lack of trust
 - d. Due to lack of preferred services
 - e. Due to lack of support from friends and family
 - f. Others
5. If you discontinued using a service, what was your reason for it? (Text)

Characteristics of Services Used Accessing Care

1. Which medium(s) of mental health service did you seek in the past?
 - a. Text Messages
 - b. Audio Sessions
 - c. Video Session
 - d. In-Person Sessions
 - e. Group sessions
 - f. Not applicable
2. Any particular reason for your choice? (Text)
3. If you are presently seeing a mental health professional (MHP), when did you first go to see them?
 - a. Less than 3 months ago
 - b. 3-12 months ago
 - c. 1-3 years ago
 - d. More than 3 years ago
 - e. Never gone to see an MHP
4. How many professionals have you consulted so far?
One/Two/Three/Four/More than four

Please answer the following questions keeping the mental health service you are presently using, or the last service you used in mind. That is if you are currently using a mental health service then think about the MHP who services you now and answer the questions. For example, if the professional you are currently seeing is a psychiatrist, then tick option f. If you were using a service in the past, but presently aren't, think about the last MHP you received services from and answer the questions. For example, if you stopped using mental health services three months ago, then think about that professional you say three months ago and tick the options relevant to them.

1.What title does the professional you visit use? (Tick all that apply)

- a.Counsellor
- b.Psychoanalyst
- c.Psychologist
- d.Clinical Psychologist
- e.Psychotherapist
- f.Psychiatrist
- g.Homeopathy/Ayurvedic Practitioner
- h.Telephone helpline
- i.I have never gone to see anyone

2.Did they specialize in/ have experience working with persons who have faced discrimination? (eg: Islamophobia, sexism, homophobia, etc) (Yes/No/Don't know)

3.If they do, which identity/identities are they trained or experienced to work with?

- a.Queer
- b.Caste
- c.Disability
- d.Race
- e.Religion
- f.Other

Evaluation of Mental Health Services Used

1.How would you rate the overall quality of service you have received?

- a.Excellent
- b.Good
- c.Fair
- d.Poor

2. Did you get the kind of assistance you wanted?

- a.No, definitely not
- b.No, not really
- c.Yes, generally
- d.Yes, definitely

3. How satisfied were you with the professional tackling those experiences?

- a.Quite dissatisfied
- b.Indifferent or mildly dissatisfied
- c.Mostly satisfied
- d.Very satisfied

4. Have the services you received helped you to deal more effectively with your problems?

- a.Yes, they helped a great deal
- b.Yes, they helped somewhat
- c.No, they really didn't help
- d.No, they seemed to make things worse

5. Were you able to bring up challenges you have faced because of your identity in the session?(Yes/No/Not sure)

6. Was the professional able to address your concerns? (Yes/No/Maybe)

7. Would you recommend others to consult the same professional?

- a.No, definitely not
- b.No, I don't think so
- c.Yes, I think so
- d.Yes, definitely

Anything else that you would like to share with us? (Text)

Can we get in touch with you for a detailed conversation on the phone? If yes, can you please share your number in the box below? (Text)

APPENDIX B

INFORMED CONSENT FORM FOR QUALITATIVE INTERVIEWS

You are invited to participate in our research study on the experiences of people using mental health services and how these relate to their identity. You have been chosen for the interview as you are 18 years and older and have experiences that we would like to learn more about. The interview is expected to take approximately 40 minutes of your time.

This study is being conducted by the Mental Health Collective at Belongg, a social organization based in India whose work revolves around diversity and inclusion in academic, literature and mental health.

Using responses from the survey and the interviews, we aim to report on the efficacy of mental health services in India in addressing the identity-related experiences of service users. Further, we aim to use the findings from this survey to inform the design of a training module on the same, that we will make available to MHPs who wish to make their services more inclusive.

If you consent to participate, then the researcher will contact you at a scheduled time of your choice for an interview. During the interview, you will be asked simple questions about your experiences. Some of the questions may require you to recollect tough experiences that you may have had. You do not have to answer these questions if you do not want to talk about it and stop participating in the study at any point without penalty. The call will be recorded for transcribing and will be deleted later on. These files will be stored safely and securely under anonymous file names. If you do not wish to be recorded, you will still be eligible to participate in the interview.

Please note that all your information will be kept confidential. The researcher is taking precautions to keep your information confidential and prevent anyone from discovering or guessing your identity by using a pseudonym to identify files with your information and storing these files in private, protected folders.

I am:

I give my consent to participate in the study: Yes/No

If yes, I wish to be contacted on:

At:

I give my consent to be recorded: Yes/No

If you have any doubts or questions about the process, you may contact the researchers at anugraha@belongg.net or saransh@belongg.net

APPENDIX C

INTERVIEW GUIDE FOR THE QUALITATIVE INTERVIEWS

Sub-questions will be used only if the information doesn't naturally arise in the conversation following the primary open-ended questions. The interview process will be reflexive and flexible, letting the participant guide the process and focus on matters which they believe to be important and worth exploring. Probing questions focusing on thoughts, feelings and beliefs will be used to capture the entirety of the experience.

1. Can you talk to me about your identities, and how they have impacted your life?
 - a. Have you faced any disadvantages or discrimination because of your identity?
 - b. Can you talk about any specific event that comes to mind, if you are comfortable?
 - c. Have such experiences impacted your health in any way?
2. Can you talk to me about your experiences with using mental health services?
 - a. What impact does/did your identity/identities have on your access to mental health services?
 - b. You have mentioned that you have consulted xx (number) professionals in the past. What were some of the factors that you considered while choosing to consult an MHP? Have they changed over the years?
 - c. Have you discussed the impact of social identity/identities on your mental health with your mental health service provider? If yes, can you share some of those discussions/realizations?
 - d. Do you think that the professional(s) was equipped to support persons from your community?
 - e. Has anything in the mental health setting made you feel uncomfortable? Can you please elaborate on these experiences of discomfort? Were they addressed by the mental health service you used?
3. Do you think MHPs should make any changes to their practice? If yes, how so?
4. How do you think mental health services could have been made more accessible to you?
5. Any advice you would like to share with people who are seeking mental health support for issues triggered by their identity?