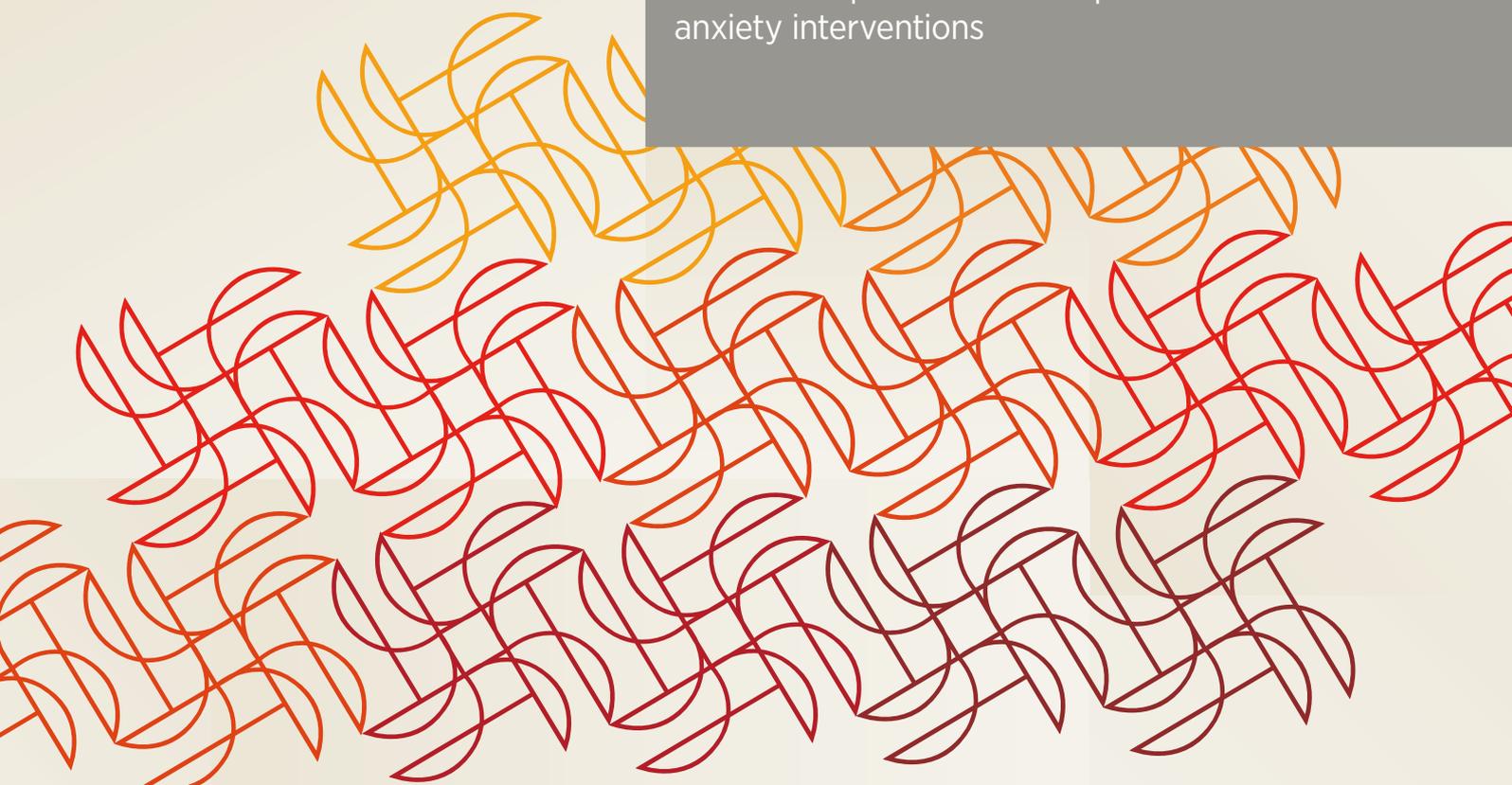


Australian Research Centre  
in Sex, Health and Society

# Improving E-therapy for Mood Disorders among Lesbians and Gay Men

A practical toolkit for developing tailored web  
and mobile phone-based depression and  
anxiety interventions



Anthony Lyons  
Tomas Rozbroj  
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## **THE PURPOSE OF THIS TOOLKIT**

This toolkit provides the first comprehensive set of guidelines for tailoring mood-disorder e-therapies to the needs of same-sex attracted people. It gives developers of e-therapies a set of practical recommendations for adjusting e-therapies to more effectively accommodate lesbians and gay men. These recommendations are supported by in-depth research that was designed specifically to inform this toolkit. Summaries of this research are provided in the toolkit and detailed findings are available in published research articles. This toolkit also provides information on the mental health-related challenges that are often faced by same-sex attracted people and links readers to key resources and organisations for further information. Checklists and other tools are included as aids for developers to assess the inclusiveness and relevance of e-therapies to lesbians and gay men. In short, this toolkit contains an extensive set of tools and explains why and how they could be implemented.

Such guidance is timely and useful, as e-therapies are an increasingly important healthcare delivery mode for the treatment of mood disorders and are now servicing significant numbers of people. Making e-therapy relevant to lesbians and gay men is especially important because these populations are far more likely to experience depression and anxiety than heterosexual people, and often face barriers to accessing other forms of therapy due to stigma and discrimination. Currently, e-therapies are largely aimed at heterosexual users and fail to respond to issues that are often central to the mental health of lesbians and gay men. It is therefore important to make e-therapies inclusive and relevant to lesbians and gay men to ensure that these groups are able to benefit from e-therapy and its growing utility as part of strategies for addressing mood disorders.

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# Introduction

**This section provides background information about e-therapies and explains why they need to be tailored to lesbians and gay men.**

## **WHAT ARE E-THERAPIES AND WHY ARE THEY IMPORTANT?**

### **What are e-therapies?**

E-therapies are internet and mobile phone-based programs that are designed to treat a range of health problems. One key area where e-therapies are particularly useful is in the prevention and treatment of depression and anxiety. Some also focus on building resilience and promoting positive mental health. E-therapies may operate with or without human support, but are invariably interactive. This interactivity may, for example, take the form of worksheets, questions and answers, and other exercises that allow the user to learn skills for improving their mental health. As digital interventions, many e-therapies take advantage of multimedia, such as videos, animations, and audio, to deliver content and to enhance user engagement.

As well as “e-therapy”, such programs may be named with other terminology, including: “internet self-help therapies”, “cCBT” (computerised Cognitive Behavioural Therapy), and “web-based interventions”. In this toolkit the term “e-therapy” or “therapy” (for short) are used.

### **The history of e-therapies**

E-therapies have been made possible by the commercialisation and popularisation of the internet, and more recently smart portable device technology. The possibility of harnessing the internet to deliver therapy was suggested as early as the 1960s (Wright, 2004, p. 3), but it was not until the new millennium that programs began making a broad impact. For example, early large-scale e-therapies like MoodGym and Fear Fighter appeared in 2001 and 2005 respectively.

Since the new millennium, there has been a large increase in the number and sophistication of e-therapies, as well as considerable growth in evidence supporting the effectiveness of e-therapies, particularly those based on Cognitive Behavioural Therapy (CBT) (Marks & Cavanagh, 2009). With the emergence of a strong evidence base for e-therapy, peak organisations and government bodies have shown increasing support for e-therapy as part of strategies for reducing the prevalence of mental health problems.

***“E-therapy is a primarily self-guided intervention program that is executed by means of a prescriptive online program operated through a website and used by consumers seeking health and mental health related assistance.”***

The growing credibility and feasibility of e-therapy as a prevention and treatment tool is reflected, for example, in the United Kingdom’s shift in policy responses. In 2002, the National Institute for Health and Care Excellence (NICE) guidelines stated that e-therapies “may be of value in the management of anxiety and depressive disorders. This evidence is, however, an insufficient basis on which to recommend the introduction of this technology into the NHS” (National Institute for Clinical Excellence, 2002, p. 1). Five years later, NICE found comprehensive evidence for the effectiveness and advantageousness of e-therapies, and recommended their use for treatment of depression and anxiety as well as several other disorders (National Institute for Clinical Excellence, 2007). In response, the NHS integrated e-therapies into its national mental health strategy, which spurred further growth in development and research on e-therapy. The UK is now one of the leading developers of e-therapies.

***“As of October 2014, Beacon... listed 75 e-therapies that applied a psychological modality (usually CBT) to the treatment of depression or anxiety.”***

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In Australia, e-therapies play an integral role in the Federal Government's mental health strategy. The Government has articulated an *e-Mental Health Strategy For Australia* (Department of Health and Ageing, 2012; Healthdirect Australia, 2014) and the Department of Health supports a range of providers to deliver e-health therapies. For example, a suite of therapies [www.mentalhealthonline.org.au] have been developed by the e-Therapy Research Unit at Swinburne University (Swinburne University, 2014). Other examples include MyCompass [www.mycompass.org.au] and BiteBack [www.biteback.org.au] which were developed by Black Dog Institute, as well as MoodGym [www.moodgym.anu.edu.au/welcome] (National Institute for Mental Health Research, 2014c) and E-Couch [www.ecouch.anu.edu.au/welcome] (National Institute for Mental Health Research, 2014b) which were developed by the National Institute for Mental Health Research at the Australian National University (Christensen et al., 2014). The application of e-therapies are supported by peak bodies such as the Australian Psychological Association (APS) (Fuller, 2013) and *beyondblue* (*beyondblue*, 2014). E-therapies are also being developed in other countries such as the United States, New Zealand, Sweden, Norway, Netherlands, Israel, and China (Cowpertwait & Clarke, 2013; Marks & Cavanagh, 2009; National Institute for Mental Health Research, 2014a). More broadly, e-health continues to proliferate and now comprises an integral part of the World Health Organisation's (WHO) strategy to address healthcare inequality (World Health Organisation, 2011).

While many popular e-therapies are web-based, there has been a steep rise in recent years in app-based e-therapies, which are delivered on mobile phones and tablets. These e-therapies take advantage of touch screen technology and the capacity for third parties to develop apps for dissemination on portable devices. Several recent reviews have highlighted the growth of app-based e-therapies (Donker et al., 2013; Harrison et al., 2011; Proudfoot et al., 2013). Indications are that, while at present many lack a strong research evidence base of their clinical effectiveness, app-based e-therapy

will increase in sophistication and significance into the immediate future.

As of 1st October 2014, Beacon – a comprehensive web database of e-therapies (Christensen et al., 2010; National Institute for Mental Health Research, 2014a) – listed 75 e-therapies that applied a psychological modality (usually CBT) to the treatment of depression or anxiety. These were a minority of listings; on the date above Beacon listed over 300 programs in total.

### **What are the advantages of e-therapy?**

There are at least three major advantages to e-therapy: accessibility, cost-effectiveness, and inclusiveness.

#### **Accessibility**

E-therapies are available 24/7, 365 days a year, to practically anyone who has access to the internet, either via a computer or a smartphone. This translates into a broad reach in most developed countries. In Australia, for example, 83% of the population reported having internet access in 2012-2013 (Australian Bureau of Statistics, 2014), and in 2012 49% reported having a smartphone (Australian Communications and Media Authority, 2012). This high level of accessibility is particularly useful in areas where mental health services are limited (Abbott, Klein, & Ciechomski, 2008; Rochlen, Zack, & Speyer, 2004; Spurgeon & Wright, 2010), such as rural, regional, and outer metropolitan areas, and for people who are restricted through lack of transport or from poor health. Accessibility is further enhanced by enabling users to complete the e-therapy in their own time. They may work through content within a timeframe that suits them, revisit sections, repeat exercises, or skip parts they do not find relevant. Although e-therapy is not necessarily designed to replace face-to-face therapy, its accessibility is particularly important for anyone who faces barriers to traditional services, either because of where they live or other difficulties accessing services, or if they are on waiting lists. This makes e-therapies a potentially important adjunct to face-to-face therapy.

### Cost-effectiveness

E-therapies are significantly cheaper than face-to-face therapy (Christensen et al., 2014; Fuller, 2013). They carry an initial development cost, but the ongoing maintenance cost is relatively low, especially if they are not therapist-assisted. For example, in 2007 the Department of Health in the UK estimated a total cost saving of £1,260,000 per 250,000 people over 2 years from using cCBT (Department of Health, 2007). The Australian e-therapy MyCompass can achieve the same quality-adjusted life-year (QALY) gain for a fifth of the cost of anti-depressant treatment and a tenth of the cost of face-to-face therapy (Christensen et al., 2014). The cost-effectiveness of e-therapies is also endorsed as a major benefit by the Australian Psychological Society (Fuller, 2013), and also by a significant number of researchers (Richards & Richardson, 2012; Richardson, Stallard, & Velleman, 2010). Cost benefits for e-therapies also apply to users, as many e-therapies are available for free or at a low fee, especially in countries that provide them as part of their universal health system, such as in the UK, or where they are funded by research grants or by non-profit organisations and made freely available, such as in Australia.

### Inclusiveness

E-therapies are particularly advantageous in catering to marginalised groups, such as lesbians and gay men (Abbott et al., 2008; Rochlen et al., 2004). Research shows that same-sex attracted populations may fear stigma or a lack of understanding from healthcare service providers, and this may dissuade them from discussing their experiences, revealing their identity, or accessing therapy altogether (Ashworth, n.d; Morrison & Dinkel, 2012; Saulnier, 2002). These fears, which may prevent them from seeing a mental health professional, are however less likely to be a concern in e-therapies, which typically allow users to remain anonymous. For lesbians and gay men, e-therapy may therefore be a safer, less confronting mode through which they can access help. E-therapies are also highly customisable. The same basic program can be adapted into different

versions for different users. It can potentially harness adaptive logic, which delivers tailored content based on a user's responses or attributes. This flexibility gives potential for e-therapies to reach out to a range of marginalised groups with content that targets the specific experiences and needs of those groups.

### How effective is e-therapy?

A number of studies have demonstrated the clinical effectiveness of e-therapies. Although, in general, e-therapies have high user dropout rates, they have nevertheless proven to be clinically effective as a general healthcare mode. This has been demonstrated in a number of academic review publications (Barak, Hen, Boniel-Nissim, & Shapira, 2008; Ferooshani, Schneider, & Assareh, 2011; Griffiths & Christensen, 2006; Richards & Richardson, 2012). Some of the more prominent e-therapies are supported by significant bodies of research proving their effectiveness. For example, MoodGym is evidenced by 17 research trials and 7 randomised controlled trials (National Institute for Mental Health Research, 2014a).

The following is a list of open-access resources that provide useful information on evidence for the clinical effectiveness of e-therapies:

- Beacon 2.0: a website that catalogues and reviews e-therapies from around the world. [www.beacon.anu.edu.au](http://www.beacon.anu.edu.au)
- NICE technology appraisals: guidance by the National Institute for Health and Care Excellence (NICE) for the use of e-therapies within the National Health Service, UK. [www.nice.org.uk/guidance/ta97](http://www.nice.org.uk/guidance/ta97)
- Evidence-based psychological interventions in the treatment of mental disorders: A literature review: summary of evidence of the effectiveness of different therapies, including e-therapies. [www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf](http://www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf)
- e-Mental health services in Australia 2014: Current and future: A summary of e-mental health services in Australia. [www.emh Alliance.fedehealth.org.au/wp-content/uploads/sites/42/2014/10/e-Mental-Health-in-Australia-2014.pdf](http://www.emh Alliance.fedehealth.org.au/wp-content/uploads/sites/42/2014/10/e-Mental-Health-in-Australia-2014.pdf)

### **How do e-therapies fit in with face-to-face therapy?**

As mentioned earlier, e-therapies are unlikely to outmode face-to-face therapy. They may be an appropriate alternative in some cases, or as a complementary therapy in others. The Australian Psychological Society considers e-therapies to be appropriate for mental health problems that are “mild or moderate” (Fuller, 2013). NICE guidelines express a similar view, suggesting that e-therapies are most appropriate as one option within a “stepped model” of therapeutic options, and notably the NHS’s commitment to supporting the growth of e-therapy coincided with additional funding to increase the numbers of clinical therapists (National Institute for Health and Care Excellence, 2006). A stepped model is also recommended by the e-Mental Health Alliance, representing key Australian developers. Thus, e-therapies are best thought of as an addition rather than a replacement to traditional clinical psychology, but have many important benefits for reaching populations that might otherwise be unwilling to or are unable to engage with face-to-face services.

#### **Key points**

E-therapies are:

- Available on both computers and mobile phone/tablet devices.
- A recent but strong trend in mental health provision.
- Supported by evidence from extensive randomised control trials and other research.
- Supported by peak and government bodies, including the NHS, Australian Government bodies, and the Australian Psychological Society.
- Advantageous because they are cost-effective, accessible, and inclusive, particularly for marginalised populations.
- Best thought of as an addition to existing tools to address mood disorders, rather than a wholesale replacement of traditional services.

### IMPROVING E-THERAPIES FOR LESBIANS AND GAY MEN

#### Key statistics

Lesbians and gay men tend to experience poorer mental health outcomes than the rest of the population. In Australia in 2008, lesbians and gay men were three times more likely to have experienced depression (19.2% vs 6%) and twice more likely to have experienced anxiety (31.5% vs 14.1%) (Australian Bureau of Statistics, 2007). Recent research shows that in the United States, lesbians, gay men, and bisexual men and women (LGB) were twice as likely as heterosexual people to have had a mental health disorder (American Psychological Association, 2014). In the United Kingdom in 2012, 22% of gay and bisexual men were experiencing moderate to severe depression.

***“In Australia, lesbians and gay men are three times more likely to have experienced depression and twice more likely to have experienced anxiety... have a higher risk of suicide, and lesbians and gay men are roughly four times more likely to self-harm.”***

Same-sex attracted people are also at greater risk of suicide. Suicide Prevention Australia's 2009 report points to LGBT people being more likely to commit suicide, and lesbian and gay men are roughly four times more likely to self-harm (Suicide Prevention Australia, 2009). In the UK, 3% of gay or bisexual men have attempted to take their own life, compared to 0.4% of men in general, and one in five lesbian and bisexual women have attempted to self-harm, compared to 0.4% of the general population (Ashworth, n.d). In the United States, rates vary between states. However, according to the Massachusetts Department of Public Health, in 2009 gay and lesbian people had almost double the rates of considering suicide (4.4% versus 2.3% for heterosexual people) (Landers & Gilsanz, 2009).

#### Why are mental health problems higher among lesbians and gay men?

Comparatively high rates of mental health problems are largely explained by the impact of stigma and marginalisation. This is described by Minority Stress Theory. Minority Stress Theory, developed in the early 1990s by Ilan Meyer, posits that society places additional stressors on lesbians and gay men as a result of non-acceptance of their orientation (Meyer, 1993, 1995, 2003). In some individuals, the experience of minority stress may create chronic stress that impacts their mental health, resulting in depression, anxiety, or other mood disorders.

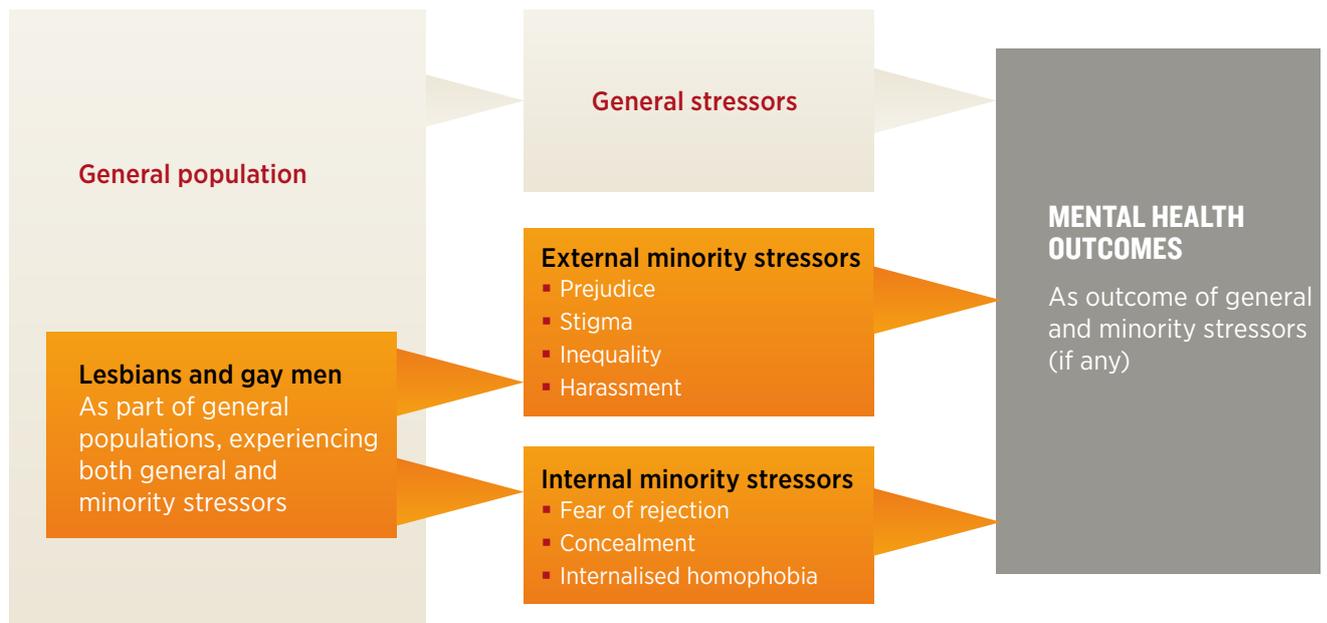
***“Society places additional stressors on lesbians and gay men as a result of non-acceptance of their orientation... [which] may create chronic stress that impacts their mental health, resulting in depression, anxiety, or other mood disorders.”***

According to Minority Stress Theory, minority stress may be thought of as either distal (a primarily external stressor) or proximal (a primarily internal stressor) (Meyer, 2003). Distal minority stressors can include experiences of stigma, harassment, rejection, legal inequality, and stress from the process of coming out or disclosing one's sexual orientation among family, friends, work colleagues, and in other settings. Proximal minority stressors may include a person internalising negative social attitudes about lesbians and gay men, such as believing that something is wrong with them, which is commonly referred to as internalised stigma or internalised homophobia. Proximal minority stressors may also include fears of discrimination, expectations of rejection, and chronic stress from fear of disclosing one's sexual orientation.

Minority stress research has found that the stressors experienced by lesbians and gay men do not have to be extreme occurrences like violence or persecution in order to cause significant harm. Seemingly inconsequential stressors such as being assumed to be heterosexual by a healthcare worker, not being able to indicate a same-sex partner on a government form,

or drawing attention in a public place for holding a partner’s hand, can accumulate over time to create long-term strain and lead to increased risk for mental health problems. Thus, addressing minority stress remains vital, even in societies that have legal situations that seek to protect same-sex attracted people against discrimination, so long as stigma and marginalisation continue in some form.

*Figure 1: Minority Stress Theory amongst lesbians and gay men*



Although peak organisations do not always refer to minority stress explicitly, they nevertheless recognise the role of social determinants in accounting for disparities in rates of mental health problems between non-heterosexual and heterosexual populations. For example, the World Health Organisation stated in the report titled *Addressing the causes of disparities in health service access and utilization for lesbian, gay, bisexual and trans (LGBT) persons* that mental health disparities for LGBT result from experience and internalisation of impacts of the social and economic determinants of health (SDH), including “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness” (World Health Organisation, 2013a, p. 2). The NHS *LGB mental health* information page also points to social determinants: “Although society has changed and homophobic prejudice is less common than it used to be, most lesbian, gay and bisexual people have experienced a range of difficulties in their lives”, which contribute to internalised issues that lead to diminished mental health outcomes (National Health Service, 2014).

While simple, the minority stress construct offers a good starting point for thinking about how seemingly banal instances like what one assumes about attraction, what is asked on a form, or what images are used to convey messages, can have a real impact on lesbians and gay men, and the effect of minority stressors need to be considered when making e-therapies more applicable to these populations.

### Accessing healthcare

While healthcare systems are a part of the solution for minority stress issues, often they can also be a part of the problem (Ashworth, n.d; Department of Health: Equality and Human Rights Group, 2009).

***“Many healthcare professionals are simply not adequately aware of how exclusion happens, and consequently are not sufficiently mindful of how they may contribute to exclusion or what they could do to address it.”***

A number of issues have been identified with access to healthcare for lesbians, gay men, and other same-sex attracted people. The World Health Organisation argues that “LGBT persons face barriers to accessing appropriate patient-centred healthcare” (World Health Organisation, 2013a, p. 3). While much of their data encompasses countries where overt discrimination against same-sex attracted people is still legal and widespread, other data shows healthcare barriers also persisting in countries like the United States (Luckstead, 2004), the United Kingdom (Ashworth, n.d; Department of Health: Equality and Human Rights Group, 2009), and Australia (Leonard et al., 2012). For example, a study by Stonewall reports that two-thirds of same-sex attracted women in the United Kingdom were confronted by inappropriate comments when coming out to healthcare professionals, while seven in ten LGBT had a public servant assume they were heterosexual (Guasp, 2012). Research in the United States and Australia has identified similar issues when lesbians and gay men encounter healthcare systems. Many healthcare professionals are simply not adequately aware of how exclusion happens, and consequently are not sufficiently mindful of how they may contribute to exclusion or what they could do to address it (Department of Health: Equality and Human Rights Group, 2009; Murphy, 1991). As result of all these issues, same-sex attracted people report lower satisfaction with health care services compared to the general population and, at least in Australia, are consequently less likely to seek treatment for health problems, including mental health.

### Why does sexuality matter in e-therapy?

Depression and anxiety are conditions that are strongly affected by life circumstances, such as relationships, support networks, life challenges, and so on. Many forms of therapy rely on addressing the relationship between the mental illness and the context within which it occurs. In this respect, e-therapies are no different. For example, the e-therapy MoodGYM (Australia) follows the lives of six characters as they cope with relationships, heartbreak, and self-perceptions (Christensen, Griffiths, & Groves, 2004; David, 2006).

A major component of the e-therapy, *Beating the Blues* (United Kingdom), which also utilises characters, delves into the impact of work and family stress. The app *iCounselor* asks users to set goals within the context of their day-to-day experience. Each person experiences unique contexts that affect their mental health, so the challenge for e-therapy developers is to create content that is relatable but also broad enough to capture the experiences of their users. Commonly, this means referring to seemingly collective experiences, such as dating and relationships, family, work and school pressures, and so forth.

***“E-therapies that focus only on heterosexual relationships or nuclear families, or that fail to address stigma or rejection, are likely to fall short of meeting the mental health needs of lesbians and gay men.”***

Lesbians and gay men often experience these areas of life in different ways to their heterosexual counterparts. Many have been or will be in same-sex relationships. Their experiences of family, school, and work are often influenced by minority stressors, such as concerns about being accepted, feelings of being lower status, or experiences of discrimination and prejudice. E-therapies that focus only on heterosexual relationships or nuclear families, or that fail to address stigma or rejection, are therefore likely to fall short of meeting the mental health needs of lesbians and gay men (Lucassen et al., 2013; Rozbroj, Lyons, Pitts, Mitchell, & Christensen, 2014). Getting this right is especially important when it comes to mood disorder e-therapies because unless lesbians and gay men feel that they are being accommodated, e-therapies may have the unintended consequence of both adding to minority stress and excluding users from receiving treatment.

So, sexuality matters in the design of e-therapies because e-therapies typically derive much of their effectiveness by linking in with the everyday experiences of users. These experiences are significantly influenced by sexual orientation. It is therefore important that e-therapies take differences derived

from sexual orientation into account to avoid excluding lesbians and gay men, and to find ways to actively engage with their mental health concerns and deliver content that is relevant to their lives.

### **Achieving strategic mental health improvement targets**

Modifying e-therapies to more effectively address mental health problems among lesbians and gay men is congruent with a wider push to address healthcare challenges faced by minority populations more broadly, and LGBT people specifically.

***“Tailoring e-therapies to the needs of same-sex attracted people will align e-therapy with broader strategic mental health aims.”***

This has been articulated at all levels, from the United Nations to government bodies to lobby groups and not-for-profit organisations. The *United Nations resolution on global health and foreign policy 2012* “acknowledges that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the promotive, preventive, curative and rehabilitative basic health services... with a special emphasis on the poor, vulnerable and marginalized segments of the population” (United Nations, 2013, p. 4). Citing this, and in response to requests by member states to address the disproportionately high rates of mental health problems among lesbian, gay, bisexual, and transgender people, the World Health Organisation has drafted a strategy to improve the health outcomes of LGBT people (World Health Organisation, 2013a, 2013b). On national levels, the NHS (UK) (Department of Health: Equality and Human Rights Group, 2009) and the Department of Health (Australia) are now funding research and adopting comprehensive strategies to address same-sex mental health challenges.

***“It is sometimes assumed by healthcare professionals, policy makers and patients themselves that LGB people can be served by a singular approach to healthcare and that they do not have unique health needs as a consequence of their sexual orientation. This, however, is not the case.”***

In addition, specialist frameworks that inform government policy, like *Going upstream: A framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people* (Australia) (Leonard & Metcalf, 2014) and *Sexual orientation: A guide for the NHS* (UK) (Department of Health: Equality and Human Rights Group, 2009), have outlined comprehensive strategies to encourage and guide health services to more effectively address mental health problems among same-sex attracted people via specific, tailored approaches. The latter document argues: “it is sometimes assumed by healthcare professionals, policy makers and patients themselves that LGB people can be served by a singular approach to healthcare and that they do not have unique health needs as a consequence of their sexual orientation. This, however, is not the case. Although research is limited, findings suggest that LGB people have very specific concerns that are not necessarily met by service providers and that they can experience both social and health inequalities. Discrimination and homophobia can have a significant impact on how they are treated by some healthcare providers. The fact that gay people are not portrayed in health sector contexts can also make lesbian, gay and bisexual people feel excluded... The health sector therefore needs to deliver targeted appropriate care to patients on the grounds of their sexual orientation. Doing so can lead to better services for a significant section of patients” (Department of Health: Equality and Human Rights Group, 2009, p. 31).

Tailoring e-therapies to the needs of same-sex attracted people will align e-therapy with broader strategic mental health aims of addressing the needs of stigmatised, vulnerable populations, such as same-sex attracted people, which are an important part of addressing health inequalities and are increasingly featuring within global and regional healthcare strategies.

### Key points

- Lesbians and gay men experience poorer mental health outcomes than the general population.
- These disparities are largely explained by the impact of stigma and marginalisation, also known as minority stress.
- E-therapies have considerable potential for improving mental health outcomes among lesbians and gay men.
- Currently, e-therapies seldom address the needs and experiences of lesbians and gay men.
- To be effective, it is important that e-therapies avoid excluding lesbians and gay men and offer content to address challenges that are often faced by these populations.
- Tailoring e-therapy to the needs of lesbians, gay men, and other same-sex attracted people will help to align e-therapy with broader strategic plans for making health care more accessible and relevant to marginalised populations.

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# Research design

The recommendations presented in this toolkit are based on evidence from a research project conducted in collaboration between the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University and Black Dog Institute, and funded by *beyondblue*. The project was developed with two primary aims:

1. To assess the degree to which current e-therapies cater to the needs and experiences of lesbians and gay men.
2. To develop a set of recommendations to help improve the applicability of e-therapies for lesbians and gay men.

These aims were addressed with a two-phase research design. The first phase involved a review of existing e-therapies. The second phase involved focus groups with lesbians and gay men to examine ways of making e-therapies more applicable to lesbians and gay men. More detail on these phases of the project is provided below.

## PHASE 1: REVIEW OF E-THERAPIES

The review of e-therapies was conducted between August 2013 and November 2013. This phase of the project was designed to provide an overview of the degree to which e-therapies cater to the needs of lesbians and gay men, and to identify issues to be explored in the focus groups. English language e-therapies (both internet- and app-based) that were open-access, dealt with depression/anxiety, and applied a recognised therapeutic modality were selected, comprising a sample of 24 e-therapies. These were analysed against eight key criteria, which evaluated the applicability of each therapy for lesbians and gay men. These criteria covered such topics as the inclusiveness of language and content and the degree to which e-therapies catered to mental health stressors that are specific to lesbians, gay men, and other same-sex attracted people.

*A full report of Phase 1, including its methodology and findings, was published in the Journal of Medical Internet Research and can be accessed at the following web address:*

[www.dx.doi.org/10.2196/jmir.3529](http://www.dx.doi.org/10.2196/jmir.3529)

## PHASE 2: FOCUS GROUPS

Phase 2 involved two rounds of semi-structured focus groups with lesbians and gay men to engage them directly on the role of e-therapies in meeting the mental health needs of this group and to gain their input on how e-therapies could be improved. Round 1 of the focus groups was conducted between September and November 2013. Participants were divided into four categories: lesbians aged 18-34, gay men aged 18-34, lesbians aged 35 and older, and gay men aged 35 and older. Two focus groups were conducted for each category. In this round of focus groups, participants discussed different aspects of the structure and content of e-therapies and the potential barriers and facilitators to participation, including issues of inclusiveness. They also discussed potential triggers for depression and

anxiety that are common or specific to lesbians and gay men, and how well e-therapies addressed key mental health issues in these populations. In Round 2, four focus groups were conducted, one for each of the above four age and sexual identity categories. This phase was conducted to test proposed solutions to the problems identified in Round 1. Throughout this process, participants evaluated case studies and offered ideas to improve the applicability of e-therapies for lesbians and gay men.

*A full report of Phase 2, including its methodology and findings from Round 1 of the focus groups, was published in the Journal of Medical Internet Research and can be accessed at the following web address: [www.dx.doi.org/10.2196/jmir.4013](http://www.dx.doi.org/10.2196/jmir.4013)<sup>1</sup>*

### **How the research project informs this toolkit**

The key recommendations included in this toolkit are all directly based on the combined findings from the two phases of the research, and these phases were explicitly designed to inform the toolkit. Quotes included in the toolkit recommendations come from the Round 2 focus groups, which were centred on testing solutions for making e-therapies more inclusive of lesbians and gay men. It is advisable that readers refer to the two research articles for further detail when considering and implementing the recommendations offered in this toolkit.

<sup>1</sup> Please note: this article only reports on the 8 focus groups that formed Round 1 of the focus group phase of the research programme.

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# Recommendations

**The following recommendations were developed with the aim of delivering a comprehensive set of ideas that could be applied to e-therapies with different complexities, structures and objectives. It is not expected that any single e-therapy should or could implement all recommendations. Rather, it is intended that e-therapy developers focus on recommendations that suit their e-therapy, much as one would select whichever tools they may need from a toolkit. The recommendations should therefore be viewed as guidelines and ideas for making e-therapies for depression and anxiety more applicable to lesbians and gay men. It is up to developers to decide which of the recommendations apply to the e-therapy they are developing or adapting.**

## **Key principles: inclusiveness and relevance**

*“The heteronormative world makes you feel different all the time.” – older male*

All the recommendations in this toolkit are underpinned by two key inter-related principles: inclusiveness and relevance. These two principles were central to all of the findings from the research project, including in the review of existing e-therapies and in the feedback from focus groups with lesbians and gay men.

Inclusiveness refers to creating therapies that welcome same-sex attracted people. Fundamentally, inclusiveness must make lesbians and gay men feel that the therapy is no less aimed at them than anyone else. This can be fostered through overt measures, such as explicitly stating that a therapy welcomes sexually-diverse users, or in subtler ways, like using symbols that signify inclusivity (such as the rainbow flag), using inclusive language and imagery, and avoiding assumptions that users are heterosexual.

Relevance refers to making sure an e-therapy addresses needs and issues that are common to lesbians and gay men. While lesbians and gay men share many similar life experiences to heterosexual men and women and may not necessarily feel excluded by an e-therapy, they also have specific challenges and experiences. These may, for example, include challenges related to disclosing one’s sexual identity in public, experiences

involving same-sex relationships, coping with stigma and discrimination, to name a few. Addressing such issues is therefore an important step toward improving the relevance of e-therapy for lesbians and gay men.

These two principles of inclusiveness and relevance should be used as a general guide when seeking to make e-therapies more applicable to lesbians, gay men, and other sexually-diverse populations.

## **Using adaptive logic**

Adaptive logic is a feature that allows only certain content to be presented to users based on their answers to previous questions. For example, those who indicate they are gay or lesbian, or those who score a particular way on a survey, may consequently be presented with a page in an e-therapy that provides content that is specific to these responses. Adaptive logic is widely used already, but presently not to customise content to the needs of lesbians and gay men. Yet there is much potential for using logic in this way. A series of recommendations are made pertaining to tailoring content that are likely to be too niche for presentation to all users, but that would be suitable if they could be presented selectively depending on the user’s attributes or responses. Although some of the recommendations are much more likely suitable for handling by logic than others, it is not specifically suggested which should be handled by logic. Every therapy is different, and it is up to developers whether, and how, they use logic. But it should be considered as one effective route for tailoring content for lesbians and gay men.

## **A note about other sexual orientations**

Due to a range of limitations, the research that underpins this toolkit focused only on lesbians and gay men. Consequently, the recommendations presented below are focused on lesbians and gay men. However, the broader principles of inclusiveness and relevance, as well as many of the issues and recommendations presented, can be applied to other same-sex attracted people as well as gender questioning or transgender populations. Although the focus of this toolkit is limited

to lesbians and gay men and further work is needed to expand it beyond this focus, this toolkit encourages readers to consider ways in which e-therapies might be modified for a range of sexual and gender diverse people.

**THE INTRODUCTORY SECTION OF AN E-THERAPY**

*“[You need a statement] about whether it doesn’t matter... what culture, what sex, race or religion you are, that this programme will hopefully help you.” – older female*

The introductory and signup pages are the first opportunities to welcome users, and thus need to be inclusive of lesbians and gay men. Furthermore, signup pages are potential drivers for adaptive logic, and included here is a suggestion about how to construct demographic questions for sensitively driving content to lesbians and gay users.

**Recommendations:**

**1. Include a statement acknowledging lesbians and gay men**

Seven out of eight of the Round 1 focus groups reported that the feeling of invisibility can be a trigger for depression and anxiety amongst lesbians and gay men. Furthermore, the findings show that a statement that welcomes lesbians and gay men would tangibly help them feel included; it was supported by all Round 2 focus groups and also by Round 1 focus groups. This is one area where a small change – perhaps only a sentence – may increase the inclusiveness of an e-therapy. A statement of inclusivity should not single out lesbians and gay men, but rather form part of a broader statement of inclusivity. For example, the statement of inclusivity that received the most support in client acceptability testing was:

**“<name of program> can be used by anyone, regardless of age, race, culture, faith or sexuality...”.**

An additional, or more subtle, way of acknowledging lesbians and gay men may be achieved by using markers of inclusivity, like the rainbow flag symbol, as discussed in the *imagery* section.

**2. If asking about sexuality on signup, avoid asking users to identify themselves**

Requesting data about a user’s sexuality may be necessary for using adaptive logic to tailor content. Asking them to indicate a sexual identity, such as ‘lesbian’, may not be the best option given that same-sex attracted people may identify with one or more of a multitude of different identities, or none at all. Instead, asking users for their sex and the sex of those who they are attracted to is preferable, and received the strongest support from focus groups. This is most effectively achieved with a format that allows a combination of fixed and multiple responses, as in the following:

Figure 2: example of sexuality questions to be used for tailoring

<b>What is your sex?</b>	Male <input type="checkbox"/>	}	Combine responses to drive tailored content for different sexual orientations
	Female <input type="checkbox"/>		
<b>Who do you find yourself attracted to?</b> Select all that apply.	Men <input type="checkbox"/>	}	
	Women <input type="checkbox"/>		

### Further resources

- LGBT Ageing Centre – Inclusive questions for older adults: A practical guide to collecting data on sexual orientation and gender identity (USA): [www.lgbtagingcenter.org/resources/resource.cfm?r=601](http://www.lgbtagingcenter.org/resources/resource.cfm?r=601)
- Department of Health – Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services (Aus): [www.glhv.org.au/files/WellProud\\_updated2011.pdf](http://www.glhv.org.au/files/WellProud_updated2011.pdf)
- Department of Health – Sexual orientation: A practical guide for the NHS (UK): [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_095634](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095634)
- Fenway Health – Why gather data on sexual orientation and gender identity in clinical settings (USA): [www.thefenwayinstitute.org/documents/Policy\\_Brief\\_WhyGather...\\_v6\\_01.09.12.pdf](http://www.thefenwayinstitute.org/documents/Policy_Brief_WhyGather..._v6_01.09.12.pdf)

### LANGUAGE

*“[I say] he’s my husband, not for shock value but to buck the stereotype I suppose, then I’ll use that: we’re husbands.” – older male*

Language is not just a passive descriptor of the world; it delineates meaning and form and influences what is perceived to be normal and abnormal. Efforts are being made across service delivery to implement language that is more appropriate for same-sex attracted people. For example, several government departments in Australia (The Department for Communities and Social Inclusion South Australia, Queensland Department for Communities, Child Safety and Disability Services, Department of Education Tasmania) have published guidelines around using inclusive language, while in the UK a paper was released highlighting the importance of using inclusive language within the NHS (Stonewall Scotland, n.d). Research, including that which informs this toolkit, consistently demonstrates that same-sex attracted people may be alienated by language that implies heterosexuality. Thus, it is also important for e-therapies to use appropriate language.

### Recommendations

1. Avoid language that potentially excludes lesbians and gay men

E-therapies mostly use ungendered language, such as “him/her” and “partner”, often because they are unsure if users are male or female. This also works to include lesbians and gay men when referring to relationships, since the sex/gender of the partner is not specified. However, occasionally words or phrases are used that either subtly or overtly assume or suggest that the user is heterosexual. Words like “spouse” or “marriage” have been used, which can be viewed as signifying a heterosexual relationship. Furthermore, examples for illustrating content in e-therapies are especially prone to using language that assumes heterosexuality, such as referring to ‘boyfriends having girlfriends’ and examples that replicate heterosexual gender norms.

So that an e-therapy does not appear to speak to a particular sexual orientation, avoid “spouse” or other words that might be construed to refer only to opposite-sex partners when discussing relationships. Ungendered words like “they” or “partner” are more appropriate alternatives. Obvious exceptions include *examples and characters* in which the sex/gender of a relationship partner needs to be specified, or modules in an e-therapy that specifically address experiences related to the relationships of people with particular orientations. In e-therapies that use features such as these, it is perhaps advisable to also include examples and other relevant content that specifically refers to same-sex attracted people or provide content that is tailored to a user’s sexual orientation using, for example, adaptive logic. Further recommendations on relationships can be found in the *relationship* section.

### 2. Avoid labelling users by sexual identity

While “lesbian” and “gay man” are widely used labels, they may exclude others who are same-sex attracted but who do not identify with these labels. It is more inclusive to address users by their orientation rather than identity markers; for example as “same-sex attracted persons”. “Queer” broadly encapsulates various non-heterosexual identities but is also problematic, as it is not a label that everyone is happy to have applied to them. While users should not be labelled, it is generally fine to label characters as “gay” or “lesbian”, and to refer to specific experiences of lesbians and gay men.

#### Further resources:

- LGBTI Alliance – Inclusive language guide (Aus): [www.lgbthealth.org.au/sites/default/files/Alliance%20Health%20Information%20Sheet%20Inclusive%20Language%20Guide%20on%20Intersex%2C%20Trans%20and%20Gender%20Diversity\\_0.pdf](http://www.lgbthealth.org.au/sites/default/files/Alliance%20Health%20Information%20Sheet%20Inclusive%20Language%20Guide%20on%20Intersex%2C%20Trans%20and%20Gender%20Diversity_0.pdf)
- Stonewall Scotland – Inclusive language in the NHS (UK): [www.equalitiesinhealth.org/public\\_html/documents/InclusiveLanguage-NHS\\_000.pdf](http://www.equalitiesinhealth.org/public_html/documents/InclusiveLanguage-NHS_000.pdf)
- Department of Education Tasmania – Guidelines for inclusive language (Aus): [www.education.tas.gov.au/documentcentre/documents/guidelines-for-inclusive-language.pdf](http://www.education.tas.gov.au/documentcentre/documents/guidelines-for-inclusive-language.pdf)

### IMAGERY

*“[The rainbow flag] It’s like a secret handshake.” – older female*

*“If you have gender inclusive language but then you have a picture of a nuclear family it’s still like, I mean you could just assume that the program was written [for heterosexual people].” – younger male*

Imagery can convey subtle and not-so-subtle messages, and is often powerful in shaping people’s impressions. Attention to imagery in public spaces, the messages it conveys, and its power to exclude particular populations, have been a major concern of advocates of greater equality. Likewise, avoiding imagery that excludes lesbians and gay men from e-therapies is important. Furthermore, imagery can be harnessed to actively foster inclusiveness.

#### Recommendations:

##### 1. Avoid images that cumulatively assume or suggest the user is heterosexual

For example, having images of opposite-sex relationships, such as a man and a woman holding hands, is not inherently problematic. However if these are the only images of relationships, non-heterosexual users may feel excluded or potentially ‘put-off’ from completing the e-therapy. Based on focus group testing, even having one same-sex relationship image is likely to be seen as welcoming and inclusive. On the other hand, participants perceived e-therapies that persistently used heterosexual-only images as ‘feeling straight’, which they found discouraging.

##### 2. Include symbols of lesbian/gay inclusion

Below from left to right, the use of a rainbow flag, intertwined male symbols, intertwined female symbols, and other symbolism can serve as important markers of inclusion, and are consistent with established practices of signifying LGBTIQ-friendly healthcare via rainbow flag stickers in, for example, general practitioners’ clinics in Australia.

##### 3. Avoid images that depict lesbian and gay stereotypes

One issue that emerged in focus group testing was that some lesbians and gay men felt excluded by depictions of stereotypes, such as ‘butch’ lesbians or ‘effeminate’ gay men, which they may not have necessarily fit into. While such stereotypes can be important markers for some, on the whole this toolkit suggests it may be best to avoid them, which is congruent with other guidance promoting LGBTI inclusion, such as *Sexual orientation: A practical guide for the NHS (UK)*, and *Working therapeutically with LGBTI clients: A practice wisdom resource (Aus)*.

##### 4. Include images that depict diversity in age, ethnicity, and culture

Lesbians and gay men from ethnic and cultural minority backgrounds may not only feel excluded within the general population, but also within lesbian and gay communities. Older age groups sometimes report similar experiences, particularly older gay men. Having images of people from different backgrounds and of older people can be an important way to maximise inclusion. For more detail on specific issues faced by these groups, see the *further recommendations* section.



### EXAMPLES AND CHARACTERS

*“There are no examples of homosexual people in those six characters; they’re all heterosexual, so it’s hard to identify with it. You don’t see same-sex attracted people as something that’s normal. I mean the issues are more or less the same I guess, like the lack of confidence or breaking up, those things are general, everybody can identify with them, but you still don’t have a good example of like a homosexual person in there.” – younger male*

E-therapies often rely on examples and scenarios involving stories and characters to deliver content. However, at present these overwhelmingly depict heterosexual experiences in e-therapies. Policies and recommendations from a range of peak organisations stress the importance of using appropriate, relevant and inclusive content in health services. Providing examples and scenarios that do not speak exclusively to heterosexual users is a key part of ensuring that content is inclusive and relevant to lesbians and gay men. This idea was strongly supported in the focus groups.

### Recommendations:

#### 1. Avoid exclusive use of heterosexual examples and characters

If sexuality is at all represented in a therapy, avoid making all instances depict heterosexual-only experiences. Lesbians and gay men may still find relevance in examples about heterosexual relationships, but are likely to feel excluded if the e-therapy only presents such examples. Making content relevant to lesbians and gay men can also be achieved by including examples of issues that relate to being same-sex attracted.

#### 2. Avoid gender-neutral examples and characters

Examples that are gender-neutral or utilise androgynous characters resolve the challenge of appealing to multiple orientations, and this solution did receive some support from the focus groups. However, many also expressed concern about difficulties relating to gender-neutral characters, both for heterosexual and same-sex attracted users. Furthermore, creating androgynous characters fails to give lesbians and gay men representation, which is important for achieving relevance. Presenting stories and characters that include lesbian and gay identities alongside heterosexual ones would more effectively achieve both inclusiveness and relevance. This could also be achieved using adaptive logic that allows relevant examples to be presented to users depending on their sexual orientation.

#### 3. Include examples and characters depicting non-traditional families and gender roles

Lesbians and gay men are less likely to form families based on a traditional nuclear family model (Leonard et al., 2012), so including alternate examples of family structures alongside more traditional structures may achieve greater inclusion and relevance. The need to account for non-traditional family structures is also recommended in other policy frameworks, such as *Working therapeutically with LGBTI clients: A practice wisdom resource*.

#### 4. Avoid gay and lesbian stereotypes

Developers need to be conscious of using stereotypes when referring to characters and examples involving lesbians or gay men. Stereotypes may be based on appearance or behaviour. However, they often do not accurately represent the experiences of many same-sex attracted people. Care needs to be taken to avoid stereotypes as these may work against the aims of inclusiveness and relevance.

#### 5. Include examples and characters that depict age, cultural and ethnic diversity

As per the recommendation in the *imagery* and *further recommendations* sections, it will broaden the relevance of an e-therapy to represent various ages, cultures and ethnicities, as those from other minority backgrounds may feel especially marginalised both within the general community and within lesbian and gay communities.

#### Further resources

- National LGBTI Health Alliance – Working therapeutically with LGBTI clients: A practice wisdom resource (Aus):  
[www.beyondblue.org.au/docs/default-source/default-document-library/bw0256-practice-wisdom-guide-online.pdf?sfvrsn=2](http://www.beyondblue.org.au/docs/default-source/default-document-library/bw0256-practice-wisdom-guide-online.pdf?sfvrsn=2)
- Centre for Culture, Ethnicity and Health – Double trouble? The health needs of culturally diverse men who have sex with men (Aus):  
[www.glhv.org.au/files/Double-Trouble\\_MHSS\\_Reeders.pdf](http://www.glhv.org.au/files/Double-Trouble_MHSS_Reeders.pdf)

### AVATARS AND PERSONALISATION

*“You’ve just made your own picture.” – younger female*

An avatar is a virtual representation of a user, somewhat like a character in a first-person computer game. It helps users represent themselves in a story by being part of it. An avatar can be a likeness, an alias, or something apparently unconnected to the user’s identity. Avatars can range from basic images or symbols to complex and customisable graphics. Avatars are useful because they allow users to express an identity that they feel comfortable expressing, and can produce a high level of engagement within a program. They are relevant for tailoring e-therapies to lesbians and gay men because users can express a range of complex identities and sexualities through avatars. Thus, using avatars is a potentially powerful tool for boosting inclusivity. The idea of including avatars was proposed and supported in a number of the focus groups.

Using avatars will not be suitable or possible for many e-therapies. Avatars are, however, currently used on a CD-ROM program for depression, and other personalisation is used in another e-therapy: Big White Wall [[www.bigwhitewall.com](http://www.bigwhitewall.com)]. The technical capacity for including avatars has been growing progressively in recent years, making the use of avatars more feasible in next generation e-therapies.

#### Recommendations:

##### 1. Consider using avatars if appropriate and feasible

Consider how avatars could be made to be inclusive of lesbians and gay men. For example, if the e-therapy involves characters and stories, is it possible to allow the user to choose an avatar and experience the story in first person, and in a way that captures common experiences of a same-sex attracted person? Are they able to make decisions within the story that lead to different outcomes, with customisability to address same-sex issues? Should avatars be incorporated, it is recommended that available options offer suitable visual representation and avoid stereotypical portrayals (see sections on *Imagery* and *Characters and Examples*). A useful reference for creating inclusive avatars is work by Lucassen et al., *Rainbow SPARX: A novel approach to addressing depression in sexual minority youth*, which details testing of the Rainbow version of the SPARX program, which allows users to control avatars in an adventure game that helps them overcome depression.

### RELATIONSHIPS

*“[There is a] constant expectation that you’re in a heterosexual relationship from strangers, which affects people on a day to day basis in terms of anxiety and depression, with having certain pronouns in the language that you use with strangers and stuff. You feel like you have to... you don’t want to make a simple conversation into coming out with a stranger that you know you’re not going to see again, but then if you don’t then you sort of feel like you’re lying and that you’re avoiding the truth, and... I hate that, and that gives me a lot of anxiety, and it’s something you have to face a lot.”*  
– younger female

Same-sex relationships are often stigmatised, and relationships and relationship issues can be critical influences on a person’s wellbeing (Berg, Mimiaga, & Safren, 2008; Meyer & Northridge, 2007; Rostosky, Riggle, Gray, & Hatton, 2007). Relationships are often covered in detail in e-therapies. However, e-therapies have focused almost entirely on the experiences of heterosexual users (Rozbroj et al., 2014) to the exclusion of same-sex relationships. Policy documents currently emphasise a need for mental health services to address stigma associated with same-sex relationships. For example, the *Working therapeutically with LGBTI clients: A practice wisdom resource* concludes that “The validation of clients’ relationships is important for LGBTI clients because some still feel that they cannot readily talk about their partner in some contexts, or walk arm in arm down the street” (p. 35). *Going upstream: A framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people* specifically includes “addressing the impact of heterosexism on LGBTI people’s friendships, intimate relationships and families” as a core part of its mental health promotion framework (p. 32). Such findings and recommendations are underpinned by considerable research highlighting issues faced by people in same-sex relationships that are not faced by those in opposite-sex relationships, particularly

issues related to stigma (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Meyer, 2003). This general point about addressing relationships in a culturally appropriate way also translates to e-therapy. It is therefore recommended that e-therapies include content on same-sex relationship issues. Data from both rounds of focus groups clearly supported this view. Participants consistently highlighted problems with how relationships are represented in e-therapies, and noted the absence of content to address important issues faced by those engaged in same-sex relationships.

#### Recommendations:

##### 1. Avoid catering only to heterosexual romantic relationship experience

As was found in the review that informed this toolkit, only one of the 24 e-therapies reviewed mentioned same-sex relationships. Many of the other e-therapies assumed or appeared to have assumed that relationships were heterosexual, and dealt with corresponding issues such as marriage and children, heterosexual dating, and so forth (Rozbroj et al., 2014). While this content is also relevant to lesbians and gay men, without additional content it may fall short of meeting their needs overall. As the focus groups indicated, the coverage of relationships in e-therapies should be inclusive of sexual diversity both in terms of content and delivery.

##### 2. Include content about potential challenges that are specific to same-sex romantic relationships

The focus groups noted that e-therapies that addressed relationships tended to focus heavily on breakups and failed to talk about how relationships are put under stress if they are not between opposite-sex partners. Wherever possible, some specific issues that could be addressed in e-therapies include:

### a. Relationship-related challenges among family and friends

Family disapproval, non-acceptance, or even rejection of a same-sex relationship are common and can be significant mental health stressors for lesbians and gay men. Consider including content that helps lesbians and gay men to manage negative reactions toward engaging in a same-sex relationship from those closest to them. These reactions can be subtle. For example, parents may give greater recognition to the opposite-sex relationship of one child than to the same-sex relationship of another child. Helping lesbians and gay men to manage such reactions from family and friends is therefore important. Issues around disclosure and displaying affection toward a same-sex partner around family and friends are also worth addressing.

### b. Relationship-related challenges in public spaces

Being seen in public with a same-sex partner can be stressful for some lesbians and gay men. Issues around disclosure and displaying affection can be significant sources of stress. As emerged in the focus groups, many same-sex attracted people often feel a need to 'hide' in public and are frequently confronted with negative reactions to engaging in a same-sex relationship, such as inappropriate questions or assumptions, inappropriate jokes, stereotyping, or exclusion. Issues around partner rights, such as visiting rights in hospitals, inheritance from a deceased partner, and caring for a partner who is ill while managing potential stigma in healthcare settings are further relationship-related challenges that may be faced by lesbians and gay men. Including modules, exercises, or information about managing these challenges may help to reduce stress that often comes from engaging in a stigmatised relationship.

### Further resources

- *beyondblue* – Stop. Think. Respect. (Aus): [www.glhv.org.au/video/stop-think-respect-beyond-blue-campaign](http://www.glhv.org.au/video/stop-think-respect-beyond-blue-campaign)
- Department of Health – Sexual orientation: A practical guide for the NHS (UK): [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_095634](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095634)
- Gay and Lesbian Health Victoria: Resource library (Aus): [www.glhv.org.au/library](http://www.glhv.org.au/library)
- National LGBTI Health Alliance – Working therapeutically with LGBTI clients: A practice wisdom resource (Aus): [www.beyondblue.org.au/docs/default-source/default-document-library/bw0256-practice-wisdom-guide-online.pdf?sfvrsn=2](http://www.beyondblue.org.au/docs/default-source/default-document-library/bw0256-practice-wisdom-guide-online.pdf?sfvrsn=2)

### FURTHER RECOMMENDATIONS FOR IMPROVING RELEVANCE

*“There’s a lot of judgement on gays, and then you’re judged within your own gay community as well.” – older female*

This section outlines further recommendations about addressing the mental health challenges that are often specific to lesbians and gay men. Many of these challenges arise from minority stress, and specifically the experience of stigma or ‘homonegativity’.

Homonegativity is an umbrella term used here to describe a range of issues that stem from prejudice or discrimination that are directed toward lesbians and gay men. Examples of homonegativity include bullying, unfair treatment, and isolating individuals on the basis of their sexual orientation. Prominent mental health strategies, including those by the National Health Service in the UK and peak mental health organisations in Australia and the United States, have worked to develop guidelines for addressing the impact of homonegativity (Department of Health: Equality and Human Rights Group, 2009; Tschurtz et al., 2011). E-therapies also have a role to play by delivering content that helps lesbians and gay men to manage the impact of homonegativity and other issues related to their sexual orientation. The following are some suggestions for topics and issues that could be covered in an e-therapy to improve its relevance to lesbians and gay men.

#### Recommendations:

##### 1. Include content about coming out

Coming out can be a particularly difficult process. Although often thought of as a singular event, coming out and concerns around whether to disclose one’s sexual orientation can be an ongoing process. This is especially so during major life transitions, such as entering a new workplace, moving to a different town or city, or forming new friendships. Challenges of coming out might therefore apply to both younger and older lesbians and gay men. Coping with stress

from environments where lesbians and gay men feel the need to conceal their sexual identity, and developing strategies for managing disclosure, are also some topics that ought to be covered in e-therapies. Specific strategies for how coming out should be responded to by a clinician are articulated well in *Working therapeutically with LGBTI clients: A practice wisdom resource* (Bradstreet et al., 2014).

##### 2. Include content about harassment, rejection, and other forms of discrimination

Bullying and other forms of stigma continue to be common experiences among lesbians and gay men. According to Stonewall, 65% of Britain’s LGB have been bullied in school because of their sexual orientation (Guasp, 2012). In Australia, the *Private Lives 2* survey found that in 2011 over 25% of same-sex attracted men and women experienced verbal abuse in the past year (Leonard et al., 2012). Some lesbians and gay men also report fearing rejection and other discrimination in healthcare (Guasp, 2012). Likewise, the focus groups that informed this toolkit frequently referred to experiences of harassment and abuse, and the resultant stress on mental health. They also mentioned a lack of media and other cultural representation and a lack of celebration of their lives as further sources of negative feelings. Having depression or anxiety is already stigmatised in society, and to experience this in conjunction with sexuality-based stigma compounds the difficulty of taking steps to get help. Addressing these challenges is an essential part of reducing the disproportionately high rates of depression and anxiety among lesbians and gay men. It may be helpful for e-therapies to explicitly acknowledge the unequal treatment sometimes faced by lesbians and gay men, and provide content to build coping, resilience, and empowerment to mitigate the effects of living with a stigmatised identity. This has been evidenced as one of the best ways for improving the lives of same-sex attracted people (Lyons, Hosking, & Rozbroj, 2014; Meyer, 1993).

### 3. Include content about self-acceptance

Internalised stigma, or feeling shame about one's sexual orientation, can be common among lesbians and gay men, and is a part of the broader impact of minority stress. Internalised stigma is linked strongly with mental health outcomes among lesbians and gay men (Herek, Gillis, & Cogan, 2009; Lingiardi, Baiocco, & Nardelli, 2012; Lyons, Pitts, & Grierson, 2013). Thus, it would be useful for e-therapies to include content that specifically helps lesbians and gay men to not only accept their sexual orientation but also form a positive sexual identity.

### 4. Include content that addresses issues specific to age, culture/ethnicity, and vulnerable subpopulations

There are a number of subpopulations within the broader population of lesbians and gay men that face specific sexuality-related issues. Improving the relevance of e-therapy also requires taking into account these differences. A set of resources is provided at the end of this section that give detailed information on issues faced by particular subpopulations of lesbians and gay men. As a starting point, developers may wish to consider:

#### a. Age-specific issues

Young people are at particular risk of heterosexist discrimination, and also present higher rates of mood disorders. Older lesbians and gay men are also at increased risk as they become more reliant on health and aged care services that are not always gay-friendly. Tailoring e-therapy to address specific issues faced by these groups, such as younger people facing stigma-related challenges at school or older people facing challenges in healthcare settings, can further increase the relevance of an e-therapy and improve its effectiveness.

#### b. Culture-specific issues

E-therapies often fail to represent cultural, ethnic and religious diversity in general. Yet research shows that cultural and religious background has a large impact

on mental health outcomes among lesbians and gay men (Guasp, 2012; Reeders, 2010; Wei et al., 2010). The World Health Organisation's report *Improving the health and well-being of lesbian, gay, bisexual and transgender persons* cites the combined impact of cultural or religious stressors and sexuality-related minority stressors as one of the main challenges to overcome for improving LGBT mental health (World Health Organisation, 2013b). This was echoed among the focus group participants who suggested that e-therapies should account for multicultural experiences of same-sex attraction. Furthermore, if e-therapies are likely to be predominantly accessed by a particular group, it would be valuable to consider whether any tailored content for that group is inclusive of lesbians and gay men. For example, the New Zealand CD-ROM program Rainbow SPARX specifically addresses Takatāpui, which is a particular Maori group that is likely to access that program (Lucassen, Merry, Hatcher, & Frampton, 2014).

#### c. Other subpopulations

Consider whether the e-therapy is likely to be accessed by a subpopulation that faces particular challenges to their mental health. For example, in Australia and many other locations around the world, living in a rural area is linked with poorer mental health for same-sex attracted people than living in an urban area (Edwards, 2005; Lyons & Hosking, 2014; Lyons et al., 2014; Preston & D'Augelli, 2013). These outcomes may be further compounded by a lack of access to support and therapy in rural areas, which makes e-therapy especially important given its near-universal accessibility. It is therefore worth considering addressing the challenges of being same-sex attracted in a rural context, which research shows is an area that needs particular attention (Lyons et al., 2014). Other vulnerable subpopulations should also be identified with a view of tailoring content to specific issues faced by these populations.

### Further resources

- Australian Research Centre in Sex, Health and Society – Private Lives 2 (Aus): [www.latrobe.edu.au/\\_\\_data/assets/pdf\\_file/0020/180425/PrivateLives2Report.pdf](http://www.latrobe.edu.au/__data/assets/pdf_file/0020/180425/PrivateLives2Report.pdf)
- Department of Health – Sexual orientation: A practical guide for the NHS (UK): [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_095634](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095634)
- National LGBTI Health Alliance – Working therapeutically with LGBTI clients: A practice wisdom resource (Aus): [www.beyondblue.org.au/docs/default-source/default-document-library/bw0256-practice-wisdom-guide-online.pdf?sfvrsn=2](http://www.beyondblue.org.au/docs/default-source/default-document-library/bw0256-practice-wisdom-guide-online.pdf?sfvrsn=2)
- IMPACT: The LGBT Health and Development Program – Resiliency among LGB youth: Overcoming victimization (USA): [www.impactprogram.org/youth-blog/resiliency-among-lgb-youth-overcoming-victimization](http://www.impactprogram.org/youth-blog/resiliency-among-lgb-youth-overcoming-victimization)
- Minus18 (Aus): [www.minus18.org.au](http://www.minus18.org.au)
- National Resource Centre on LGBT Ageing (USA): [www.lgbtagingcenter.org/index.cfm](http://www.lgbtagingcenter.org/index.cfm)
- Department of Health – The national LGBTI ageing & aged care strategy (Aus): [www.lgbthealth.org.au/ageing](http://www.lgbthealth.org.au/ageing)
- Multicultural Centre for Women’s Health – Coming out, coming home or inviting people in? Supporting same-sex attracted women from immigrant and refugee communities (Aus): [www.mcwh.com.au/downloads/publications/Understanding\\_Sexuality\\_Project\\_Final\\_report.pdf](http://www.mcwh.com.au/downloads/publications/Understanding_Sexuality_Project_Final_report.pdf)
- Centre for Culture, Ethnicity and Health – Double trouble? The health needs of culturally diverse men who have sex with men (Aus): [www.glhv.org.au/files/Double-Trouble\\_MHSS\\_Reeders.pdf](http://www.glhv.org.au/files/Double-Trouble_MHSS_Reeders.pdf)

### SOCIAL SUPPORT

*“When you’ve been growing up alone you feel that you are different from other people, you’re supposed to like, fit the norm of society, and if you don’t that can be a trigger. It can isolate you and you go into a cocoon which is very hard to break.” – younger male*

Receiving social support is linked to better mental health outcomes, and has been shown to be particularly important for marginalised populations such as lesbians and gay men. Key practice and policy documents on LGBTI mental health strategies emphasise the important role of social support in the resilience and well-being of lesbians and gay men, including the *Working therapeutically with LGBTI clients: A practice wisdom resource* (Bradstreet et al., 2014), the *Private Lives 2* report (Leonard et al., 2012), and the *Going upstream* LGBTI mental health framework (Leonard & Metcalf, 2014). E-therapies have the potential to foster social connectivity, especially given they are already operating in a digital domain, which makes it easy to provide links to other internet-based support resources such as online forums, discussion boards, and other forms of online social support networking, as well as linking users to appropriate third party social media groups. E-therapies can also provide advice and guidance for helping lesbians and gay men to extend their personal social networks and to access appropriate forms of support within the communities in which they live.

### Recommendations:

#### 1. Avoid the assumption that lesbians and gay men have common support structures in their lives

While many lesbians and gay men do have supportive friends and family, some do not. Some may also be ostracized, rejected, or treated differently upon coming out (see [relationship section, page 23](#)). Focus groups also highlighted the risk of rejection by friends and family, and participants at times took issue with e-therapies that recommended users seek help from family and friends. Consequently, while e-therapies should continue to see family and friends as important sources of strength for users, they should also account for the possibility that these may also be stressors for some lesbians and gay men.

#### 2. Include guidance for building social networks and social support

With a sense of isolation being relatively common among lesbians and gay men (Fredriksen-Goldsen et al., 2013; Radkowsky & Siegel, 1997), especially for those in rural and remote areas (Lyons et al., 2014) or when first coming out to friends and family, it is important that e-therapies address issues of social support. Assessing the social support needs of users is recommended. Providing links to online gay and lesbian communities, real world communities, and support organisations are just a few practical suggestions for helping to connect users with other lesbians and gay men and for locating appropriate support services. It is not uncommon for lesbians and gay men to feel isolated when first coming out or when experiencing discrimination or harassment. Normalising these experiences through content delivered in e-therapy is advisable as one additional way of helping lesbians and gay men feel that they are not alone.

### 3. Consider including an online forum as part of the e-therapy program

Directing users to online chat rooms, discussion boards, and social groups and forums where social connectivity is fostered may enhance coping and resilience. Of course this may also have some challenges, as it may be perceived as a tacit endorsement of third party content over which there is no direct control, and which may potentially be vulnerable to trolling if not appropriately moderated. As an alternative, and if resources allow, an in-house forum could be provided as part of the e-therapy. One example of this is Big White Wall [[www.bigwhitewall.com](http://www.bigwhitewall.com)], which includes writing and art therapy as well as text forums that are populated with user-generated discussion topics on issues facing lesbians and gay men, and which appear to be regularly utilised by users. Having a dedicated online forum or group where users can share their experiences of living as lesbians and gay men may provide a great opportunity to overcome isolation by uniting the known benefits of social support and the abundant capacity for interactivity via the internet.

The following are some moderated online forums, discussion boards, and chat rooms that provide dedicated spaces for same-sex attracted people to connect and share their experiences:

- SameSame, health and support forums (Aus): [www.samesame.com.au/forum/forumdisplay.php?f=10](http://www.samesame.com.au/forum/forumdisplay.php?f=10)
- PaceHealth (UK): [www.pacehealth.org.uk/interact/message-boards](http://www.pacehealth.org.uk/interact/message-boards)
- Empty Closets (USA): [www.emptyclosets.com/forum](http://www.emptyclosets.com/forum)

### Further resources

- *beyondblue* – Feeling queer and blue: A review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people (Aus): [www.glhv.org.au/files/Feeling\\_Queer\\_Full.pdf](http://www.glhv.org.au/files/Feeling_Queer_Full.pdf)
- National LGBTI Health Alliance – MindOUT! webinars (Aus): [www.lgbthealth.org.au/mindoutwebinars](http://www.lgbthealth.org.au/mindoutwebinars)
- *beyondblue* – Building the evidence base of risk and protective factors for depression and anxiety within the GLBTI community (Aus): [www.beyondblue.org.au/docs/default-source/research-project-files/bw0168.pdf?sfvrsn=2](http://www.beyondblue.org.au/docs/default-source/research-project-files/bw0168.pdf?sfvrsn=2)
- National LGBTI Health Alliance – Going upstream: A framework for promoting the mental health of lesbians, gay, bisexual, transgender and intersex (LGBTI) people (Aus): [www.beyondblue.org.au/docs/default-source/default-document-library/bw0257-going-upstream-online-o-lgbti-mental-health-promotion-framework.pdf?sfvrsn=2](http://www.beyondblue.org.au/docs/default-source/default-document-library/bw0257-going-upstream-online-o-lgbti-mental-health-promotion-framework.pdf?sfvrsn=2)

### REFERENCES TO MENTAL HEALTH RESOURCES

*“Knowing immediately that you’re going into a safe space is one of the most important things for me, in terms of getting any help.” – younger female*

Helplines and other forms of referral are included in most e-therapies. However, very few e-therapies provide resources explicitly tailored to lesbians and gay men. Such resources are valuable, because they often provide expertise on issues that are specific to the life experiences of lesbians and gay men. Feeling welcomed and accepted is also important; the fear of being judged or misunderstood by mainstream resources may discourage some lesbians and gay men from contacting mainstream resources.

#### Recommendation:

##### 1. Include tailored helplines and other resources

Both rounds of focus groups showed near-unanimous support for including helplines and other support resources that are specifically tailored to lesbians and gay men. Doing so is also recommended by existing LGBTI-health expert resources, such as *Going upstream: A framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people* (Leonard & Metcalf, 2014). Helpline options are widely available, and adding them to an e-therapy is easy to implement as a way of improving both inclusiveness and relevance for lesbians and gay men.

#### Further resources:

The following are some resources that may be considered:

##### Australia

- A list of LGBT helplines is provided on the Helplines Australia website: [www.helplines.org.au/Content\\_Common/search.aspx?sk=&ct=8](http://www.helplines.org.au/Content_Common/search.aspx?sk=&ct=8)

##### United Kingdom

- A good starting point is to refer to the list of helplines compiled by Stonewall, which is available at: [www.stonewall.org.uk/cymru/english/at\\_home/helplines/default.asp#uk\\_general](http://www.stonewall.org.uk/cymru/english/at_home/helplines/default.asp#uk_general)

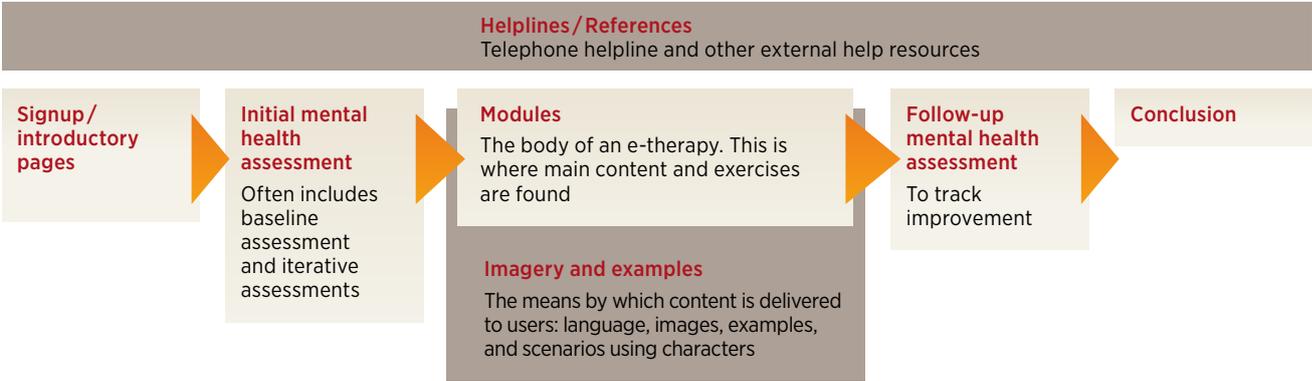
##### United States of America

- The Gay, Lesbian, Bisexual and Transgender (GLBT) National Hotline: [www.glbtnationalhelpcenter.org](http://www.glbtnationalhelpcenter.org)  
1-888-843-4564
- The Gay, Lesbian, Bisexual and Transgender (GLBT) Youth Talkline: [www.glbtnationalhelpcenter.org/talkline/index.html](http://www.glbtnationalhelpcenter.org/talkline/index.html)
- Further USA-based resources are listed on the Gay Alliance webpage: [www.gayalliance.org/directory/health-and-well-being/hotlines.html](http://www.gayalliance.org/directory/health-and-well-being/hotlines.html)

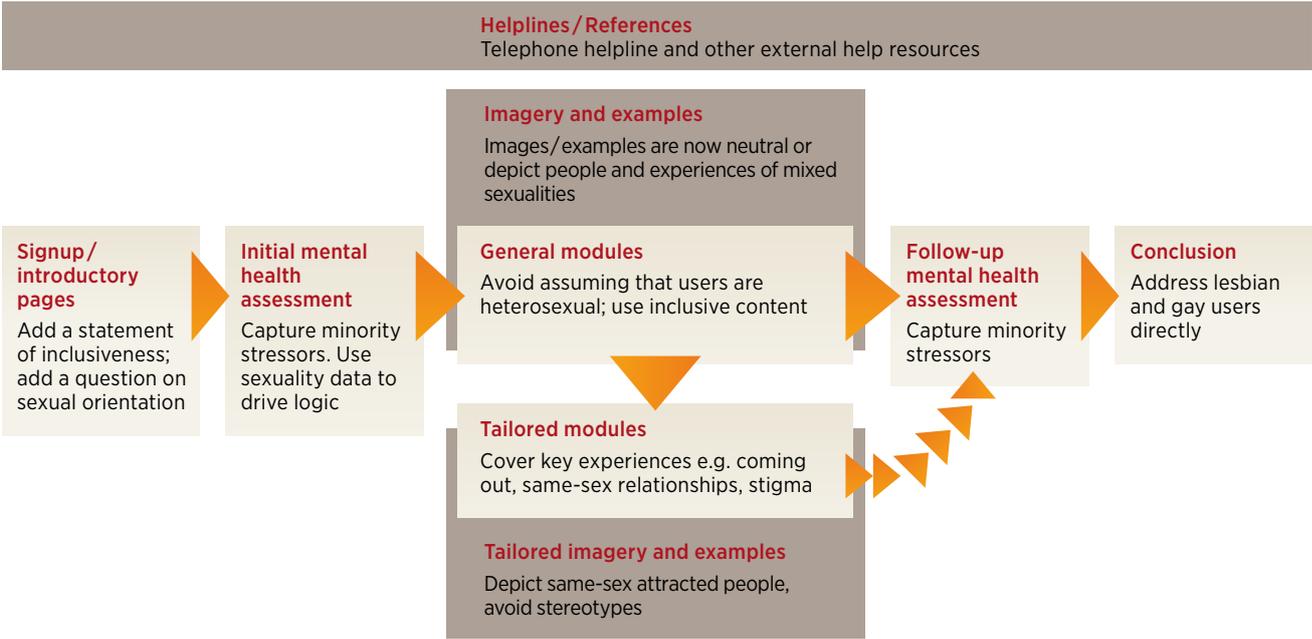
# Case example

The following is a visual schematic of how some of the recommendations in this toolkit might come together to help make an e-therapy more inclusive and relevant to lesbians and gay men. A typical simplified structure of an e-therapy is first presented, followed by a modified version. The arrows indicate a user's progress through the therapy. The light grey boxes indicate modules, while the dark grey boxes indicate other auxiliary content, such as examples and imagery, which are typically module-specific but may also occur at any point in the e-therapy.

## TYPICAL STRUCTURE OF AN E-THERAPY



## MODIFIED STRUCTURE OF AN E-THERAPY



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# Checklist of recommendations

The following is a summary of the recommendations and a checklist for assessing how inclusive and relevant an e-therapy is for lesbians and gay men. Every e-therapy is different and it may not be possible to include all of the recommendations, but this checklist can be useful as a quick guide for identifying recommendations that would be suitable for developing or modifying an e-therapy.

## Introductory sections of an e-therapy (more information on page 16)

Include a statement acknowledging lesbians and gay men.

If asking about sexuality on signup, avoid asking users to identify themselves. Use orientation/gender to drive content.

## Language (more information on page 17)

Avoid language that potentially excludes lesbians and gay men. e.g. “spouse”.

Avoid labelling users by sexual identity. Use orientation/attraction instead.

## Imagery (more information on page 19)

Avoid images that cumulatively assume or suggest the user is heterosexual. e.g. every picture being of heterosexual couples.

Include symbols of lesbian/gay inclusion. e.g. rainbow flag, linked gender symbols.

Avoid images that depict gay and lesbian stereotypes. e.g. butch lesbian, flamboyant gay man.

Include images that depict age, ethnic, and cultural diversity.

## Examples and characters (more information on page 20)

Avoid exclusive use of heterosexual examples and characters.

Avoid gender-neutral examples and characters. e.g. androgynous characters.

Include examples and characters depicting non-traditional families and gender roles.

Avoid gay and lesbian stereotypes in examples and for characters.

Include examples that depict age, cultural and ethnic diversity.

## Avatars (more information on page 22)

Consider using avatars if feasible.

---

### Relationships (more information on page 23)

- |                                                                                                                                                               |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Avoid catering only to heterosexual romantic relationship experience.                                                                                         | <input type="checkbox"/> |
| Include content about relationship-related challenges among family and friends.<br>e.g. lack of recognition of relationship, ostracisation, misunderstanding. | <input type="checkbox"/> |
| Include content about relationship-related challenges in the public sphere.<br>e.g. coming out in public, at work, and at school.                             | <input type="checkbox"/> |

### Further recommendations (more information on page 25)

- |                                                                                                                                                  |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Include content about coming out.                                                                                                                | <input type="checkbox"/> |
| Include content about harassment, rejection, and other forms of discrimination.                                                                  | <input type="checkbox"/> |
| Include content about self-acceptance.                                                                                                           | <input type="checkbox"/> |
| Include content around homonegativity that addresses issues specific to age, culture, and other relevant demographics or vulnerable populations. | <input type="checkbox"/> |

### Social support (more information on page 28)

- |                                                                                                                                                                                |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Avoid the assumption that lesbians and gay men have common support structures in their lives, such as family and friends                                                       | <input type="checkbox"/> |
| Include guidance for building social networks and social support, and consider linking to forums or other online sites where lesbians and gay men can connect with each other. | <input type="checkbox"/> |
| Consider including an online forum as part of the e-therapy program.                                                                                                           | <input type="checkbox"/> |

### References to mental health resources (more information on page 30)

- |                                                 |                          |
|-------------------------------------------------|--------------------------|
| Include tailored helplines and other resources. | <input type="checkbox"/> |
|-------------------------------------------------|--------------------------|
-

# User testing

One of the best ways to assess whether an e-therapy is suitable for users from a particular population is to ask them. A brief 12-item questionnaire is provided below to assist e-therapy developers in the process of consulting with lesbians and gay men, and to test the inclusiveness and relevance of an e-therapy. The questionnaire is printable/photocopier-friendly. Developers may also wish to delete some items or add new items depending on the specific aims and features of the e-therapy.

## Utility for other sexual minorities

Items are targeted to lesbians and gay men, but depending on the focus of the e-therapy, items referring to “lesbians and gay men” could be replaced with “LGB” or “non-heterosexual”, or with alternative groups such as “bisexual men and women”.

## Scoring

Agree = 1                  Disagree = 0

Compute a mean score by adding the score for each item then dividing by the number of items answered, excluding those marked as “not applicable”. The mean score indicates the degree to which a lesbian or gay male user felt the e-therapy was inclusive of and relevant to lesbians and gay men.

Thinking about your experience using this program, please tell us whether you agree or disagree with the following statements:	Agree	Disagree	N/A
1 I felt comfortable using this program	<input type="checkbox"/>	<input type="checkbox"/>	
2 I did not feel excluded or alienated from any part of this program	<input type="checkbox"/>	<input type="checkbox"/>	
3 This program appears to be relevant to people who identify as lesbian or gay	<input type="checkbox"/>	<input type="checkbox"/>	
4 At no point did this program appear to assume or suggest that I was heterosexual	<input type="checkbox"/>	<input type="checkbox"/>	
5 I felt that the images used in this program would appeal to lesbians and gay men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I felt that any examples, stories, or characters in this program were sufficiently inclusive of lesbians and gay men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I felt that this program sufficiently addressed issues related to being lesbian or gay, such as challenges with discrimination, prejudice, and coming out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 This program appears to be inclusive of same-sex relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I thought that any portrayals of gay or lesbian people were not overly stereotypical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Suggestions and links to additional resources, such as helplines, were sufficiently inclusive of lesbians and gay men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 I was able to relate to the content in this program	<input type="checkbox"/>	<input type="checkbox"/>	
12 I think this program would be useful for lesbians and gay men who need some help	<input type="checkbox"/>	<input type="checkbox"/>	

---

## ADDITIONAL RESOURCES

The following webpages provide useful research, resources, and advocacy for understanding and improving the mental health of same-sex attracted people, and may be useful when designing and developing the content for e-therapies that are applicable to lesbians and gay men.

### Australia

- The Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University  
[www.latrobe.edu.au/arcshs](http://www.latrobe.edu.au/arcshs)
- The National LGBTI Health Alliance  
[www.lgbthealth.org.au](http://www.lgbthealth.org.au)
- Gay and Lesbian Health Victoria  
[www.glhv.org.au](http://www.glhv.org.au)
- Minus18  
[www.minus18.org.au](http://www.minus18.org.au)
- Gay and Lesbian Switchboard  
[www.switchboard.org.au/index.php](http://www.switchboard.org.au/index.php)
- *beyondblue*, LGBTI people  
[www.beyondblue.org.au/resources/for-me/lesbian-gay-bi-trans-and-intersex-lgbti-people](http://www.beyondblue.org.au/resources/for-me/lesbian-gay-bi-trans-and-intersex-lgbti-people)

### United Kingdom:

- The Lesbian and Gay Foundation  
[www.lgf.org.uk](http://www.lgf.org.uk)
- London Lesbian and Gay Switchboard  
[www.llgs.org.uk](http://www.llgs.org.uk)
- Stonewall UK  
[www.stonewall.org.uk](http://www.stonewall.org.uk)
- The LGBT Network  
[www.lgbtnetwork.eu](http://www.lgbtnetwork.eu)
- NHS, Gay health  
[www.nhs.uk/livewell/lgbhealth/Pages/Gayandlesbianhealth.aspx](http://www.nhs.uk/livewell/lgbhealth/Pages/Gayandlesbianhealth.aspx)

### United States of America

- GLBT National Help Center  
[www.glbtnearme.org](http://www.glbtnearme.org)
- American Medical Association, LGBT Health Resources  
<http://ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-advocacy-committee/glb-resources/lgbt-health-resources.page>
- Fenway Health  
[www.fenwayhealth.org/site/PageServer](http://www.fenwayhealth.org/site/PageServer)

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