LGBTQIA+ MENTAL HEALTH IN CHILE AND THE UK

DEPATHOLOGISATION, AFFIRMATION AND INTERSECTIONALITY IN THE EXPERIENCE OF MENTAL HEALTH PROFESSIONALS

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Acknowledgements

Content Note and Note on Terminology

This report contains descriptions of some of the social and political effects of LGBTQIA+ hatred in the experience of the mental health and wellbeing of minoritised sexual and gender groups from Chile and the UK. These descriptions include references to pathologisation, human rights violations, disciplinary violence, discrimination and distress as mental health practitioners from both countries have experienced them.

The report also utilises various sexual and gender terminology to reflect their contemporary usage in Chile and the UK. For consistency, we use the LGBTQIA+ acronym throughout the document as an inclusive umbrella term for lesbian, gay, bisexual, trans, queer, intersex and asexual people. The preferred terms used by the workshop participants and quoted here are referenced while keeping their meaning and original sense.

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EXECUTIVE SUMMARY

'LGBTQIA+ mental health in Chile and the UK: Depathologisation, affirmation and intersectionality in the experience of mental health professionals' is a knowledge exchange project that ran from March to May 2023. It was a collaborative initiative between mental health professionals from the cities of Valparaíso, Concepción and Santiago (Chile), and Brighton and Hove (UK), who met to exchange knowledges on LGBTQIA+ mental health. The project was funded by an Economic and Social Research Council Post Doctoral Fellowship and supported by the South Coast Doctoral Training Partnership.

Through a series of three Knowledge Exchange Workshops (KEW), the project mapped the state of LGBTQIA+ mental health provision in the two countries, by analysing the socio-political conditions in which it takes place. The project also contributed new insights about the principles of depathologisation, affirmation and intersectionality, and suggested recommendations to inform affirmative practice and policy on LGBTQIA+ mental health, which are currently in a state of crisis in both contexts.

This report presents lessons learned from the KEW, which were collected through various online and in person methods of co-production and mapping activities. The workshops' key lessons are organised around two main themes:

1. Reflections on our work:

- First, it describes the socio-political context of Chile and the UK and reflects on the need to incorporate this contextual dimension in any analysis of LGBTQIA+ mental health; secondly, it reflects on the principles that commonly define LGBTQIA+ mental health work (e.g., depathologisation, affirmation and intersectionality), and suggests the principle of reparation as another equally relevant ethical orientation, which is often neglected in discussions on mental health issues; and lastly, this first theme highlights the situated nature of participants' work and the role that emotions of fear, anger and joy play in shaping their professional practice.

2. Reflections on the experience of exchanging knowledges:

▪ First, this theme emphasises the importance of having transnational conversations and connecting with others in generative and creative ways, forging solidarities and networks of support both locally and internationally; secondly, this theme challenges the alleged incompatibility between psychology, academia and activism, criticising academia's extractivist relationship with people's knowledges, and broadening the scope of what counts as 'activism' and 'political' in LGBTQIA+ mental health work.

The report ends with recommendations that are relevant for different stakeholders, such as mental health practitioners, activists, professional training bodies, service users, policymakers, and others. Overall, these include:

▪ Promoting professional ethics inspired by the principles of depathologisation, affirmation, intersectionality and reparation.
▪ Challenging the cis-heteronormative, racist and ableist ideologies that shape existing curricula of training organisations.
▪ Addressing burnout, stress, and mental ill health on practitioners.
▪ Acknowledging the voices of LGBTQIA+ people as experts in their health needs.
▪ Creating opportunities for dialogue and reparation at the community level.

INTRODUCTION

In the last few years, there have been significant changes in the life conditions of LGBTQIA+ people in Chile and the UK. However, progress in sexual and gender norms does not always come paired with substantive changes in material lived realities, especially when persisting intersectional inequalities[1] still shape access to health,[2] housing,[3] culture,[4] security and social benefits, employment and rights protection.[5] ILGA-Europe's 2023 report shows an increase in hate crimes, with homophobic hate crimes increasing by 41% and transphobic ones increasing the most by 56% in England and Wales, attributed in part to a rise in anti-trans media reporting and moral panic over trans affirmative care.[6] On the other hand, reports of hate crimes in Chile have experienced an increase of 79% between 2015 and 2019.[7] Despite discrimination rates having decreased by 6% in 2022, hate crimes have increased, especially online hate speech.[8] [9]

Study after study has thus confirmed that when it comes to changes in LGBTQIA+ rights, we need to account for these two sides of the story and not simply stay with what legal progress tells us. For example, a recent review of UK evidence on LGBTQIA+ health inequalities found a "depoliticised 'it's getting better' narrative" is not underpinned by evidence that things are indeed getting any better.[10] In the field of mental health, there is extensive evidence showing that poor health indicators in the LGBTQIA+ community are the norm rather than the exception in both countries.[11] Marked inequalities in access and experiences of healthcare have increased as a consequence of the COVID-19 pan-

1 Inequalities that are explained by the intersection of multiple systems of oppression, such as those produced by the interactions of race, gender, sexuality, disability, class, etc.
2 Zeeman et al., 2019.
3 Besoain Arrau, Ojeda Güemes, & Rihm Bianchi, 2023.
4 Comisión Interamericana de Derechos Humanos, 2020.
5 Alveal R. et al., 2019; Defensoría de la Niñez, 2022; Madrigal-Borloz, 2023.
6 ILGA-Europe, 2023.
7 Fundación Iguales, 2021.
8 MOVILH, 2022.
9 LLYC IDEAS, 2023.
10 McDermott, 2021.
11 Barrientos, 2015; Boden-Stuart et al., 2022

demic[12], the 2019 social uprising in Chile[13], and the ongoing economic crisis affecting most marginalised communities.[14] We also know that LGBTQIA+ people experience elevated rates of depression, anxiety and distress compared to heterosexual and cisgender populations. Studies in the UK[15] have found significantly higher suicide risk across all LGBTQIA+ groups that echo those done in Chile.[16] Studies indicate that LGBTQIA+ people seek psychiatric and psychological care at a higher rate than their heterosexual and cisgender counterparts.[17] However, most of them have reported that their health needs are not met due to experiences of discrimination and violence in their encounters with the health system.[18]

These elevated rates of psychological distress are the outcome of socio-political, economic and cultural factors that contribute to LGBTQIA+ people's further marginalisation. These numbers are also connected with the effects of ongoing prejudice, discrimination, family rejection, hate crimes, bullying and harassment, the rise of authoritarianism and transnational anti-gender attacks, particularly those targeting trans and non-binary people.[19] These effects, however, are unevenly experienced within the LGBTQIA+ communities across lines of race and ethnicity, age, sexual orientation and gender identity, disability and neurodivergence, immigration status, class, educational background, and employment.[20]

LGBTQIA+ mental health inequalities are explained by a combination of factors, which, if not addressed, contribute to creating healthcare conditions that are unsafe for those who need them. These factors include those accounted for by the minority stress model[21] and those produced by inadequate training on the specific needs of sexual and gender diverse people, a lack of commitment to improve service provision, and lack of monitoring and evaluations of public services.[22] This report thus aims to share insights about the particularities of each of the contexts in which these inequalities take place, set out the principles that orient the practice of LGBTQIA+ mental health, and make policy recommendations to improve them. This is a co-produced effort that centres the expert

12 Urzúa, Barrientos, Guzmán-González & Ulloa, 2022.

13 Alveal R. et al., 2019.

14 Government Equalities Office, 2018.

15 Stonewall, 2018; Jones & Crossland, 2023.

16 Bühring & Inostroza, 2022; Organizando Trans Diversidades, 2017; Tomicic et al., 2020

17 Martínez, Tomicic & del Pino, 2019.

18 Ibid.

19 Ojeda, 2022.

20 Boden-Stuart et al., 2022.

21 Meyer, 2003.

22 Martínez, Tomicic & del Pino, 2019.

knowledge of mental health professionals from Chile and the UK working directly with LGBTQIA+ people in different institutional settings—clinical, psychotherapeutic, counselling, academic, and activist. It highlights the importance of forging transnational conversations on these issues, exchanging resources and articulating solidarity politics in times of increased hostilities towards LGBTQIA+ affirmative care.

LGBTQIA+ MENTAL HEALTH AND WELLBEING IN CONTEXT

3.1 UK – Brighton and Hove

Brighton and Hove is a city located in East Sussex, England, on the south coast around an hour's train ride from the capital, London. It has been referred to as the 'gay capital' of the UK and most recently, the 'LGBTQ capital' in recognition of the growing visibility of trans communities.[23] It has the largest LGB population in England and Wales, with over 10 percent of the population identifying as 'not straight' according to the 2021 census, and the highest number of people identifying as non-binary.[24] Social perception around the city tends to 'mythologise' Brighton as "liberal, radical, and bohemian"—and Brighton and Hove has the country's only Green Member of Parliament. However, it is also one of the most disadvantaged regions of the UK, with considerable suicide rates.[25] Moreover, hate crimes based on sexual orientation have increased by over 20 percent from 2021-2022, according to data gathered by Sussex Police.[26]

Personal experiences and stories shared among the workshop participants challenge mainstream narratives that living among the largest LGBTQIA+ population in England means the creation of a 'queer utopia'. Some of them talked of increasing hostility towards people with intersectional expe-

23 Smith, Gilchrist & Lim, 2023.

24 Office for National Statistics, 2021.

25 Boden-Stuart et al., p. 7, 2022.

26 Green, 2022.

riences, exclusionary discourses and increasing pathologisation of LGBTQIA+ identities. These are a few first-hand examples:

- Friends being spat at and homophobically verbally abused during Pride.
- Tales from clients of gender neutral toilet signs being vandalised and ripped off the walls in their place of work.
- Openly transphobic views being allowed in public discourse under the guise of liberalism and "difference of opinion".
- Local women-only charities being sued for including trans women.

Myths around Brighton's alleged progressive and welcoming nature have motivated research into the reasons why LGBTQIA+ people migrate to (and leave) Brighton and Hove.[27] For some, Brighton represents "belonging" and "community", whilst it can also be a very lonely place to be. Those who migrate end up finding that the city is not necessarily a safe place due to the high cost of living, which often leads to poverty and exclusion.

> *Brighton has often been described to me like a bubble where LGBTQ people can come, be happy, have a great life...But from my experience that is not quite as straight-forward. But it is true that if I had a private practice somewhere else in the country it would look very different from the practice I have here – workshop participant.*

Being part of a visible LGBTQIA+ community can also put a target on your back, increasing your likelihood of experiencing hate crime. At the same time, many LGBTQIA+ people mistrust of police/institutions of power and doubt their ability to protect them. Due to its popularity for nightlife, England's predominant cis white heterosexual macho culture also permeates Brighton, and the city is also known as a place for 'hen' and 'stag' weekends and party culture. The two universities (Sussex and Brighton) also bring a large student population into the city, that are sometimes at odds with the needs of local residents.

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27 Boden-Stuart et al., 2022.

3.2 Chile – Concepción, Valparaíso and Santiago

Concepción: Concepción is a city in south-central Chile with a high population of young itinerant[28] university students, due to the presence of several universities. The last political elections have seen a growing trend towards the right, corresponding to the presence of an important group of people who belong to Christian-evangelical churches of conservative tradition. Regarding LGBTQIA+ activism, the work is not carried out under the wing of large organisations as in Santiago, but through groups, collectives and *cells*, characterised by their critical and dissident stance, which makes dialogue with state institutions and articulation between the different collectives difficult. The city has had a municipal anti-discrimination ordinance since 2016 and a Municipal Office of Diversity. Recently, it has implemented an 'accompaniment programme' for trans children and adolescents in the public health system that support them in their transition. Likewise, the hospital of Talcahuano, a neighbouring port city, has the first Comprehensive Health Unit for the Trans population, becoming a reference health care facility in the country's south.

Valparaíso: Valparaíso is a city located on the pacific coast. It is known for its port and high poverty levels, and since 1990 Valparaíso has been the home of the National Congress. The city is surrounded by hills, and there is a high concentration of informal settlements, each of them strongly marked by territorial belonging. Because of its particular topography, Valparaíso is particularly vulnerable to urban fires and earthquakes, and like Concepción, it is recognised as a university city. In terms of LGBTQIA+ organisations, it is known for having more of an anarchist and outright counter-hegemonic tradition. Generally speaking, two apparently contradictory indicators coexist: on the one hand, Valparaíso is known for being a culturally inclusive city, and on the other, it is considered a 'red zone'[29] due to the high rates of hate crimes against the sexual-dissident community, particularly butch lesbians and trans women. Since 2012, Valparaíso has democratically elected trans representatives in its municipal council and is home to one of the first specialised trans-affirmative care centres. For many years the Carlos Van Buren Hospital was the only public institution that performed affirmative surgeries during the dictatorship. This tradition makes Valparaíso a kind of *mecca* to which the trans population migrates to access public trans health.

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28 Many of them come to Concepción to study and return to their homes and cities of origin on a frequent basis.

29 Mohan, 2019.

Santiago: Chile is a highly centralised country, and over half of the total population of the country live in Santiago, the country's capital, which also provides opportunities for social mobility. The country follows a centralist politico-economic administrative model that shapes access to information, funding opportunities, health and educational services, which are critical for LGBTQIA+ people. In this sense, the territory, one's residential address, migration status, the rural/urban divide and location within the city determine differential access to these services and networks. Santiago is home to most LGBTQIA+ organisations, some of them with a more institutional and collaborative approach with the state; most of its municipalities have their own Diversity and Non-discrimination Offices, and it concentrates the significant number of gender identity health programmes in the country. Santiago hosted one of the largest demonstrations since the return to democracy in May 2018, known as *Mayo Feminista*[30] (Feminist May), and it was the place where the 2019 October *Estallido Social*[31] (Social Uprising) was sparked.

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30 In April 2018, a group of students occupied the Faculty of Philosophy and Humanities of the Universidad Austral (Valdivia city) in response to a series of allegations of sexual harassment. What happened there sparked a series of occupations and student mobilisations against gender violence, sexist education and discrimination, which set the basis for what was called the *Mayo Feminista* (see Hiner & López Dietz, 2021).

31 From October 18th until the appearance of the first cases of Covid-19 in March 2020, people came together to protest against long-standing inequalities, human rights violations and different forms of oppression. They asked for a varied range of transformations, among which the definite eradication of the dictatorship-era 1980 Constitution, which is still in force, and which is one of the last *authoritarian enclaves*. The demand to change and rewrite the Constitution forced the then government to open a constitutional process that continues today (see Badilla Rajevic, 2021).

TIMELINE: MAIN EVENTS AND MILESTONES

In this section, we made a necessarily selective list of the main events and milestones we felt were significant in shaping mental health practice and policy in the UK and Chile. We are aware that many other significant events for LGBTQIA+ lives have taken place in recent history, however we wanted to focus on those relevant to thinking about the wellbeing of our communities.

4.1 UK 1988 ------> 2023

1988 → Section 28 is brought into law which prohibits the promotion of homosexuality by local authorities and schools.[32]

1989 → The Tavistock and Portman NHS Foundation Trust established the Gender Identity Development Service (GIDS).

1998 → 'Diagnosis: Homophobic' The first published research study into the experiences of LGB people who used or worked in mental health services. This provided evidence for LGBTQIA+ run mental health initiatives that were developed all over the UK.[33]

1998, December → The 'Lesbian and Gay Section' of the British Psychological Society (BPS)

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32 Stonewall, 2016.
33 McFarlane, 1998.

was founded. It was renamed the 'Psychology of Sexualities Section' in 2009.[34]

1999 → Funding from 'Comic Relief' for mental health advocacy for LGBTQIA+ people in Brighton and Hove led to the creation of MindOut, a service run by and for LGBTQIA+ people with experience of mental health issues, offering a unique blend of advocacy, peer support, group work, counselling, suicide prevention, anti-stigma campaigning, training for professionals and national lobbying.[35]

2000 and 2008 → Award winning research into the lives and mental health experiences of LGBTQIA+ people in Brighton were published:[36] 'Count Me In' (2000) and 'Count Me In Too: LGBT Lives in Brighton and Hove' (2008).[37]

2003, November → Section 28 abolished in the rest of the UK.[38]

2004 → Gender Recognition Act (GRA). It allows for the issuing of a Gender Recognition Certificate once a 'Gender Recognition Panel' is satisfied and the individual has met specific requirements: is eighteen years or over, has a diagnosis of 'gender dysphoria', has lived in their affirmed gender for at least two years, and intends to live in their gender until death.[39]

2010 → The Equality Act replaces existing anti-discrimination laws with a single Act, and includes 'protected characteristics' such as gender reassignment, race, sex, sexual orientation, and disability, among others.

2012 → The BPS publish 'Position Statement: Therapies Attempting to Change Sexual Orientation'.[40]

2015 → The 'Brighton and Hove Trans Needs Assessment 2015' was published.[41] It led directly to setting up a 'Trans Advocacy Service' with funding from the local council and local NHS jointly. Trans Advocacy later became an integral part of local community advocacy commissioning aimed at addressing health inequalities and navigating trans care pathways.

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34 Jowett & Semlyen, 2016.

35 https://mindout.org.uk/

36 https://www.countmeintoo.co.uk/

37 Browne & Lim, 2008, in consultation with 'Count Me In Too Mental Health Analysis Group'.

38 Stonewall, 2016.

39 https://www.gov.uk/apply-gender-recognition-certificate

40 Jowett & Semlyen, 2016.

41 Hill & Condon, 2015.

2017 (updated November 2022) → A Memorandum of Understanding (MoU) is signed by over 25 health, counselling and psychotherapy organisations (including the NHS) with the aim of ending the practice of conversion 'therapy' in the UK.[42]

2018 → Since 2018 the UK Government has pledged to reform the GRA. Many activists and academics continue to argue that the GRA is draconian, lengthy, medicalised and invasive. In 2022, the Scottish parliament introduced a bill to significantly improve the current GRA process, which the UK Government currently blocks.[43]

2019 → The BPS published their 'Guidelines for Psychologists Working with Gender, Sexuality and Relationship Diversity: For adults and young people (aged 18 and over)'.

2021 → UK Government begins consultation on legally banning conversion therapy, in line with 16 other countries including Brazil, Canada and Germany.

2023 → NHS England announced that the Tavistock and Portman's Gender Identity Development Service will be replaced by two regional centres in London and in the Northwest to decentralise and offer a more 'holistic' approach to trans affirmative care.

2023, August → Following the publication of the LGBT Veterans Independent Review on July 2023, the BPS[44] issued an apology to all LGBT+ veterans "who were subject to treatments that were traumatising and discriminatory" under the Sexual Offences Act that criminalised those subjected to service law from 1967 until January 2000.

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42 British Association for Counselling and Psychotherapy, 2022.

43 Thurlow, 2023.

44 British Psychological Society, 2023.

4.2 Chile 1973 ------> 2023

1973-1989 → During the civic-military dictatorship, professional colleges had their regulatory powers reduced, including ethical protections for professional practice.[45]

1976 → Trans-affirmative surgeries (specifically genitoplasty) began to be performed clandestinely at the Carlos Van Buren Hospital in Valparaíso.[46]

1990s → Until the early 2000s, some universities established exclusionary norms that discriminated against students with physical disabilities, epilepsy or who showed 'homosexual traits' from studying psychology through the application of projective tests.[47]

1999 → Abolition of Article 365 of the Penal Code that criminalised the practice of sodomy between men.

2010 → The Ministry of Health launches the 'Clinical Pathway for Bodily Adaptation for People that present incongruity between physical sex and gender identity', addressing the international recommendations of the World Professional Association for Transgender Health (WPATH).

2012 → Antidiscrimination Law. It establishes measures against arbitrary discrimination based on sexual orientation and gender identity, among other characteristics.

2015 → Todo Mejora Foundation launched a free online helpline aimed at offering emotional support to children, young people, and adults up to 29 years old as part of their LGBTQIA+ suicide prevention strategy.[48]

2015 → The Commission for Gender and Sexual Diversity of the Chilean School of Psychologists was founded. In 2015 they launched a position statement and technical guidelines on the risks and ethical problems involved in promoting 'reparative therapies' for LGBTQIA+ people.[49]

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45 Lira, 2008.

46 Mac Millan, as cited in Cofré A., 2019.

47 Ligüeño Espinoza & Parra Moreno, 2007

48 https://todomejora.org/que-hacemos/hora-segura

49 Comisión de Género y Diversidad Sexual, 2015.

2016 → The Ministry of Health announces for the first time their opposition against the practice of so-called 'conversion therapies'.

2017 → The Ministry of Education announces its 'Circular 768' which facilitates the inclusion of trans people in the education system. This regulation was updated in 2021 by the 'Circular 0812'.

2018, November → The Non-Network of Affirmative Trans Public Health Professionals was established outside the state, bringing together Trans Polyclinics with civil society organisations from across the country with the aim of articulating efforts to provide trans-affirmative care and calling out the state's lack of support.[50]

2018, December → Gender Identity Law: It enables trans people over fourteen years to change their legal name and sex on the registry without needing surgical intervention. LGBTQIA+ activists criticised the law because it left non-binary people, children and youth under fourteen years outside the law.[51] Requests for gender certificates[52] by psy professionals[53] still operate as one of the barriers for access to gender-affirming health care in Chile.

2021 → Law 21.331 on the Recognition and Protection of the Rights of People in Mental Health Care. It is established that neither identity nor sexual orientation, among other characteristics, can be considered for a mental health diagnosis.

2021 → Trans Health for Chile Action Bloc: different civil society organisations, health professionals, and trans, non-binary and travesti activists have organised the campaign #SaludTransParaChile to create a National Programme for the Health Care of Trans People.[54]

2022 → Draft legislation that 'Promotes affirmative accompaniment for LGBTQIA+ people and prohibits efforts to change sexual-affective orientation and gender identity or expression'.

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50 The establishment of the *Non-network* bears witness to the complexities of inhabiting a space and a health policy that has not been designed to account for people's different ways of being but, on the contrary, operates by standardising and homogenising the trans and non-binary body, their desires, affects and dreams.

51 Saavedra & Valdés, 2018.

52 Yáñez Castillo, 2016.

53 Hereafter, we use the expressions 'psy professionals' and 'psy professions' to refer to a set of practices and professions connected to disciplines as heterogeneous as psychology, psychiatry, psychoanalysis, and psychotherapy.

54 https://www.instagram.com/saludtransparachile/

AIMS

This report emerges from three Knowledge Exchange Workshops (KEW) that took place online and in person between March and May 2023. The aims of the KEW were:

- To forge dialogue between mental health professionals and advocates from Chile and the UK on the main challenges and opportunities they face in their work with LGBTQIA+ people.
- To understand what a depathologising, affirmative and intersectional approach to LGBTQIA+ mental health means and does for the participants and the community they work with, with particular attention to knowledges that come from activist spaces, academics and people's lived experiences.
- To identify some of the barriers and facilitators for the implementation of these principles.
- To suggest recommendations to inform practice and policy on LGBTQIA+ mental health and wellbeing of interest to different stakeholders.

6

WHAT WHE DID

What are the main challenges that mental health professionals face when working with LGBTQIA+ people? What does it mean for us to work from a depathologising and affirmative approach? What socio-political, cultural, economic and institutional contexts must be considered when thinking about this work? These and other questions inspired a series of three Knowledge Exchange Workshops (KEW) that took place once a month between March and May 2023, in sessions of ninety minutes. The March and May meetings were held online through Zoom with simultaneous translation; and in April, we held separate encounters with the participants from the UK and Chile, which took place in-person and online respectively. The meetings were facilitated by the project's Principal Investigator (PI), Tomás Ojeda, as part of a broader research project funded by an Economic and Social Research Council Post Doctoral Fellowship.

6.1 THE KNOWLEDGE EXCHANGE GROUP: WHO WE ARE

The group consisted of fifteen mental health practitioners, including psychologists, one psychiatrist, psychotherapists and other mental health front-line workers practising in different institutional settings with LGBTQIA+ people. Most of them identified as activists, academics, community organisers, trainers, psychotherapists, counsellors, and educators, which felt for some as if they were "wearing different hats"—as one of the participants mentioned.

In terms of the group composition, eight of the participants were Chilean—one of whom lived in the UK and another in Canada; three lived and worked in Santiago, two in Concepción and one in Valparaíso; and seven lived and worked in Brighton and Hove, UK, of whom one is from Ireland. Participants were invited to participate in the KEW meetings through already established networks of collaboration between the PI and his mentor and workshop participant, Zoë Boden-Stuart.

6.2 EXCHANGING KNOWLEDGES: A NOTE IN METHOLOGY

Knowledge Exchange is a methodological practice that seeks to share insights and produce new ways of seeing and understanding a topic that speaks to the lived experience of people dealing with similar concerns. The KEW did so by forging dialogues between stakeholders with different backgrounds and from different geographical locations, learning together through the process. The exchange took place with the hope of enhancing what we know about LGBTQIA+ mental health and contributing to what other communities, service users, and activists are doing in the field.
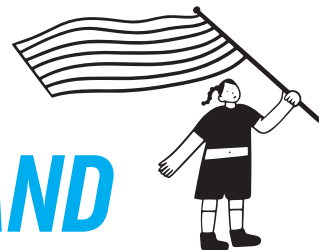
This method involved a collaborative dimension and different degrees of co-production that took place in the meetings through participation in mapping exercises, note-taking, the writing of this report, and crowdsourcing ideas about dissemination and public engagement. To facilitate dialogue across language and cultural barriers, simultaneous translation had a crucial role in the implementation of the workshops, which facilitated the communication and flow of ideas.

6.3 ETHICAL CONSIDERATIONS

This project took the form of knowledge exchange workshops rather than empirical research, and, therefore, formal ethical approval was not sought. However, we were guided by ethical principles throughout, based on a feminist ethics of care, as well as University of Brighton and British Psychological Society ethical guidelines. Everyone involved in the project was a mental health practitioner and thus had an advanced understanding of ethical principles and practice.

Consent was a key part of our process, and all participants were fully informed in advance of the aims and approach to be taken in the project. The content of the workshops was co-produced between the participants, and on-going assent was assured through continuing dialogue. Anonymity was negotiated individually: those who wished to be named in this report have been, and those who did not, have not been. Everyone was given the option as to whether or not they wished to be involved in the writing stage, or only take part in the workshops. Modest honoraria were provided to support participation at each stage and in recognition of their expertise, time and dedication.

7

WHAT WHE FOUND AND WHAT WE LEARNED

This section of the report describes key findings and ideas exchanged throughout the workshops. Here, we quote directly, but anonymously, from the participants and the workshop materials (e.g., flipchart sheets and collaborative digital whiteboards, such as Google Jamboard) to illustrate some of the ideas and to accompany the text. The different learning outcomes are divided into two sections: 1) Reflections on our work and 2) Reflections on the process of exchanging knowledges.

7.1 REFLECTIONS ON OUR WORK:

7.1.1 THE CONTEXTS IN WHICH WE WORK:

LGBTQIA+ mental health work is situated work. Mental health practices, discourses and policies must consider the contexts and communities to which they refer in their cultural, socio-political and economic dimensions. Both Chile and the UK are going through important processes of change that impact the wellbeing of LGBTQIA+ people, which were referenced in our conversations during the workshops.

This year is significant for Chile because it commemorates 50 years of the civil-military dictatorship that interrupted and broke Chilean democracy, committing atrocious crimes against its own people. Denialism and relativisation of widely documented facts have marked the preparation of this milestone, generating new tensions and re-victimising thousands of survivors. At the same time, Chile is experiencing a moment of cultural adjustment after having had the opportunity to vote in favour of a new political constitution guaranteeing social rights for all citizens, a text that was ultimately rejected.

In the UK, the cost of living has risen significantly since the pandemic and the government's priorities seem to be focused on making living conditions even more precarious for various minoritised groups, creating a 'hostile environment' against migrants and refugees, essential workers, activists, students, teachers, etc. Such hostility has also been directed against trans and non-binary people, whose existences are constantly debated and scrutinised by most of the corporate media, who insist on presenting their demands as an alleged threat to other groups, particularly cisgender women, and misrepresenting evidence about the benefits of trans-affirmative care.

> *The media environment is incredibly toxic towards trans people in particular. Since Brexit, UK right-wing media have just two targets left – trans people, and immigrants – KEW participant.*

> *I feel like some people think of our issues as theories or topics to debate, rather than real life issues which are life and death for so many – KEW participant.*

> *Training to be a therapist as a LGBTQIA person is not always safe as the systems of therapy training replicate the othering logic of white/hetero/cis power – KEW participant.*

LGBTQIA+ health cannot be separated from these tensions. It coexists alongside an increase in LGBTQIA+ pathologisation, exhausted affirmative activism, and resistance from within the community to establish closer relationships with existing health providers, just to mention some factors.

In Chile, the growing marketisation of the therapeutic 'offer' turns expert knowledge into specialised training programmes that enter the market as exchange products, depoliticising their transformative potential.

> *I am concerned about how private clinics are beginning to look at trans and non-binary people as a niche market…. There is a need that is not covered by the State, and the demand for hormones and affirmative surgeries is increasing, and today more and more private spaces are offering 'packs' for trans health – KEW participant.*

I am also concerned about how in recent years spaces that define themselves [as LGBTI-friendly] have been multiplying, describing themselves as LGBTI specialists, gender specialists, with whatever name you like. Because I see it with a certain strong neoliberal logic, as if a new product had been created that you can choose from a showcase. And I am concerned about how the training processes of the professionals themselves are also being undermined by this logic – KEW participant.

Those working within civil society organisations and state services are often the same people who are working on these issues, which causes a significant human overload that needs to be considered when looking at LGBTQIA+ health practice. Many of us work in conditions of economic precariousness, without access to quality healthcare and go through cycles of burnout and stress that affect our work.

In line with the above, budget allocated to LGBTQIA+ mental health is scarce and, in many cases, competes with other benefits and/or health policies considered to be of 'higher priority'. It is in this context that civil society organisations, together with state funded services committed to a depathologising, affirmative and intersectional healthcare ethics, have built a clinical and community praxis that often operates outside of universities, study centres and the state itself. These KEW are a clear example of these commitments in operation.

7.1.2 PRINCIPLES THAT ORIENT OUR WORK

Depathologisation

Depathologisation is an ethical and political orientation that recognises LGBTQIA+ identities and experiences as *normal variants of human behaviour*. It overcomes a more traditional clinical-psychiatric understanding of sexuality and gender to promote an inclusive and respectful approach to human diversity and people's bodily autonomy. It involves the following ideas:

1. It recognises that identifying as an LGBTIQANB+[55] person alone does not imply being an object of therapeutic, clinical or hormonal treatment.

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55 Expression mostly used by practitioners and activists from Concepción. It stands for Lesbian, Gay, Bisexual, Trans, Intersex, Queer, Asexual and Non-binary.

Barrier: the phenomenon of the 'trans broken arm syndrome'[56]: when the medic sees every issue through the patient's trans identity – KEW participant.

Not all mental health problems relate to sexuality or gender – KEW participant.

Providing low-cost therapeutic support to gender and relationship diverse adults. Don't care who they are or how they identify within the LGBTQ+ umbrella – KEW participant.

2. A depathologising principle involves raising awareness of how LGBTQIA+ identities have been constructed as pathological. It suggests, instead, to approach them from a historical, political and situated perspective.

    Discourses of medical pathology that other and 'thingify' trans and queer people bring them to therapy with the idea that they are in some way a problem – KEW participant.

3. Giving up the power given to psy professionals to 'diagnose' identity, focusing instead on addressing suffering and mental ill health as an effect of social discrimination and marginalisation.

4. Problematising the hetero-cisnorm and calling into question rigid and binary dichotomies such as normal/pathological, male/female, hetero/homo, cis/trans, as well as the biomedical discourses that inform them.

    We need to de-individualise our ways of approaching LGBT+ people's mental health, understanding that the cis-heteronorm negatively affects everybody and all relationships – KEW participant.

5. Challenging the need to certify gender through tests and the issuing of gender certificates, aiming for a practice that recognises people's healthy variations of gender and sexuality.

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56 Colloquial term that refers to a form of discrimination faced by trans and gender diverse clients, where a health professional incorrectly assumes that a 'medical condition' is explained by the person's gender identity or transition (see Wall, Patev, & Benotsch, 2023).

6. Questioning the psy professions' gatekeeping power as providers of affirmative care. It is the person, their time and expert knowledge of themselves that needs to be centred to inform mental health practice.

> Who gets to speak/name experiences? Who is kept quiet or kept out of conversations... De-pathologising acts as a counter-weight to the power/violence of the medical model — KEW participant.

> You don't need your identity to be proven! — KEW participant.

<u>Reparation</u>

Reparation and depathologisation are connected. Reparation entails putting into practice corrective gestures and actions to the historical damages, abuses and human rights violations inflicted towards minoritised groups through laws that have criminalised the existence of LGBTQIA+ people, through forced and coercive medical interventions, state and police violence. It also involves promoting reparative actions to heal and correct historical and disciplinary wrongs, and structural inequalities.

Reparation focuses on different levels: personal, community group-based, and state-based:

1. On a personal level, reparation is experienced when the person or the community receive an apology or a public acknowledgement of the damage caused, which concrete measures must accompany. The apology or acknowledgement can come from an institution, a professional body, individuals or state representatives.

2. At the group/community level, the opening of spaces for conversations and gatherings that facilitate community re-composition and conflict resolution are included as part of the measures. However, we recognise that this process can be complex because it is not easy to transform experiences of violence and mistreatment into healing. In this case, therapeutic care is insufficient and cannot be the only alternative. Reparation takes place within the community and through relationships of care, love and respect.

3. At the state level, reparation takes place in the form of public policies aimed at recognising people's rights and ensuring access to basic needs through economic compensation and im-

provements in their housing, health and overall material/symbolic life conditions.

> *It is very painful to talk about violence among us. We understand that one of the spaces for reparation is the community and through conversation, but we also need to be careful in facilitating those conversations because what motivates them brings back many situations that still do not have justice — KEW participant.*

Reparation has to be grounded in history by publicly recognising that the community has faced cycles of structural violence and inequalities that have passed on across generations. Reparation seeks to restore said rights and commits to the enactment of policies of non-repetition. A paradigmatic case in Chile that can be used as an example of good practice is the PRAIS[57] programmes aimed at victims of torture by the civic-military dictatorship. As some of us mentioned, the idea would be to replicate this model with the LGBTIQANB+ community in Chile, especially with those made ghostly by their exclusion in the official records of victims of the dictatorship.[58]

> *We need reparation and historic pardoning for those convicted of queer crimes, such as 'cottaging'[59] — KEW participant.*

> *The need for economic and psychological reparation for trans people victims of structural violence during the [Chilean] civic-military dictatorship, the 2019 social uprising and the forced sterilisation [of trans and intersex people] — KEW participant.*

> *These conversations give me hope for thinking about a model that might heal some of the stuff we have going on right now for young trans people. Because I think there is a story or a kind of mission for many trans young people who have been really harmed or dismissed or ignored by health care services here in the UK: to have that met, to have that seen and understood and to get some reparations — KEW participant.*

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57 Reparation and Health Care Programme (known as PRAIS in Spanish).

58 Hiner & Garrido, 2019.

59 Queer slang that refers to anonymous sex between men in a public toilet or outdoor space.

Affirmation

By affirmation and affirmative practices we mean recognising, celebrating and valuing diverse gender identities, sexual/romantic orientations and gender expressions outside a pathologising framework. This approach to mental health and wellbeing involves:

1. Advocating for making LGBTQIA+ identities visible and celebrating them in their uniqueness and difference.

   Affirmative practices involve actions at an individual, community and group level that celebrate, legitimise and make visible sexual and gender diversities and dissidences – KEW participant.

2. Creating 'affirmative spaces' that recognise the right of people to explore their identities in their own terms and time. Contrary to the myth that affirmation forecloses possibilities of exploration, affirming people's assertions of being fosters a relationship of trust, comfort and autonomy that creates space for people wanting to explore their identities.[60]

   Affirmation is an opportunity to, for the first time, affirm an identity for a client. This creates a powerful bond. This awards safety and often saves lives. Examples: using preferred pronouns, and preferred names; assumptions go against this principle, assumptions of sameness, assumptions of an identity being inherently disordered, or that the struggle is solely identity-based — KEW participant.

   Celebrate gender/sexual questioning, uncertainty, exploration (not expecting a 'destination' or outcome) — KEW participant.

   There was a really good conversation around affirmative practices and what that means, and particularly what feels like kind of front line at the moment around trans people, trans identities and trans inclusion being a particular kind of place where affirmative practices are being called on — KEW participant.

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60 Ashley, 2019; Hidalgo et al., 2013.

3. Recognising the practitioner's prejudices towards LGBTQIA+ people and making them conscious to avoid the enactment of microaggressions[61] or any other action or discourse that might interfere with our relationship with them.

> I work from a position of relative privilege (politically, racially, financially, in terms of 'passing', etc.) and I'm convinced that I must never lose sight of this in what I do — KEW participant.

4. Listening to, validating and learning from the experiences, knowledges and criticisms that come from LGBTQIA+ people towards society, the psy professions and their history of pathologisation and disciplinary violence.

<u>Intersectionality</u>

Intersectionality is a critical tool developed by Black feminist scholar Kimberlé Crenshaw[62] to account for the particular ways in which intersecting structures of power such as racial capitalism, ableism, and hetero-patriarchy shape our experiences of distress, oppression and access to health. As a guiding principle for our practice, it:

1. Recognises and addresses multiple forms of exclusions in their intersecting nature. It is important for us as professionals to acknowledge that LGBTQIA+ people are not equally affected by these structures of inequalities, and that they are experienced differently across lines of race, gender, class, neurodiversity, religion, age, etc.

2. By accounting for these differences, an intersectional approach to mental health involves questioning the centring of particular groups and identities within the community.

> White, cis, male queers still at the centre… why? — KEW participant.

> Poverty in LGBTQ communities is an intersectional issue — KEW participant.

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61 Martínez et al., 2018.

62 Crenshaw, 1991.

3. Intersectionality helps us to address relationships of power, particularly those involved in the ways we draw lines of inclusion and exclusion in our work. We need to focus not only on sexuality and gender but on how they interact with other axes of difference.

4. An attentiveness to intersectionality helps us to avoid presenting the struggles and concerns of LGBTQIA+ people as competing interests or at the expense of other groups. As one KEW member mentioned, we need to avoid transforming this into an "oppression olympics".

5. Following the above, intersectionality places emphasis on the need to foster solidarities across struggles, and build alliances and coalitions through liberatory practices.

7.1.3 EMOTIONS AND COMMUNITY WORK:

LGBTQIA+ mental health is not only professional work, but it is also emotional work. We live in contexts crossed by the social and political circumstances that take place in our cities, regions and communities, which directly impact the conditions in which we work, and the kinds of struggles and needs that shape demands for health care. Emotions are also powerful forces for radical change that inspire different courses of action.

Anger, fear and hopelessness appeared in the meetings in response to the prompt, *"If I had to tell someone not familiar with my context and my work about their main characteristics, what would I say?"*. For some, fear, anger and hopelessness emerged in relation to the current political scenario and the difficulties of keeping their hopes up amid constant threats to the rights of LGBTQIA+ people:

> *The socio-political context of recent years in Chile has been very intense, with moments of great hope and despair and many contradictions* — KEW participant.

> *Why would anybody listen to us, take on board any output from what is produced?* — KEW participant.

> *I feel anger and fear at the advance of anti-trans feminisms and the rise of so-called specialists who forge alliances with anti-gender right-wing discourses* — KEW participant.

I feel scared for the future of queer people (and my queer family)... I no longer trust that 'things will get better' anymore — KEW participant.

It is incredibly difficult to be trans in this world. For some people, the world makes it impossible just to 'be' - hence the terrible toll of LGBTQ+ mental health impacts, suicides etc. — KEW participant.

My work is driven by my experiences of prejudice and discrimination and the awful effect that has on people's mental health — KEW participant.

For some of us, the feminist phrase "the personal is political" is an inspiring source of energy and positive emotions to deal with the hardships of our work. For us, working on LGBTQIA+ mental health requires the connection and sense of belonging to the community:

My 'work' context(s) cannot easily be separated from my personal context(s). I "live, love, laugh" in a closely-woven community of personal professional and political bonds — KEW participant.

Bringing LGBTQ+ people together to provide peer support around mental health is transformative — KEW participant.

This [phrase, 'the personal is political', represents] what excites me about my academic and professional identity: the queerness and the vibrancy of queer life: what I do is political and is radical — KEW participant.

It feels here [in the UK] that there is a disappearance of trans children, particularly in policy and documents; by not being able to say the word (trans), by relying on over-medicalisation. This [exchange] represents hope, but also resistance to the pathologising discourses — KEW participant.

Some of us referred to the paradoxes involved in working with the suffering of others while simultaneously holding on to hope and joy in their transformative potential. For us, affirming people's existence means celebrating their sense of self and helping them to reconnect with joy. LGBTQIA+ lives are not reduced to stories of suffering, lack and poor mental health outcomes.

I was left wondering how our work connects us with these two sides: the side of violence, the continuous violation of our rights, etc. On the other hand, there is a need to show different narratives; stories that highlight joy and the celebration of life. And how these two dimensions coexist. Not only in the stories of the people we work with but also in the work we're doing here, in the conversations we have just had — KEW participant.

Being an LGBT person is not synonymous with sadness; they are not a 'case'; it doesn't equate to holding sour or negative visions, but also LGBT existences can also be happy — KEW participant.

7.2 REFLECTIONS ON THE PROCESS OF EXCHANGING KNOWLEDGES

7.2.1 BECOMING A KNOWLEDGE EXCHANGE GROUP

As important as the content of the exchanges was the process of becoming a group. The participants built a space of trust and collaboration that allowed them to share their opinions, differences and knowledges with respect, curiosity and genuine interest despite not being physically present altogether—except for the Brighton and Hove group, which met in person once.

Technology and simultaneous translation played an important role in facilitating access to conversations that usually do not occur due to geographic, linguistic and cultural barriers. The online format allowed us to decentralise the discussion around LGBTQIA+ mental health from both countries' capital cities, incorporating the spatial and territorial dimensions of mental health needs and the local histories that shape how the academy, the state, the psy professions and activism respond to them.

Throughout the workshops, the participants confirmed the need to have spaces like this and connect to each other in generative and creative ways to deal with the difficulties of current times, find mutual support and forge solidarities across borders.

> *Being connected across different spaces in Chile and the UK, seeing so many professionals involved in these matters, and who are not only concerned about their professional knowhow but also in sharing these knowledges with others, is an enormous learning experience — KEW participant.*

> *There is something about being able to do something together on the Jamboards that feels very different to the didactic talking. Those moments where we were all working on something together, it feels almost the most connecting even though we are not talking — KEW participant.*

> *There was a general feeling of physical 'togetherness' in the being in the same room face-to-face — KEW participant.*

> *I liked listening and meeting other people and seeing how, in these spaces of resistance, of people doing super powerful things in different places, there is an*

awareness of how complex and contradictory the contexts in which we live are: we see that society is moving forward as if there is greater inclusion, acceptance; but we dig a little, and it's not so much. Progress is very fragile — KEW participant.

7.2.2 ACADEMIA AND ACTIVISM: THE POLITICS OF LGBTQIA+ MENTAL HEALTH

The workshops were an opportunity to reflect on the divisions that exist within and outside our communities of practitioners, among our friends and colleagues. This realisation resulted from the conversations and the process of becoming a knowledge exchange group. The group composition helped us to consider the differences among us and how they shaped the tone, emphases, themes and the direction that the conversation took.

Despite cultural, linguistic and political differences specific to the countries and locations we spoke from, the struggles connected with how LGBTQIA+ mental health is understood and practised, the presence of fear and hopelessness in the face of increasing hostility towards our work, and the exclusions that take place in queer circles were shared features that contributed to fostering a warm and welcoming space where we felt comfortable to talk about such differences.

Academia and the university were named as spaces associated with feelings of distrust that can be experienced as "locked doors", in the words of one participant. For some of us, academia perpetuates a kind of relationship with LGBTQIA+ people that is instrumental and where knowledge from the community is extracted and their life experience not considered as evidence or expert knowledge. At the same time, academia can be a place that contributes to social change through research practices that are inclusive, respectful and critical of extractivist relationships.

> *There is probably an awful lot of what can be referred to as autoethnographic data in everybody's experiences and that can well be a source of powerful information to be included in any research report that is produced, and that could also enforce people's participation in a group such as this — KEW participant.*

> *[During the feminist and sexual-dissident university occupations of 2018], some graffiti read that the revolutionary struggle is not only a class struggle but also an anti-patriarchal one. This is linked to my work: in teaching, my big fight is to contest the devaluation of feminist knowledge in the social sciences — KEW participant.*
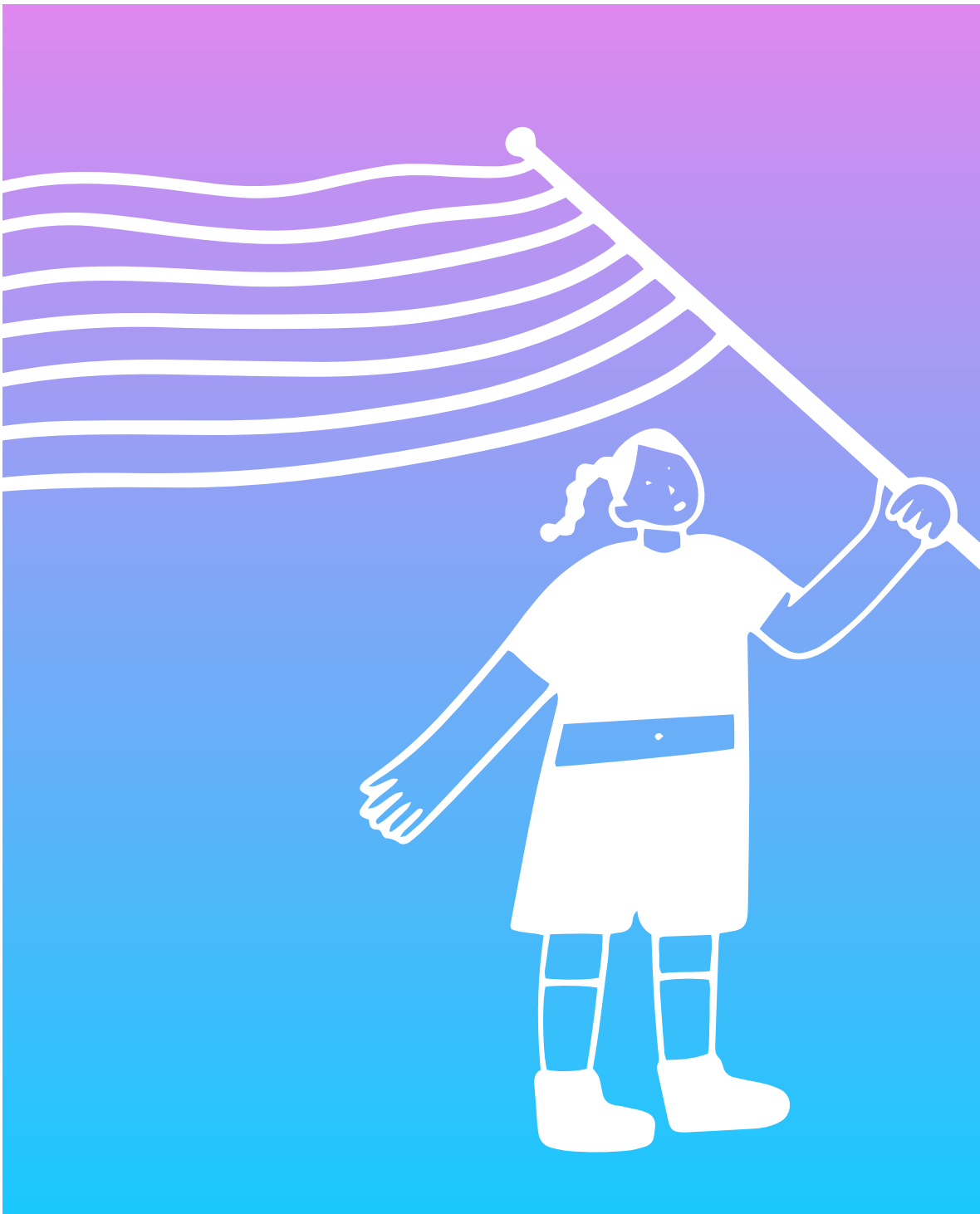
Some participants expressed their uneasiness with the idea that academia and activism are mutually exclusive and incompatible. The group discussed their different understandings of the word 'activism' and how those meanings translate into different actions that need to be accounted for in their cultural and geographically specific nature. Most participants identified both as practitioners and activists, inhabiting different identities and stakes to knowledge that play out differently in their encounters with institutions, the state, their clients, colleagues and friends.

> *There was a sense of cultural difference between participants especially in the context of activism leading to a reflection on differences between societal situations of the UK vs Chile. Are we lucky/privileged to be situated in the UK? — KEW participant.*

Despite activism being usually looked upon with suspicion by academia and some of our psychologist colleagues due to its political dimensions, we agreed that our work is driven by a commitment to social justice, inclusive feminism, gender equality and scientific rigour, which we revindicated as political due to its transformative potential. For some, the very fact of doing what we do is a political and activist act, as we are being "active" in exposing the effects of trans-hatred violence and social exclusion, even within the psy professions.

> *My activism is me being out in the community and in my own training organisation — KEW participant.*

> *We are constantly being 'active' in denouncing the effects of either pathologising discourses or homo-transphobic violences. So, it can be felt to be very powerful for some of us to work in spaces with other cisheterosexual people. The very fact of doing our work in spaces that are not necessarily designed for us or for the kind of ethics that inspire our practice, is quite a powerful thing to do — KEW participant.*

RECOMMENDATIONS

Building on the knowledge exchange workshops and our own professional and activist work, we propose a series of recommendations to improve our practice and training, and to facilitate community articulation:

8.1 RECOMMENDATIONS FOR PRACTICE:

- Discuss what a depathologising, affirmative and intersectional approach to LGBTQIA+ mental health and wellbeing means.
- Recognise and validate LGBTIQANB+ identities as normal expressions of sexuality and gender, actively promoting a professional ethics and praxis inspired by the principles of depathologisation, affirmation, reparation and intersectionality.
   ◊ In this sense, being sexually or gender diverse does not necessarily equate to needing therapeutic intervention. And if interventions are required related to themes of gender and/or sexual identities, the focus should be on the effects of discrimination, hate and marginalisation on wellbeing.
- Familiarise ourselves and each other with the processes of marginalisation, exclusion, stigmatisation and disciplinary violence, their histories and how they shape LGBTQIA+ people's experiences of distress and mental ill health.
- Prioritise the communities' expert knowledge of their health needs to inform policies, draft guidelines, and provide services. Their voice and expertise should inspire our ways of intervening and approaching their problems. Our therapeutic judgement, beliefs and attitudes should not be the only guiding principles.
- Constantly challenge the pervasiveness of heteronormativity, cissexist, ableist and racist assumptions that threaten our practice and the institutions in which we work.
- Establish mental health policies with budget allocation that allow the funding and implementation of long-term initiatives inspired by principles of depathologisation, reparation, affirmation and intersectionality.
- Identify the barriers (institutional, personal, structural) and opportunities that can put these principles into practice.

8.2 RECOMMENDATIONS FOR TRAINING:

- Include core areas of LGBTQIA+ psychology in university curricula and professional trainings:
  ◊ Promote a deep understanding of the historical and political processes involved in constructing LGBTQIA+ identities as pathological and how the psy professions have contributed to this in their respective contexts.
  ◊ Encourage the need to constantly train ourselves in affirmative care and the workings of cissexism, heteronormativity, minority stress, ableism and racism. These efforts should combine sources coming from the scholarly literature with evidence that emerges from the community and the life experiences of LGBTQIA+ people.
- Raise awareness about the need to reflect on our sexual prejudices, gender anxieties and privileges as a preventive measure against the enactment of discriminatory discourses and practices to foster a caring and respectful relationship with the community.
- Identify and actively challenge oppressive discourses that question the experience of LGBTQIA + people as if they were up for debate.
- Identify the institutional and social barriers to bringing about change in our ways of approaching the needs of LGBTQIA+ people.
- Promote opportunities for dialogue and exchange among colleagues and allies across different institutional settings, locations and disciplines.
- Address burnout, stress and mental ill health on practitioners, LGBTQIA+ activists and healthcare workers.

8.3 RECOMMENDATIONS FOR COMMUNITY ARTICULATION:

- Acknowledge the voices and experiences of the LGBTQIA+ community as experts in their own needs. Psy professionals, particularly those who identify as heterosexual and/or cisgender, should not have the final say on matters they ignore or are prejudiced against.
- Promote the inclusion of voices of those most marginalised and silenced within the LGBTQIA+ communities.
- Promote the issuing of reparation policies and/or institutional statements that repair the historical debt that society and the psy professions owe to generations of LGBTQIA+ people.
- Create opportunities for dialogue, encounter and healing at the community level, especially in the face of collective experiences of grieving and trauma as effects of hate crimes, anti-gender attacks, moral panics, and economic precarity.

- Foster political participation and involvement in activist-led initiatives across different groups and communities.
- Actively establish safe spaces for the LGBTQIA+ community, making sure not to exclude or discriminate against others because of our own beliefs and biases.

Who is the target audience for these recommendations?

1. Health and mental health professionals, policymakers and state programmes.
2. Ministry of Health and Education, the NHS, public hospitals and local practices.
3. Health commissioners at local and national levels
4. Political parties
5. Professional training bodies, such as clinical and counselling psychology and psychotherapy institutions and programmes; community, mental health and social psychology programmes at universities
6. Research and ethics bodies, such as the British Psychological Society sections, and the Chilean School of Psychology and its Gender and Sexualities Commission.
7. Mental health charities, civil society organisations and activist groups such as MindOut, LGBT Switchboard, Todo Mejora, OTD Trans, Fundación Meridiana, Espacio Seguro, CERES, etc.
8. Local councils, Diversity and Non-discrimination Offices, Municipalities.
9. LGBTQIA+ communities.

Summary

These recommendations emphasise the need to train ourselves and learn from other colleagues and the LGBTQIA+ communities. They represent a challenge to all of us as practitioners who work in the field of gender, sexual and relationship diversity. Our work and ethics should be informed by our commitment to advance a depathologising, affirmative and intersectional practice sensitive to the socio-political determinants of mental ill health, and the histories of medicalisation and criminalisation that still shape people's experiences of health and wellbeing. Social justice, inclusive feminism and care ethics should inspire our work and commitments towards our communities.

The recommendations also emphasise the need to challenge ourselves to become aware of our own biases as well as challenge existing curricula of our training organisations. Processes of reparation, healing and social change should be approached as community issues that require the will, knowle-

dges and labour of multiple actors. We cannot do this alone. We need to question the divides that separate us (e.g., academic/activist) and use all our creativity to bring about the changes we want. Mental health front-line workers and the LGBTQIA+ communities should also be at the forefront of our work and decision-making, communicating our ideas with a language that is accessible to all and that reflects our joys and aspirations, not only our sufferings.

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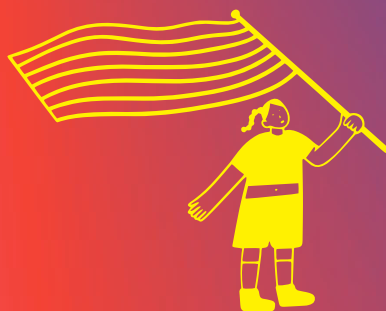
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