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Mental Health Disparities of Sexual Minority Refugees and Asylum Seekers: Provider Perspectives on Trauma Exposure, Symptom Presentation, and Treatment Approach

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Abstract

Refugees and asylum seekers who identify as sexual minorities (SM) and/or who have been persecuted for same-sex acts(Sexual Minority Refugees and Asylum Seekers or SM RAS) maneuver through multiple oppressive systems at all stages of migration. SM RAS report experiencing a greater number of persecutory experiences and worse mental health symptoms than refugees and asylum seekers persecuted for reasons other than their sexual orientation (non-SM RAS). SM RAS are growing in numbers, report a need and desire for mental health treatment, and are often referred to therapy during the asylum process. However, little research has been conducted on the treatment needs of SM RAS in therapy or the strategies therapists use to address these needs. This study sought to identify these factors through qualitative interviews with providers at a specialty refugee mental health clinic ($N = 11$), who had experience treating both SM RAS and non-SM RAS. Interviews were transcribed and coded for themes of similarities and differences between SM RAS and non-SM RAS observed during treatment and factors that could be leveraged to reduce mental health disparities between SM RAS and non-SM RAS. Clinicians reported that compared to the non-SM RAS, SM RAS reported greater childhood trauma exposure, increased isolation, decreased support, identity-related shame, difficulty trusting others, and continued discrimination due to their SM identity. Suggested adaptations included reducing isolation, preparing for ongoing identity-based challenges, creating safe spaces to express SM identity, and a slower treatment pace. Providers reported benefits and drawbacks to centering the client's SM identity in treatment and encouraging community involvement for SM RAS, and noted additional training in cultural awareness would be beneficial.

Keywords: sexual minorities, refugees and asylum seekers, mental health treatment, mental health disparities, treatment adaptations

Impact Statement

This study assessed mental health providers' perspectives on the treatment needs of sexual minority refugees and asylum seekers. Providers identified multiple challenges and barriers to positive mental health outcomes when treating this population and adaptations that could be leveraged to reduce disparities for sexual minority refugees and asylum seekers. The need for additional intervention research was highlighted.

Mental Health Disparities of Sexual Minority Refugees and Asylum Seekers: Provider Perspectives on Trauma Exposure, Symptom Presentation, and Treatment Approach

Refugees and asylum seekers (RAS) are vulnerable to experiencing traumatic events (e.g., resource restriction, punishment, torture, prejudice, alienation, and imprisonment) at all stages of migration (Theisen-Womersley, 2021). Indeed, most RAS experience some form of trauma, often seeking protection from persecution and discrimination based on their race, gender, sexual orientation, and political and religious affiliations (Bird et al., 2022; Pittaway & Bartolomei, 2001; Šorytė, 2018). In their countries of asylum, RAS may face additional oppression-based stressors such as navigating societal biases and identity-based discrimination (Adida et al., 2019). These deleterious experiences increase the risk of high rates of mental health disorders in RAS populations (Hameed et al., 2018); with researchers calling for novel interventions to address the specific needs of RAS groups (Murray et al., 2010).

A particularly vulnerable subgroup of RAS appears to be RAS who identify as a sexual minority (SM) individual and/or RAS who have been persecuted for engaging in romantic, consensual same sex acts (hereinafter identified as Sexual Minority Refugees and Asylum Seekers or SM RAS Bird et al., 2022; Fox et al., 2020; Piwowarczyk et al., 2017); a population increasing in number in the United States (U.S.) Williams Institute—University of California Los Angeles (UCLA) School of Law, 2021). While research is scant on this population, recent studies have demonstrated that SM RAS experience higher rates of trauma than those persecuted for reasons other than their sexual identity or for engaging in romantic, consensual same-sex acts (e.g., political, religious; hereinafter referred to as non-SM RAS) (Bird et al., 2022; Piwowarczyk et al., 2017). Unlike non-SM RAS, SM RAS carry the additional burden of having experienced identity-related trauma due to their sexual orientation via oppressive, majority systems, as outlined by minority stress theory (MST; Brooks, 1981; Meyer, 2003). MST posits that minoritized individuals contend with proximal (e.g., identity concealment, internalized homophobia) and distal (e.g., external trauma; rejection) factors. Raised in the cultures where homosexuality is criminalized (Shidlo & Ahola, 2013,), many SM RAS may contend with conservative familial and community beliefs about their sexual expression, contributing to fears of persecution and concealment both inside and outside of the home. Additionally, in their country of origin, SM RAS face persecution experiences (e.g., torture, assault) related to their SM identity (Bird et al., 2022) and stressors such as being forced to "change" their sexual orientation via marriage to an opposite-sex partner (Piwowarczyk et al., 2017). Postmigration, SM RAS report continued stressors such as experiencing anti-SM prejudice similar to what they experienced in their country of origin, including being banned from familial and community networks both in their countries of origin and asylum (Kahn, 2015). These additional SM-related stressors can detrimentally affect the mental health of SM individuals (Meyer, 2003) resulting in disparities for

SMRAS (e.g., higher rates of posttraumatic stress disorder, depression, and anxiety disorders) compared to non- SM RAS (Piwowarczyk et al., 2017).

In addition to navigating oppressive systems and minority stressors, SM RAS have the burden of proving a well-founded fear of persecution due to their SM identity, which can be a debilitating process (Dustin, 2018). As a result of continued fear of persecution and internalized homophobia, many SM RAS may be unwilling or unable to report their sexual identity during and after the asylum claims process, affecting their asylum claim, and resulting in unaddressed mental health difficulties (Alessi, 2016; Dustin, 2018). Indeed, SM RAS who engage in the asylum-seeking process are often referred to individual therapy by their attorneys to increase the accuracy and coherence of their claims and to reduce retraumatization of trauma disclosure to multiple strangers (McClure et al., 1998). Immigration records report a dramatic increase in precedential SM RAS asylum claims (Immigration Equality, 2021), ostensibly leading to an increase in treatment seeking SM RAS. Additionally, recent literature indicated that most SM RAS in North America are interested in mental health care (Fox et al., 2020) and that receiving proper mental health care is an important mediator in improving outcomes for SM RAS (Yarwood et al., 2022).

There is evidence to suggest that identifying specific needs and challenges of individuals in treatment and implementing appropriate mental health adaptations can be effective for general RAS populations (e.g., Nosè et al., 2017) as well as for SM individuals (e.g., Pennant et al., 2009). SM RAS hold multiple marginalized identities (e.g., SM, RAS); fleeing from and toward countries with hegemonic societies that disempower and oppress individuals with nondominant identities (Few-Demo, 2014). Taking an intersectional approach requires consideration of how an individual's marginalized identities interact and operate within these systems of oppression (Few-Demo, 2014). However, despite the clear need for effective mental health treatment and the potential for identity-based treatment adaptations, little research has been conducted on the needs of SM RAS in treatment. One conceptual article formulated a therapy framework for clinicians who provide individual therapy to SM RAS. This article identified elements of reducing isolation, establishing and promoting safety and peer support, mitigating the risk of retraumatization, and addressing cultural challenges of migration and acclimation through social action as being particularly beneficial during therapy with SM RAS clients (Alessi & Kahn, 2017). One qualitative study assessed the perspective of SM RAS providers and identified additional themes reported to improve mental health for SM RAS, including recognizing stigma and shame, accessing competent providers, manifesting resilience, and healing through community (Kahn et al., 2018). These themes have also been found to be helpful in therapy within general RAS populations (e.g., Murray et al., 2010; Orang et al., 2023). This article seeks to build off of these existing frameworks to identify whether additional unique treatment needs exist for SM RAS and how clinicians try to address these needs in therapy

Researchers have called for interventions that address the needs of individuals who hold intersecting, marginalized identities such as SM RAS (Cerezo, 2020) , and for increased support to prepare clinicians for an international, anti-LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex) crisis (Streed et al., 2023). Clinicians who treat RAS, including SM RAS, are knowledgeable about whether clinical systems are set up to address the needs of their clients; including knowledge of their clinical training history and areas where they may struggle to provide treatment. They are also in a unique, privileged position to be privy to the lived experiences of SM RAS clients, who may not otherwise disclose information related to their past experiences or sexual orientation (Chávez, 2011). Extant research has identified that the best clinical practices include assessing the experiences of clinicians to build on existing policies and programs and make recommendations that improve treatment outcomes (Anderson et al., 2021). Therefore, interviewing clinicians about their experiences working with SM RAS may provide key insights into possible treatment adaptations that could address the complex mental health needs of SM RAS, as well as the training needed to skill up future generations of clinicians to work with this growing and underserved population.

Taken together, SM RAS encounter persistent stigmatization and persecution linked to their sexual orientation in their country of origin, prompting many to seek refuge in foreign nations like the U.S. However, in their countries of asylum, SM RAS often encounter discriminatory systems and continued minority stressors based on their sexual identity, RAS status, or other minoritized identities; perpetuating mental health concerns. During the asylum process, SM RAS are often referred to mental health clinicians, who may not only help address the heightened mental health challenges that affect SM RAS but may also serve as their first confidants for disclosing their SM identity. Unfortunately, SM RAS report worse mental health disparities compared to non-SM RAS, and there is a dearth of identified treatment adaptations specially developed to address the needs of SM RAS. Adaptations in treatment are needed to improve the accessibility and acceptability of mental health treatment, to ensure SM RAS receive SM-inclusive, trauma informed treatment, and to increase the cultural competence of clinicians of SM RAS (United Nations High Commissioner for Refugees (UNHCR), 2023). Therefore, understanding clinicians' perspectives on clinical presentations and factors reported in the treatment room that impact the mental health of SM RAS and non- SM RAS could provide a starting point for developing treatment interventions that may better address the needs of SM RAS. This study utilized qualitative interviews with clinicians who had experience providing mental health treatment to both SM RAS and non-SM RAS to answer the following questions: (a) What are the similarities and differences in the mental health presentation of, and the challenges faced by, SM RAS and non-SM RAS and (b) if differences exist, what factors can be leveraged, or adaptations implemented, in therapy to reduce mental health disparities between SM RAS and non-SM RAS?

Method

Researcher Description

The research team was composed of doctoral, graduate, and undergraduate researchers from diverse backgrounds. C. B. is a doctoral candidate in clinical psychology at UCLA. She has 7 years of graduate-level experience in mixed-methods research within underserved populations, 5 years of research experience focused on mental health disparities faced by SM RAS, including 4 years of qualitative data analysis, and has previously published studies on SM RAS mental health. She identifies as a straight, white, second generation American, cisgender female researcher, and graduate student clinician. A. S. holds a bachelor's degree in psychology from UCLA. She has 4 years of experience working with mixed-method research and working with various local communities, including low-income and LGBTQI+ populations. She identifies as a Chinese Indonesian, cisgender female researcher. R. N. holds a bachelor's degree from UCLA and has studied public health for 4 years. She has 3 years of experience with qualitative and quantitative coding in studies designed to improve the health of underserved populations. She identifies as a straight, South Asian, cisgender, female medical student. I. L. holds a bachelor's degree from UCLA and identifies as a straight, Asian American, cisgender female researcher. She has 4 years of mixed-methods research experience, particularly within underserved, minority populations. G. B. has engaged with coding and analyzing the data while holding intersecting identities as a white, SM, queer, and transgender researcher and individual and has 9 years of experience in research methodology and mixed-methods analysis; having worked directly with immigrant and refugee populations such as undocumented students and families. S. L. holds a PhD in public health and policy research. She has 15 years of experience in qualitative and mixed-methods research experience focusing on underserved communities, including sexual gender minorities and forcibly displaced communities. She identifies as a straight, Asian American, cisgender, female researcher. L. P. is a psychiatrist, holding both MD and MPH degrees, and identifies as a second-generation, white American of Polish descent. She has over 25 years of clinical experience working with refugees and survivors of torture, including sexual minority refugees and asylum seekers, and has served as the director and founder of Boston Medical Center's Boston Center for Refugee Health and Human Rights (BMC's BCRHHR). She has 2 years of experience as a Principal Investigator (PI) in mixed-methods research. L. N. is a Black and Chinese American, lesbian, cisgender woman, and a clinical psychologist and professor of psychology at UCLA who previously saw clients at the BCRHHR for 3 years.

While the authors held some shared salient identities with SM RAS (e.g., identification as a racial, sexual, or gender minority), they also acknowledge their differences and their privileges in comparison to this population including greater financial stability and the opportunities afforded by citizenship in the asylum country. Further, the authors acknowledge that these privileges may have

inadvertently influenced interpretations during the coding process. Notably, L. P. and L. N. were providers to general RAS and SM RAS populations at the BCRHHR and were heavily involved in the development of the study. L. N. was both the study PI and a participant in the study. These experiences likely aided in their understanding of the population's needs and also may have introduced bias in the study design. To reduce these concerns, the authors were committed to continued discussion throughout the coding process to both recognize and mitigate any potential biases that may arise due to their positionalities. Before analysis, the coding team (e.g., the first through fifth authors, led by the first author) discussed plans for establishing coder reliability through the initial analytic plan development and coding process with the last author. The coding team also met to discuss the strategy for analysis and individuals' approach to coding at the onset, following the guideline of self-reflexivity in qualitative analysis (Tracy, 2014). For example, the coding team met regularly throughout the process to examine the influences of researchers' diverse backgrounds in analysis and codebook application, individuals' thought processes in initial coding, theme generation, and defining and refining codes. Coder positionality informed the collaborative nature of analysis and consensus meetings for codebook ratification to allow opportunities to discuss data and relevant themes as they emerged from and were applied within the data by researchers. This approach followed standards of qualitative analysis reporting in postpositivist approaches (Morrow, 2005) through the use of coder reflexivity and transparency to promote overall rigor and methodological integrity (Levitt et al., 2017).

Participants

Study participants were 11 mental health service providers (cisgender female = 100%; 20–49 years of age) who were either currently employed or had recently been employed at the BCRHHR. Of the sample, six participants identified as White, two identified as Asian, two identified as multiracial, and one identified as Black. The BCRHHR is a multidisciplinary program at BMC that serves the needs of refugee and asylum seeker survivors of torture and trauma in Boston, MA. The BCRHHR provides specialized clinical training for clinicians working with RAS populations. All current and former BCRHHR mental health clinicians who had provided mental health services to SM RAS and non-SM RAS were recruited by email to take part in the study. Clinicians who did not respond received a follow-up call from the study coordinator regarding participation in the study. Those who responded to the query were contacted by email to schedule an interview. The roles of the clinicians who participated in the study included clinical directors, clinical psychologists, social workers, and trainees in psychiatry, psychology, and social work; all of whom were trained in providing therapy to RAS populations and had experience providing mental health treatment to SM RAS and non-SM RAS clients at the BCRHHR. At the time of the interview, clinicians reported they had worked as mental health providers for an average of 4.2 years (range 8 mos.—22 yrs.) in the field.

Procedure

Interviews were held between March and April 2019 and were conducted by a psychiatry resident, a doctoral student in public health, a trained data coordinator, and a clinical psychology trainee. Before starting the interview, participants were made aware of the purpose of the study: "[y]ou met with clients who were seeking asylum from persecution due to their sexual minority status and/or their political activism. We would like to learn more about your experiences working with these two client groups." Participants met with the interviewer individually either in person or online. Sessions consisted of a structured interview of 36 questions including four short demographic questions (e.g., "When did you work/start working at BCRHHR?"), 10 questions/probes regarding RAS clients who were seeking asylum for political reasons (e.g., "From your experience at BCRHHR, what was it like working with an asylum seeker fleeing political persecution?") and 10 identical questions/probes regarding RAS clients who were seeking asylum due to persecution experiences related to their sexual identity. Interviewees were then asked 12 questions/probes regarding the similarities and differences between the two groups (e.g., "Were there any differences working with clients seeking asylum for political reasons than those seeking asylum based on sexual orientation? If so, what differences did you notice?"). Topics covered included strengths and challenges faced by the individual, stressful experiences, responses to treatment, successes, and difficulties in treatment, recommended approaches to care for individual clients and as a group, and prior experiences with treating SM RAS or non-SM RAS clients (see Supplemental File A, for the full list of interview questions). Interviews lasted approximately 30– 60 min; all interview responses were included in the coding process Transcription and coding of the interviews were led by the first author, a doctoral candidate at UCLA, and the fifth author, a master's level researcher at UCLA. Transcripts were reviewed by all members of the team for accuracy. Individual coding was carried out by the second, third, and fourth authors, all undergraduate research assistants at UCLA.

Data Analysis

A thematic analysis approach, a well-established, robust, flexible, and diverse method of qualitative data analysis (Braun & Clarke, 2006; Braun et al., 2019, p. 850), was used to collaboratively analyze the interview transcripts (Fereday & Muir-Cochrane, 2006; Richards & Hemphill, 2018). Specifically, researchers utilized a postpositivist framework aligning with the "coding reliability approach" (Braun et al., 2019, p. 847; Braun & Clarke, 2021) in the analysis. The coding reliability approach, a form of thematic analysis, is an objective approach that aims to reduce coder biases and prioritizes answering a priori research questions while establishing reliability across coders and summarizing research findings into specific domains or themes. Therefore, coding included testing an a priori codebook to answer the study's research questions (e.g., explicitly looking at differences in SM RAS and non-SM RAS experiences in treatment). As little research exists on clinicians' perspectives on

SM RAS in the treatment room, this study also employed an inductive thematic approach to capture any additional themes. For example, in addition to the a priori research questions, a list of potential new codes was generated by the coding team, from an initial review of the interviews. These codes were iteratively refined to adjust the codes through consensus of the coders' notes on the first readthroughs of the transcripts (Fereday & Muir-Cochrane, 2006; Srivastava & Hopwood, 2009). Additionally, the conceptual framework of providing therapy to SM RAS by Alessi and Kahn (2017) was reviewed by the first author before the coding process.

Following the review of all interview transcripts ($N = 11$), a codebook was developed by the coding team (i.e., the first through fifth authors), led by the first author. This codebook was then entered into the Taguette software qualitative coding platform (Rampin & Rampin, 2021). Similarities and differences in codes, between researchers, were discussed and examined throughout analysis through regular meetings and review of data. The initial codebook was applied to five transcripts selected at random, to finalize the codebook. Coders reconvened to evaluate the suitability of the codes, adding or redefining codes as needed to produce the final codebook. Coder backgrounds and their impact on code identification and application were continually discussed as a team. Decisions on codebook adaptations were made through consensus while emphasizing objective code application and reliability guided by a postpositivist approach. The final codebook was grounded in data that were present in the interviews and informed by the coders' backgrounds, to promote analytic integrity (Levitt et al., 2017).

Interrater reliability was established by applying the codebook to 20% of the coded excerpts (i.e., the direct quotes coded in the transcripts), chosen at random. The second, third, and fourth authors engaged in interrater reliability coding, led by the first and fifth authors. Kappa analysis was conducted which yielded good interrater reliability of the final codebook (*Light's k* = 0.72; Belur et al., 2021). The three reliability coders applied the final codebook to all transcripts (i.e., coders were randomly assigned three, four, and four interviews to code, respectively). Disagreements in code applications were managed using collaborative consensus coding (Cascio et al., 2019). Once all data were coded, final themes were then "refined and defined" using the thematic analysis methodology, by collating the data and organizing the themes into coherent groups as outlined by Braun and Clarke (2006). Then, higher order themes were grouped and subthemes were identified and discussed. Subthemes were omitted only if they appeared pertinent to one specific client and were not generalizable (e.g., a specific social suggestion based on one client's hobbies). Themes and subthemes were collated by the first through fifth authors and were considered complete when they were able to be defined in a couple of sentences (Braun & Clarke, 2006). Once finalized, themes and subthemes were reviewed and agreed upon by the first through fifth authors and final author. The final presentation and analysis of themes and coded transcripts were discussed with all coders with reflection on the individual backgrounds of coders and narratives derived from the data.

The data that support the findings of this study are available from the corresponding author, L. N., upon reasonable request. This study was not preregistered and was approved by the institutional review board at Boston University/Boston Medical Center, IRB No. H-38,403.

Results

Disparities Between SM RAS and Non-SM RAS

Trauma Experience in Country of Origin

Participants identified a clear difference between SM RAS and non-SM RAS' trauma experiences in their countries of origin. Participants (n = 10) noted that SM RAS often experienced trauma in childhood through adulthood from several perpetrators, including the government as well as their communities (particularly religious communities) and families. On the other hand, participants (n = 5) reported that, typically, non-SM RAS experience trauma after entering adulthood, mostly at the hands of state agencies. This difference is highlighted by one of the participants who stated:

> [F]or the women who are fleeing because of their sexual orientation … they were … threatened and or harmed by family members or … neighbors. Whereas the people who have been persecuted because of political opinion, it's most often because of participation in political activism. They are persecuted by the army, police, or … government officials.

Isolation Due to Fear of Further Persecution

One of the most frequently mentioned participant themes (n = 8) was that SM RAS were more isolated than non-SM RAS. Isolation was often linked to SM RAS' beliefs that they could not be themselves and could not share why they fled their country of origin with their communities in the country of asylum. Indeed, some participants (n = 3) mentioned that there is still the fear of being persecuted for their sexuality by other RAS in their country of asylum:

> [For SM RAS] it could be hard to develop a network with other individuals from their country of origin here in the U.S. because of fear that these people, even though they're fellow citizens and even though there might be some comfort from having a network with people from your country of origin. I could imagine more isolation because of that.

Participants also noted (n = 3) that some non-SM RAS are also unable to share their reason for fleeing due to fear of government spies. One participant shared, "I've had many people say like, you know, don't know who's a spy here and you don't know who's going to report back, and that's true for people in both, different groups … kind of a sense of distrust." However, clinicians stated that most non-SM RAS were proud of their background and ability to connect with people from the same ethnic community, especially those from the same political background, within their country of asylum. For example, one clinician stated, "Most [non-SM RAS] were involved in the same political party and most of them were advocating against the same things … there's a little bit more openness, I think, with talking about your reasons for asylum."

Lack of Ongoing Support

Support systems differed between SM and non-SM RAS, where participants (*n* = 7) described SM RAS as often lacking social support in their lives. As explained by one participant:

> Most LGB asylum seekers did not have any figures of support in their lives except their romantic partners …people who are sexual minorities often have yet to tell their families … or it's their families that are advocating against them …that can be extremely isolating. I think that the sense of isolation with LGBTQIA populations is much more.

Further, clinicians (*n* = 3) also noted that many SM RAS faced additional challenges of their partner facing persecution or their partner being killed for being SM. For example, a clinician stated, "One [SM RAS's client's partner] was killed, and others have partners who are in ambiguous situations in terms of their partner's safety. And sort of this feeling of not being able to talk about it here." On the other hand, participants (*n* = 5) noted that non-SM RAS typically had the support of their communities, partners, and families, which continued even after fleeing to the country of asylum. One participant identified, "somebody who is fleeing after his activism, he certainly has the support of his family and wishes that he could be … reunited with his family." Further, clinicians noted that SM RAS may not receive support from their religious communities: "Many [SM RAS] are being betrayed by their religious community, and even if they personally still have that faith—re-entering that community can be tough."

Identity: Shame Versus Pride

Another theme that emerged from the data was that SM RAS and non-SM RAS experienced different emotions related to their identities. Participants (*n* = 8) explained that many SM RAS internalized the homophobia that they had faced. There was general agreement that SM RAS had negative emotions of shame surrounding their identity, something that they tried to, but could not, change. For example, one participant expressed, "Being persecuted for your sexual identity or gender identity …comes with you, this idea of shame around who you are. You are living in a country where you've had to operate behind closed doors. You couldn't be yourself." Further, another clinician remarked on the shame in not wanting to hold an SM identity, "What [my SM RAS client] wants is somebody to help her not be gay anymore and [held] shame around that and wanting to change."

On the other hand, many participants (*n* = 9) described that most non-SM RAS stated their reason for fleeing their country of origin with a sense of pride. Participants (*n* = 5) noted that non-SM RAS' work had given them a sense of purpose, and they believed that the government was to blame for their situation, rather than themselves. One participant stated:

> For [non-SM RAS] there's probably an element of pride in having kind of fought for justice, fought for–a political group that you believed in. Many of my clients who—were

> engaged in like social movements, or— um, opposing the government—feel very proud of that. Like they believe that they were on the right side of justice, and the right side of history … and their country just wasn't ready to handle them.

Difficulty Trusting Others and Continued Discrimination

Clinicians reported (n = 7) that all RAS experienced a sense of uncertainty and many were not sure whom to trust. Participants expressed that this was a shared feeling among both groups that came with the status of being an asylum seeker,

> [T]here's people who don't know who they can trust, who they can go to, who are spies, and who will judge them. Meanwhile … they might be talking to the same people that are—feeling the same things they are.

However, clinicians (n = 8) noted that SM RAS held the additional layer of holding a SM identity, withdrawing from communities, often due to fears of betrayal or exposure, which increased feelings of isolation. One participant shared:

> [SM RAS] struggle more with loneliness and isolation because they have the double challenge of not only refugee or immigrant, but they also have the challenge of sexual minority or gender minority, so both of those can be—stigmatized in reasons that someone—would feel isolated, whereas somebody who is straight, or male, and–an immigrant, it might you know, it's one fewer—stressor.

see Supplemental File B Table 1 for more detailed information.

Mental Health Treatment of SM RAS: Factors That Can Be Leveraged or Adapted

Reducing Isolation

Provider Support. Participants (n = 2) recommended offering social support to SM RAS to combat isolation and emphasizing the resources and aid currently available to RAS that may also help alleviate perceived loneliness. Participants (n = 4) made sure to reiterate that they and other providers would offer consistent support and assist with identifying existing systems of support within the clients' community:

> Keep him rooted in facts … keep acknowledging that yes, there are scary things and you know that better than anyone, but … there are people who help you. …There was the woman who helped you escape from the safe house. There are people here who have you living with them. There are people here who want you to do well, who want you to succeed. … And just keep reiterating that no matter what's happening in the outside

> political world, like, everybody within this context and everybody working with you through BMC wants you safe and wants you healthy and is really happy that you're here.

Clinicians noted providing this type of support provided a "grounding presence" in treatment.

Community Engagement. Some participants advised encouraging SM RAS clients to engage with communities to combat their feelings of isolation (n = 3). A few suggested forming groups specific to SM RAS (n = 2):

> Trying to help them find other ways to meet people who were in similar situations, like through online meetups or … there's like an LGBT soccer league … just trying to connect them to more community support so they weren't so isolated and vulnerable. …They had a group that was the LGBT coffee hour, where those clients who identified that way were invited to join this group where they would just come into the center. …When group time happened, they would just drink coffee and socialize. …It was not a structured group but sort of an opportunity for them to connect in a safe place.

However, other participants (n = 3) reported that their SM RAS clients were hesitant to engage with their communities, often due to fear or mistrust of community members. One participant reported, "trying to see if [their client] wanted to connect to a church, but … she didn't want to go to a church with other [immigrants from their country of origin]." Another stated,

> The LGBTQ group … is definitely struggling with what communities to be a part of. Everyone's struggling with their attachment to …faith …but …LGBTQ are less likely to join a church even if they're still … practicing.

Preparing for Ongoing Identity-Based Challenges in the United States

Several participants (n = 5) described difficulty in not being able to assure SM RAS in treatment that they would not be persecuted for their sexuality in the United States, and participants (n = 5) stressed the importance of preparing SM RAS for continued stigmatization against the SM community that still exists within the United States, "It is important for me to express to my client [that] there's a stigma against homosexuality … it's not to scare her, but it's more to inform her of …the realities …of being here in the United States." Participants acknowledged that SM RAS face a unique host of challenges on their journeys toward recovery and reported adopting different psychoeducational strategies for their non-SM RAS and SM RAS clients:

> With political torture survivors, I framed [psychoeducation] as "This is an event that happened, this is how your body is reacting after that event is over." Whereas LGBTQIA

> populations, yes they may have been tortured at one point in their home country … but that doesn't necessarily mean that the trauma is over for them because they can't openly talk about their sexual identity or they are still living in fear of retribution from their sexual identity from their community.

To address challenges, one participant suggested keeping up with LGB-specific resources and information to provide better care to SM RAS clients:

> I would pay more attention to trying to find organizations that specifically are focused on working with LGBTQ asylum seekers. For example, I would try to be more aware of and around what are those organizations and resources that may be more LGBTQ-friendly …and specifically focused on working with individuals, with that identity.

Participants (n = 2) also mentioned SM RAS' experiences of systemic oppression in relation to their race/ethnicity in the United States. In particular, one clinician emphasized advising Black clients of ongoing racism in the United States, "I always would try to—and fail in various ways—to talk about racism in the United States which, as African asylees, they don't always realize they're going through this socialization to U.S. racism."

Speed of Exposure to Resources and Treatment

Paced Exposure to SM Resources. Participants highlighted the importance of exposing SM RAS clients to resources and spaces for sexual minority individuals, with one clinician noting it is the provider's responsibility to provide SM-related resources. However, some clinicians (n = 2) described the importance of adopting a slower pace for exposing clients to SM-related resources. Rather than pushing SM RAS clients to engage with these resources before they are ready to fully accept their identity, providers suggested allowing clients to utilize them at their own pace:

> [T]rying to be open in the introduction. Like, I know you might not be ready for this, but I want you to know in the United States, this is okay. There's communities and supports here and when you're ready for it I/we can introduce you to them or we can talk to you about them … I know on the intakes it can be overwhelming. I know you might not want all of this right now, but I want [somewhere in the] back of your head to remember.

Moving at a Slower Pace in Treatment. Participants also advised a slower pace of treatment in general when counseling SM RAS (n = 3) as doing so, "creates a feeling of safety for clients." Another clinician disclosed:

> There's no need to rush treatment …if you can just demonstrate to the client that, "I will just sit here quietly with you as you cry. We don't need to talk about—I don't need you to tell me about any specific information in any amount of time."

Relatedly, another clinician noted: "[SM RAS, compared to the non- SM RAS] are more ambivalent and slower to engage and higher to drop out" when describing the importance of a slower pace.

SM Identity in Treatment

Creating Safe Spaces for Clients to Express Sexual Orientation. Participants (n = 5) stressed the theme of safety and acceptance in the therapeutic environment—particularly for SM RAS. They advised creating a safe space where clients could, "feel free to express their sexual orientation … even if they previously didn't feel comfortable doing that." Other clinicians (n = 3) reported the importance of creating safe spaces as many clients are religious and have been turned away from places where they expected to find support and safety, such as their religious communities, "almost everybody that we meet is religious and what they're hearing the messaging is God thinks—this is bad and evil." Related to gender, one participant recommended separating SM RAS men and SM RAS women to increase feelings of safety for SM RAS women:

> [SM] men and women's experiences are very different … it could be worthwhile trying to separate those groups … because obviously a lot of the gay women have been victimized by men, so they often have a lot of issues around men.

Centering SM Identity During Treatment. Some participants conveyed that SM RAS' sexual identities significantly influence their treatment needs and advocated for focusing on SM RAS' sexuality during treatment (n = 4):

> With people who have been persecuted based [on] … sexual identity … you're gonna have a lot of identity work—in the treatment plan … coming to terms with who you are, what your values are, what people have said was shameful or not okay about you and becoming okay with it …versus some people who are here for political reasons, they might have a different type of trauma …but their identity could be more fully formed.

Participants acknowledged that SM RAS clients' shame regarding their identities often necessitated targeted therapeutic interventions, "for [SM RAS clients] if there is a risk of them internalizing their experiences and how they've been treated, and perhaps [doing] more work [in treatment] to challenge those cognitive processes of internalizing."

However, other participants advised against centering SM RAS' sexual identities during treatment (n = 2), citing identity-related shame. One participant remarked, "If you're being persecuted for your sexual orientation, there potentially could be more risk of internalizing that persecution." Some providers found that emphasizing SM RAS clients' sexual orientation during treatment elicited discomfort:

> I referred a few people to primary care and programs that are for [the] LGBTQ population …when I brought that up, I got a signal that I was going like, whoa, like that's too visible, or like that's too gay … too much uh, centering that in a way that maybe they just weren't feeling or maybe felt unsafe.

Another participant commented:

> I would approach with a lot of caution in the talk about sexuality. I think we …would bring it up once in a while, just to make sure people are … having safety in their relationships … do sort of the domestic abuse chat. In any of these conversations, I'm trying to be very cautious around that, because of what people have been through.

Many participants emphasized the importance of tailoring to clients' comfort levels. One recommended allowing clients to direct the focus of treatment:

> Show that you're an ally but you don't want to go overboard … be positive and open and say, oh, you know, that's fine, but also we don't have to make it all about that. Take people's leads on whether they're presenting it, whether they want to talk about that, or whether that's incidental [and] can think about that some other day. Didn't want to make that front and center, unless the patient put it front and center.

One clinician stressed the importance of the clinician's language, particularly during intake interviews, noting, "When I do the intake [I am] completely nonjudgmental no matter what their story is, don't make any judgments, or insert my own personal opinions or beliefs." Another clinician advocated for discussing SM identity at the clients' pace as many SM RAS present to treatment citing concerns other than SM identity, "For SM RAS clients, the primary issue was probably anxiety or a psychosocial issue, 'I can't pay rent'. I never have had a patient here have a primary presenting complaint that is, identifying as a person who is LGBTQ."

Lack of Cultural Awareness

Many clinicians (n = 6) described a lack of cultural attunement or awareness regarding the treatment of SM RAS' and non-SM RAS' various salient identities (e.g., racial, cultural, sexual orientation, religious, and political identities). One participant stated:

> Cultural attunement was one thing that I wish I had …and just cultural awareness of how comfortable people are in accepting a diagnosis …or [identity]. So really … being very aware of your own privilege, bias, and [culture], our American norms, and how that doesn't necessarily translate to the person who is sitting in front of you.

see Supplemental File C Table 2 for more detailed information.

Discussion

This qualitative study aimed to identify clinicians' perspectives on disparities between SM RAS and non-SM RAS in treatment presentation and how to address these disparities to ensure treatment is meeting the needs of SM RAS.

Isolation, Social Disconnection, and Accessing Systems of Support

Clinicians in this study identified that both SM RAS and non-SM RAS reported isolation due to the asylum journey, however, SM RAS expressed more widespread isolation per clinician report. This disparity is echoed in a recent study that found SM RAS reported greater symptoms of isolation than non-SM RAS, even after controlling for exposure to traumatic experiences (Bird et al., 2022). Many SM RAS flee countries with antihomosexuality laws that encourage individuals in SM RAS's lives to "out" the individuals which can result in interpersonal rejection, physical attacks, and the loss of employment, housing, and other basic human needs for many SM RAS (Human Rights Watch, 2014). In countries of asylum, such as the U.S., SM RAS face physical abuse, verbal abuse, and discrimination for their sexual identity (Kahn, 2015; Kahn & Alessi, 2018) which can be compounded by discrimination experienced in relation to other held identities (e.g., RAS status, racial, ethnic, gender, religious, and cultural identities). Research in non-RAS populations demonstrates that the accumulation of minority stressors experienced by members of stigmatized minority groups (see MST; Brooks, 1981; Meyer, 2003) can lead to increased isolation (Arnoso et al., 2023). This suggests the SM RAS isolation described by clinicians may be further driven by minority stressors such as identity concealment. Indeed, as a result of lifelong identity-based oppression, SM RAS may seek to conceal their identity which can contribute to social isolation and create a barrier to connection with other SM individuals (Berg & Millbank, 2009).

Relatedly, clinicians in this study identified that many SM RAS may have experienced trauma or rejection from their families and communities and, as a result, may struggle to find social support in their country of asylum. This is echoed by research that has found SM RAS experience an early onset of victimization (Alessi et al., 2016, 2017), compared to the non-SM RAS (Hopkinson et al., 2017). Research has identified that a history of childhood and complex trauma can lead to loneliness and isolation (Dagan & Yager, 2019). Clinicians also noted that in their country of asylum, non-SM RAS generally have support from their families and partners, however, SM RAS are often without familial support. Further, clinicians stated SM RAS may have to manage fears of safety and/or loss of their same-sex partners due to SM-related persecution. Clinicians also described the difficulties faced by SM RAS in finding support via traditional channels such as their religious communities due to ostracization and continued fear of discrimination and persecution.

As a result of the increased isolation and difficulty connecting with communities, clinicians noted the importance of providers recognizing their role as a main source of SM RAS' social support. This

finding underscores the importance of the role of providers in reducing isolation, as proposed in the treatment framework by Alessi and Kahn (2017). Clinicians in this study also noted SM RAS were less trusting of others due to their history of persecution, and thus more ambivalent about therapy and more likely to drop out of treatment than non-SM RAS. To address this, clinicians suggested slowing the pace of treatment to decrease the likelihood of overwhelming SM RAS in treatment and thereby potentially reducing dropout rates.

To support SM RAS who have experienced extensive trauma, clinicians in this study described the importance of creating "safe spaces" in treatment. For example, clinicians suggested providing a "grounding presence" such as reminding clients that there are individuals in their lives who are trying to keep them safe. Clinicians also cited the need for clinicians to remove their own biases and to use nonjudgmental language both during the initial intake and in treatment. Research has identified safe spaces for SM individuals are those where providers are caring, honest, comforting, and nonjudgmental, and offer treatment in an environment that is LGBTQI+ affirming, clean, and upholding of client confidentiality (McClain et al., 2016). Therefore, in addition to ensuring the interpersonal relationship between provider and client is a safe space for SM RAS, the environment of treatment should also be considered. For example, clinicians in this study recommended creating safe environments for SM RAS women by providing treatment and access to facilities that are separated from both SM RAS and non-SM RAS men, as many SM RAS women have experienced violence perpetrated by men. Overall, these findings align with research that describes the importance of assessing and adapting treatment to meet the co-occurring needs of individuals with multiply marginalized identities (e.g., Schmitz et al., 2020).

A portion of the study clinicians suggested that promoting community involvement offered a way for SM RAS to create a network of support. This again aligns with the proposed conceptual framework that noted community building activities such as volunteering may be beneficial for SM RAS to increase feelings of safety and connection (Alessi & Kahn, 2017). Indeed, connectedness to an LGBTQI+ community in a country of asylum has been identified to have positive associations with mental health for SM RAS (Fox et al., 2020). Potential opportunities for exploration of social support for SM RAS may be with queer-affirming communities which may be helpful by establishing supportive groups that can increase resilience. For example, ministries providing services to RAS that openly describe their acceptance of SM individuals of all faiths (e.g., the LGBT Asylum Taskforce) may demonstrate that the organization prioritizes the safety of SM individuals. Legal advocacy groups (e.g., Immigration Equality; National Center for Lesbian Rights Immigration Project) may also be helpful queer-affirming avenues for SM RAS who are navigating the asylum process. Organizations providing services to SM RAS may wish to state online that they are LGBTQI+ affirming to signal to SM RAS that they are willing to provide a safe space for SM RAS.

However, as a result of chronic persecution and discrimination via oppressive systems, multiple barriers to social integration for SM RAS have been identified (Gowin et al., 2017); including intentional avoidance of their communities (Kahn, 2015) which can perpetuate the cycle of isolation and disconnection (Sha'ked & Rokach, 2014). Indeed, some clinicians in the study proposed exercising more caution when promoting community involvement for SM RAS due to the potential of continued fear of persecution. The conceptual framework for treating SM RAS also identified that SM RAS may not feel comfortable or safe in their interactions within their communities (Alessi & Kahn, 2017). For example, engagement with LGBTQI+ affirming spaces could elicit an iatrogenic response where SM RAS may veer away from queer-affirming organizations due to the fear of being "outed" in their communities.

Considering the lack of clarity and the conflicting reports from clinicians regarding community involvement, it may be appropriate for therapists and clients to have an open discussion in session regarding external community involvement in treatment, while centering the clients' agency, priorities, and perceived risk of community engagement. Queer-affirming community organizations may wish to openly disclose what participating in the community entails (e.g., if identity disclosure is required), allowing SM RAS to be more informed about what to expect and allowing the construction of strong referral pathways for providers. Community organizations could also engage in conversations with treatment providers (and vice versa), so SM RAS can learn about external services in a private setting, allowing clients to discuss related emotional and safety concerns with a trusted clinician. Importantly, SM RAS may not feel at home or safe in queer-affirming spaces such as LGBTQI+ communities due to language and culture barriers (Kahn, 2015). Therefore, the language and cultural identities of SM RAS should be considered when providing resources. In developing networks with queer-affirming organizations, a secondary benefit may be that clinicians could create collaborative projects and grants to support SM RAS.

Addressing Shame

Clinicians noted SM RAS clients expressed feelings of shame about their sexual identity. Core concepts in MST posit that individuals in the sexual minority may experience proximal stressors such as internalized homophobia which can lead to identity-based shame (Brooks, 1981; Meyer, 2003). To address shame in the treatment room, some providers relayed the importance of centering sexual minority identity in therapy, a process found in treatment adaptations that seek to alter or modify internalized homophobia for SM individuals (e.g., LaSala, 2006). This theme was also supported by Alessi and Kahn's (2017) conceptual framework which suggested preparing a trauma narrative of the persecution experiences of SM RAS could help address internalized shame. Alternatively, other providers expressed the need for caution when centering sexual orientation in the treatment room as it could further exacerbate

stigma and shame for SM RAS. As clinicians were not united in this area, future research is needed to better understand the outcomes of discussing sexual orientation in treatment.

Providers also noted many SM RAS were overwhelmed by the process of identifying as a sexual minority, which is often required of SM RAS during the asylum process (Immigration Equality, 2021). Therefore, clinicians reported that it is critical to consider the timing of introducing sexual minority-based resources (e.g., information on sexual identity; access to LGBTQI+ centers) as providing resources too early in treatment could overwhelm the client and decrease therapy attendance. Many clinicians in this study determined the content and timing of SM identity discussions in treatment were based solely on their clients' responses. With past and continued persecutory experiences and stigmatization, SM RAS may be reticent or prefer to avoid disclosure in treatment. However, disclosure of stigmatized identities is integral to social interaction and a critical component of the therapeutic process (Chaudoir & Fisher, 2010). This suggests an understanding of when and how to discuss sexual identity in treatment may be of particular importance for treating SM RAS. Learning directly from SM RAS about the role of centering sexual identity in treatment is an important area for future research.

Need for Additional SM RAS Treatment Resources and Research

In Alessi and Kahn's (2017) conceptual framework, the importance of validating intersecting experiences of discrimination and prejudice is critical in treatment. Indeed, intersectionality theory is founded on the concept that identification with multiple, nondominant identities is fluid and nuanced, requiring a person-centered approach (Torres et al., 2018). Clinicians in this study reported awareness of how they believed SM identity conferred risk for different treatment challenges than those faced by non-SM RAS. Clinicians also expressed a desire to provide culturally responsive treatment that responded to the multiply marginalized identities of SM RAS. However, clinicians felt underprepared and expressed a desire for additional resources to address the concerns of SM RAS. Relatedly. recent research has placed a call for studies that address the behavioral health needs of SM RAS, particularly about experiences of oppression (Cerezo et al., 2020). Treatment options that take an individualized approach, focusing on addressing compounding stigma-related stressors among individuals who face overlapping, interdependent systems of oppression, have been found to decrease isolation (Jackson et al., 2022). Therefore, future research must develop or expand existing evidence-based treatment options for SM RAS using an intersectional lens. In the short term, clinicians may wish to access cultural competence training for SM RAS providers (e.g., Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), 2023).

Environments of Oppression

Importantly, clinicians noted that SM RAS have experiences and identities that have been historically marginalized. Therefore, the onus of change is not on SM RAS's shoulders, but rather on

changing systems of oppression that create and perpetuate discrimination and stigmatization of SM individuals. In 2019, when data were collected for this study, U.S. laws negatively affecting transgender individuals' access to health care and enrollment in the military were in place, in addition to a proposed rule that would allow government-contracted employers to fire sexual minority employees (Esseks, , 2019). Further, in the U.S., in 2019, racist and anti-immigrant sentiments were salient in the xenophobic rhetoric of former President Donald Trump (Santa Ana et al., 2020) and exclusionary policies against immigrants, particularly immigrants of color (e.g., suspended entry of individuals from Muslim majority nations, the strengthening of immigration enforcement agencies; Held et al., 2022). These events may have signaled to SM RAS, particularly those who hold multiple marginalized identities, that they would not be affirmed, welcomed, or wanted in the U.S. Unfortunately, this milieu has not changed dramatically. Racist and anti-immigrant policies continue to dehumanize Black, Indigenous, people of color and immigrants in the U.S, (Jardina & Piston, 2023). Recent legal U.S. rulings have also carried anti-LGBTQI + sentiments (e.g., 303 Creative vs. Elenis, (GLBTQ Legal Advocates & Defenders (GLAD), 2023); Arkansas Medical Ethics & Diversity Act (Cook, 2021)) which could perpetuate both fear of and actual SM-based persecution, thus increasing the chronicity of minority stress for SM RAS in the U.S. Future research may wish to determine how the sociopolitical context of the U.S. is impacting SM RAS mental health.

Despite these concerns, there are laws in place in the U.S. that can Support SM RAS. For example, under Section 207 of the Immigration and Nationality Act, official refugee status in the U.S. provides immediate lawful status with all the rights and privileges of a U.S. citizen, except the right to vote or work for a government entity (Office of Law Revision Counsel (OLRC) United States Code, 2023) . Certain rights and privileges exist under U.S. laws that do not allow discrimination based on sexual orientation such as marriage equality (Obergefell v. Hodges, 2015) employment (Equal Employment Opportunities Commission, 2023), and housing protection (U.S. Department of Housing & Urban Development, 2023). Further, the U.S. public's sentiments toward RAS have continued to improve over time, with many individuals reporting more support toward refugees who are already on U.S. soil (Sana, 2021). The U.S. is also home to multiple advocacy groups (e.g., American Civil Liberties Union (ACLU), Amnesty International, Human Rights Watch, Rainbow Railroad) that challenge oppressive systems through collective action and ultimately provide a safer harbor for SM RAS.

Clinicians may also be able to improve SM RAS safety and facilitate an easier transition in their country of asylum. A recent article in *the New England Journal of Medicine* noted, "While we work to promote safety in health care, clinicians are also well positioned to sound the alarm about the harmful effects of anti- LGBTQI+ legislation within their own countries" (Streed et al., 2023). Indeed, Streed et al. (2023) suggested clinicians could enter into medical–legal partnerships to ensure SM RAS' legal needs

are being addressed, facilitate embedded monthly legal clinics hosted at treatment centers, and support SM RAS through the legal process by aiding in the preparation of testimony and serving as expert witnesses for SM RAS. Additional work can be done to support specific policy and programming opportunities that currently exist at the national level. These can include but are not limited to, advocating for (a) the development of inclusive policies for SM individuals such as SM RAS in the U.S.(see United States Agency International Development (USAID), 2023; Rainbow Railroad, 2021); (b) reducing restrictions on same-sex RAS partners (see International Refugee Assistance Project (IRAP), 2023); (c) granting SM RAS organizations such as Rainbow Railroad, an entity aimed to help transport at-risk SM RAS to safe locations, the ability to be official referring partners for RAS resettlement (i.e., an organization that identifies RAS in need of resettlement and aids in the screening, processing, reception, and integration of RAS; see Rainbow Railroad, 2021; UNCHR, 2023); (d) collection of voluntary data on RAS sexual and gender identity, and (e) qualifying SM RAS for visa designations which could allow for petitioning via the U.S. embassy instead of border checkpoints (e.g., Priority 1 or P-1 designation) and/or designations which identify SM RAS as individuals in need of resettlement based on a persecuted identity (i.e., the Priority 2 or P-2 designation); both of which could improve resettlement efficiency and safety (see Grueberg et al., 2018, Rainbow Railroad, 2021).

Strengths and Limitations

This qualitative study of RAS providers offers a critical lens into the treatment needs of a highly vulnerable subpopulation of RAS living in the U.S.. Clinicians who regularly treat SM and non-SM RAS felt there was a difference between these two groups and that they do not feel fully prepared to address the needs of SM RAS, which could compromise the care they deliver. This study highlighted strategies for adapting therapy to SM RAS (e.g., assessing early rejection and childhood trauma, centering sexual identity in treatment, having the provider act as a central form of support, modifying the pace of treatment, and providing more social support resources and opportunities for community involvement) that could be further studied in effectiveness research. The results of this study were well-aligned with the conceptual framework by Alessi and Kahn (2017) to treat SM RAS, adding validity to the proposed treatment adaptations.

While there are many strengths, it is important to note the limitations. To access providers with experience working within predominantly RAS populations, clinicians were recruited from the BCRHHR a specialized, RAS treatment-seeking center. A recent study on all RAS who sought services at BCRHHR between January 2013 and March 2019 ($N = 959$), identified that 58.1% were fleeing from Uganda, 21.1% were fleeing countries that did not criminalize same-sex acts, and 20.8% were fleeing countries other than Uganda that criminalized same-sex acts (Bird et al., 2022), and that over 85% of SM RAS in the clinic were fleeing Uganda. As a result of prejudice, discrimination, and racialization (Asante et al.,

2016), African refugees and migrants are more likely to experience dehumanization during migration (Howard et al., 2022), othering, or being treated as intrinsically different in their countries of asylum (Udah & Singh, 2019), and face significant barriers to accessing services, care, shelter, and employment (Asgary & Segar, 2011). These experiences may not be shared with RAS from other cultural or ethnic backgrounds indicating the results may not generalize to all global diaspora communities. However, the recent reinstatement of antihomosexuality laws in Uganda (Human Rights Watch, 2023), and the subsequent increase in SM RAS from Uganda (Streed et al., 2023), suggest that this population of RAS with potentially salient racial and sexual minority identities may be of particular importance to study. Another limitation is the study only included providers in Boston, thereby reducing the generalizability of treatment implications to other countries of asylum and other regions in the U.S. Future research may wish to study the treatment experiences of SM RAS more broadly, particularly in countries with varying laws on consensual same-sex romantic acts, and different immigration laws and policies, and immigrant populations.

An additional limitation of this study is that clinicians were asked to compare RAS who were persecuted for being in the sexual minority and RAS who were persecuted for political reasons. These two forms of persecution are not mutually exclusive, as some political asylees may identify in the sexual minority and some SM RAS may have experienced political persecution. However, assessing sexual minority status is often difficult in RAS populations due to fears of disclosure, fears of continued persecution, and differences in the conceptualization of sexual minority orientation (Chávez, 2011). As a result, research has used persecution for same-sex acts as a proxy for sexual minority status (e.g., Bird et al., 2022; Hopkinson et al., 2017). Finally, clinicians are not the major stakeholder involved in the treatment of RAS. Future research should amplify the voices of the SM RAS clients' perspectives, priorities, and needs as they are the experts in their own lived experiences of therapy. An additional suggestion is to consider analyzing therapy session recordings to reduce any potential personal or recall bias about what is happening in the treatment room. As all individuals may also present with their own conscious or unconscious biases in the treatment room, research comparing the outcomes of treatment based on both clients' and clinicians' experiences could be beneficial.

Conclusion

SM RAS are a population who have to navigate extensive trauma and stigmatization from oppressive systems both in their countries of origin and asylum. In this study, SM RAS providers were able to identify multiple disparities between SM RAS and non-SM RAS in the treatment room and many treatment adaptations for SM RAS which aligned with the conceptual framework developed by Alessi and Kahn (2017). This suggests a continuity between existing conceptual research and the treatment practices of SM RAS clinicians. However, clinicians in this study reported feeling underprepared to address the

needs of SM RAS. More evidence-based research needs to be conducted on the treatment requirements for this growing population, such as developing culturally sensitive mental health services, identifying ways to create safe spaces for SM RAS to connect and form social networks, and increasing advocacy for policies that protect the rights of sexual minorities in the asylum process. By recognizing the unique challenges faced by this population and taking steps to address their needs, clinicians, researchers, policymakers, and activists can help to ensure that SM RAS have access to the support and resources needed to address the harm that has been unduly placed on this population.

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