DOI 10.18471/rbe.v36.44573
Original Article

KNOWING THE DEMANDS OF MENTAL HEALTH CARE OF THE YOUNG HOMOAFFECTIVE

CONHECENDO AS DEMANDAS DE CUIDADO EM SAÚDE MENTAL DE JOVENS HOMOAFETIVOS

CONOCIENDO LAS DEMANDAS DE CUIDADO EN SALUD MENTAL DE JÓVENES HOMOAFECTIVOS

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How to cite this article: Werner JM, Guimarães AN, Brum MLB, Vendruscolo C, Zanatta EA, Marqui GDS. Knowing the demands of mental health care of the young homoaffective. Rev baiana enferm. 2022;36:e44573.

Objective: to know the demands of mental health care of young homosexuals. Method: qualitative research, conducted with 18 young homoaffective, university students in Santa Catarina. The production of information occurred in 2016, through semi-structured interviews, with questions about perceptions regarding mental health, homoaffectivity and expectations regarding health care. The information was interpreted through content analysis. Results: individual, social and programmatic vulnerabilities of young homosexuals were identified, which can interfere with mental health, leading them to seek professional support. Weaknesses of health services for this care were reported. Final considerations: young homosexuals experience situations of vulnerability, with demands for care that are neglected in health services. They lack innovations, especially in mental health, since they suffer aggression, oppression and stigma, which contribute to drug use. Still, they question about equal care, problem-solving, free of prejudice and humanized assistance.

Descriptors: Youth. Homoaffective. Mental Health. Needs and Demands of Health Services. Care.

Objetivo: conhecer as demandas de cuidado em saúde mental de jovens homoafetivos. Método: pesquisa qualitativa, realizada com 18 jovens homoafetivos, estudantes universitários, em Santa Catarina. A produção de informações ocorreu em 2016, por meio de entrevista semiestruturada, com questões sobre percepções em relação à própria saúde mental, a homoafetividade e expectativas frente ao cuidado de saúde. As informações foram interpretadas mediante análise de conteúdo. Resultados: foram identificadas vulnerabilidades individuais, sociais e programáticas dos jovens homoafetivos, que podem interferir na saúde mental, levando-os a buscar suporte profissional. Foram relatadas fragilidades dos serviços de saúde para este cuidado. Considerações finais: os jovens homoafetivos vivenciam situações de vulnerabilidades, havendo demandas de cuidados que são negligenciadas nos serviços de saúde. Eles carecem de inovações, sobretudo em saúde mental, uma vez que sofrem agressões, opressões e estigmas,

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que colaboram para o uso de drogas. Ainda, questionam sobre atendimentos igualitários, resolutivos, livres de preconceitos e assistência humanizada.

Descritores: Jovens. Homoafetivos. Saúde Mental. Necessidades e Demandas de Serviços de Saúde. Cuidados.

Objetivo: conocer las demandas de cuidado en salud mental de jóvenes homoafectivos. Método: investigación cualitativa, realizada con 18 jóvenes homoafectivos, estudiantes universitarios, en Santa Catarina. La producción de información ocurrió en 2016, por medio de entrevista semiestructurada, con cuestiones sobre percepciones en relación a la propia salud mental, la homoafectividad y expectativas frente al cuidado de salud. La información se ha interpretado mediante análisis de contenido. Resultados: se identificaron vulnerabilidades individuales, sociales y programáticas de los jóvenes homoafectivos, que pueden interferir en la salud mental, llevándolos a buscar apoyo profesional. Se han reportado debilidades de los servicios de salud para este cuidado. Consideraciones finales: los jóvenes homoafectivos experimentan situaciones de vulnerabilidad, habiendo demandas de atención que son descuidadas en los servicios de salud. Carecen de innovaciones, sobre todo en salud mental, ya que sufren agresiones, opresiones y estigmas, que colaboran para el uso de drogas. Aún, cuestionan sobre atenciones igualitarias, resolutivos, libres de prejuicios y asistencia humanizada.

Descriptores: Jóvenes. Homoafectivos. Salud Mental. Necesidades y Demandas de Servicios de Salud. Cuidados.

Introduction

Human sexuality involves attributes such as pleasure, reproduction, friendship, love, affection, sexual practices, sexual orientation and gender. It includes pleasant tactile sensations, affectivity and conjugal, fraternal or friendly relationships. The way it manifests itself is related to several contexts: historical, sociocultural, family and subjective[1].

For psychoanalysis, sexuality is always a singular construction, and the way the subject experiences it, consciously or unconsciously, is the result of a long identification process. It is an equation that involves different variants – body, love, desire, joy – before which, as in a vector system of forces, a result will be found[2].

However, when it comes to the population with sexual and gender diversity: Lesbians, Gays, Bisexuals, Transsexuals, Queers, Intersex (LGBTQI+), this equation is not so simple. By expressing their sexuality, this public faces some psychological, political and socio-cultural adversities, which weaken their self-esteem and sense of belonging to society, and lead them to experience a life marked by fear and invisibility[1].

Among the mentioned adversities, homoaffective individuals, when dealing with their sexual orientation, take into account the established social models of sexuality expression. Some end up choosing to hide their condition, being deprived of expressing their own subjectivity, which could allow an experience of their own sexuality as it really is, without having to repress what they feel[3].

Given the possibility of investigating a group of homosexuals, it was possible to know the vulnerabilities of this population under the conceptions of Ayres[4-5]. For the author, vulnerabilities are interconnected to the possibilities of exposure of people to illness and is articulated through three components: the individual, the social and the programmatic. The individual refers to the degree and quality of information that individuals have about a particular problem, and the possibility of using them for protection. The social involves aspects that depend on access to the media, availability of material resources and political factors. The program is related to the actions of programs aimed at prevention and care, and may be regional, local and national policies, which must be made available in an effective and democratic way[4-5].

Studies indicate that the LGBTQI+ public may experience situations of vulnerability: at the individual level, arising from social desires in the face of little information and heteronormative social construction on sex and sexuality; due to

the violence experienced in their social contexts; and in the context of programmatic vulnerabilities, because policies and programs are still incipient on health promotion and human rights actions for this population[6].

With this panorama of oppression, stigma and violence, the possibility of impaired mental health of LGBTQI+ is a fact. Psychic suffering, seclusion, loss or loneliness can occur, and even lead young people to consider suicide, a fact that deserves due attention from health services and professionals[7]. Thus, it is understood that health services and educational institutions, as members of a social support network, should carry out health-promoting actions, to encourage the deconstruction of heteronormative and homophobic postures aimed at meeting human rights based on the integrality of care of LGBTQI+[8].

In this context, it is necessary to instrumentalize health professionals, especially nurses, for the attention demands of individuals vulnerable to psychic suffering related to their sexual orientation, familiarizing them with the different faces of this problem, in order to feel safe for interventions[7]. From this perspective, this study may foster reflections in nursing professionals on mental health care practices of the LGBTQI+ population and their vulnerabilities, with a view to strengthening the Primary Health Care (PHC) model in Brazil. The study was conducted with the objective of knowing the demands of mental health care of the young homoaffective.

Method

This is a qualitative, descriptive research developed in two universities located in the West of Santa Catarina, southern Brazil. The study population consisted of 18 young homoaffective.

The inclusion criteria were: to be a student matriculated in an graduate course in the period of information collection, to self-declare to be homoaffective and to be aged between 18 years and 24 years. Exclusion criteria were: to present a speech disorder that would hinder communication and/or understanding between the researcher and the respondent; be a student matriculated in disciplines taught by professors who were part of the research team in the period of information collection; and be matriculated in disciplines that the academic members of the research team attended in the period of production of information.

Participants were recruited through the "Snowball" technique. Contact was made with a representative of the National LGBT Union (UNA) of the city where the research was conducted, which indicated a homoaffective student from each university. After the interviews with each of these students, they indicated other participants and so, successively, until the saturation of information occurred in the 18th approach.

For the collection of information, semi-structured interviews were conducted in the second half of 2016, containing identification questions and open questions that met the objective of the study. The duration of the interviews was between fifteen minutes and one hour and thirty minutes and occurred in a closed room, provided by the universities involved, ensuring privacy.

The information was recorded, transcribed in full and subsequently interpreted following the content analysis[9], consisting of three stages: pre-analysis, exploration of the material and treatment of the results and interpretation. The pre-analysis consisted of reading and re-reading the transcribed material and the initial organization of the reports, aiming to have an overview of what was declared by the young people and perceive the particularities. The exploitation of the material allowed grasping the relevance between the speeches of each participant, classifying the central ideas and organizing them into two categories Demands of mental health care of the young homoaffective. Finally, in the stage of treatment of the obtained results and interpretation, an interpretative synthesis of the categories was elaborated, allowing the dialogue between the empirical data and the scientific literature.

The research was approved by the Research Ethics Committee of the Universidade do Estado de Santa Catarina (UDESC) under Opinion

number 1,777,561, of 2016. The anonymity of the participants was preserved by assigning the letter M to the male interviewee and F to the female interviewee, followed by the corresponding interview number.

Results

The 18 young homoaffective were in the age group between 18 and 23 years of age, being 8 self-declared gay men and 7 self-declared lesbian women, 14 were Nursing students, 1 Computer Science, 1 Social Sciences, 1 Language and 1 Mathematics.

Individual, social and programmatic vulnerabilities of the young homoaffective

In their manifestations, the young reported that homoaffectivity interferes or interfered with their mental health at some point in life. Most young people reported that being gay or lesbian directly affected their emotional balance due to the prejudices and discrimination they suffer before society and the LGBTQI+ community itself. The interviewees expressed situations in which they experienced fears, insecurities, oppressions and sexual violence.

> *The homoaffective person, in all the spaces they are in, needs to overcome difficulties that are imposed, so this affects their mental health* [...] *over time we get used to dealing with these situations of oppression that we live in, society is unfortunately not going to change.* (M6).

> *We know that in that adolescent phase, the hormones are in full swing, and it ends up being a joke, prejudice, and I felt that it was not doing me any good.* [...] *so those situations were somehow traumatic.* (M7).

> *I am a troubled person today* [...] *because when I was younger I was raped, it wasn't just one, there were several, because I'm gay, because the person said exactly like this "ah! you're a fag, so you have to have dicks, because that's what you want for your life", and that was horrible.* (M9).

> *It really interferes* [...] *dating is very complicated, I can't walk hand in hand on the street, because we're going to be lynched. I know that, it bothers me that there are still people who don't accept it.* (F11).

On the other hand, some reported that being homoaffective did not affect their mental health and, if at some point it did, it does not currently represent a stress factor for psychoemotional balance.

> *I manage to keep a balance of things that happen daily* [...] *because I am well resolved with my sexuality, being accepted at home, in my network of friends, I have never suffered any kind of prejudice, so I think my sexuality does not interfere much in these imbalances.* (F14).

> *I'm fine with myself, I accept myself and that's what matters, it's what I feel, so it doesn't harm me, it doesn't affect me, it just helps me. Every day it gets better and becomes visible to people who have this rejection.* (F17).

The young people exposed self-care measures that they adopt for the maintenance of mental health or for the promotion of their well-being such as: practicing sports, talking to family and friends, meditating, reading, listening to music, watching movies or serials, shopping and taking time for yourself.

> *One thing that helps me a lot is practicing slackline* [sport] *that you can make a physical and mental balance to be on top of the elastic because otherwise you can't.* (F10).

> *I talk. I talk to my girlfriend or my friends, but I have to talk, talk, talk, talk and when I see it, it calms down.* (F15).

> *The only thing that makes me feel good is listening to music, so most of the time I was listening to music, sometimes I risked dancing in the video game* [...] *if there's a situation that's going to bother me, I'm going to listen to a song, to occupy my mind or I'm going to play the guitar, draw, I'm going to watch a movie, so I don't have to let it consume me.* (M17).

> *For my mental health, I take care of her by taking time for myself.* [...] *I liked to do things for myself, when my birthday arrives I buy something in an internet store, I write a letter and have it wrapped and send it to myself, that is, always keeping myself connected* [...] *I always have my goals in mind.* (M1).

Self-care is also emphasized for the prevention of Sexually Transmitted Infections (STI), control of alcohol intake and use of illicit drugs. The intention is not to acquire an STI or become a chemical addict. The use of drugs for depression and sleeping or having sex are devices that help them forget about problems.

> *Self-care in relation to STDs* [...] *that you need self-care.* (F6).

> *Cigarettes, sometimes weed, but not too much because it's expensive, but it gets me high so I can sleep or else I take clonazepam to sleep, fluoxetine and I drink sometimes, not every day* [...] *having sex helps me too.* (F9).

> *Self-care would be in the matter of drinking, because it can take me to several branches, because when I'm drinking, I don't want to be just drinking, I go to other drugs that are a little harder.* [...] *Today I stopped, but for a long time, alcohol was a way to forget about the problems.* (F13).

For some, family, friendships, religion and university are sources of support for their sexual orientation.

> *My family and friends are very important, because every time I feel a little off balance, I can find my center, or with my family, or with my closest friends, I think someone like you can trust, can tell the things is important* [...] *religion is also helping me a lot. I attend the Spiritist Center and I have very strong support in this spiritual matter.* (F14).

> *The only support network I have today is the university. I do several things to keep my head busy: research project, extension project, tutoring, class leadership, graduation committee, student representative. It makes me have several things and I don't think nonsense.* (F13).

When conflicting relationships about sexual orientation occur in the family environment, professional support is a resource often used by them. Sometimes parents themselves seek help for their children. Of the 18 young people interviewed, 3 sought medical help, 2 psychiatric and 1 gynecological, 5 sought psychological support and 4 psychopedagogical support. The most common cause for seeking professional support was the difficulty in accepting sexuality; the most sought-after professional was the psychologist. The use of drugs and alcohol were again highlighted as support for confrontations with homoaffectivity. Suicide was mentioned as an attempt to overcome adversity.

> *I used to be more unstable, now I'm in a more stable period. I had a period when I went into depression, a lot of stress too. It was pretty complicated. I went to psychiatrists, psychologists, I took a lot of medicine* [...] *I think sometimes it would be easier if I were straight.* (F18).

> *I went at the age of 16 to 17, I spent two years hiding at the psychologist* [...] *What I really find most interesting is that I listened to what I was saying to the psychologist and I kept thinking, I wonder if it's all that?* [...] *helped me a lot.* (F2).

> *I tried suicide a few times. I started taking several pills, I treated myself to a psychologist and then to a psychiatrist, I took medication, I always got to a stage where I thought I was super well, then I fell down again and ran to the medication.* [...] *now I'm a little more focused, policing myself more on the issue of drinking, because as it is a refuge* [...] *I'm trying to avoid it because when I'm drunk I feel like taking pills and jumping off my balcony* [...] *several bad things come to my mind.* (F13).

Nine of the informants said they did not need professional support and did not seek health care, but believed that this would have been necessary at times. The reasons were family, financial issues, fear of being judged or lack of courage.

> *I never sought help. I already thought, at the time this episode happened, when my mother didn't accept me with the relationship I had, I thought, yes, of looking for it, but I didn't have the courage to go after it, I was afraid, I think it was the very fact of the judgment , I was even afraid of the psychologist judging me, I thought what she would think of me.* (F3).

> *In the time that it was latent* [referring to the discovery and acceptance process of homoaffectivity], *at first I believe I should have looked. I didn't know I could go after a person and my mother didn't want to take me. I believe she was afraid of what I would have to hear, and maybe afraid of what she would have to hear, because maybe she would have to accept that her son was gay.* (M4).

> *I could have looked when I decided to accept myself, but I didn't go because, as I was going to say, "Dad, I need a psychologist" "What for?" "because I need". So I think that a little bit it was because of that, and the question whether you like it or not has a cost* [...] *then I looked for help from friends and people who had already been through this and, in fact, these people, teachers, helped me a lot and that's how I got through this phase.* (F10).

Regarding access to health services, some mentioned that they were well assisted. Nevertheless, they showed that the treatment is not egalitarian, reinforcing the prejudices and judgments that exist from health professionals.

> *I think you have to be especially careful in the way you treat it, know how to deal, not judge* [...] *I felt very offended because sometimes homosexuals came to the unit and when they left, the professionals started to talk badly and laugh and I would say something and they would judge me, and then we would debate. It's a normal person! The relationship he has outside of here is not about the person and this is something I realize a lot, that people are prejudiced against gay homosexuals.* (F11).

> *I was treated well, I was treated well, my appointments didn't take long, so I had nothing to complain about, and I hope I don't. But I've seen cases where they weren't treated badly.* (M17).

In this context, individual vulnerability situations were identified when expressing feelings of fear, prejudice, insecurities and rejections of family and society; social vulnerabilities, when reporting situations of violence and oppression, expressed in various ways and performed by components and social environments; and programmatic vulnerabilities, by exposing the prejudice and stigma they experience in health services.

Demands for mental health care of the young homoaffective

The study participants mentioned that they expect from health services resolution and quality of care. They consider the care fragile, focused only on pathology, so as not to consider the patient in their entirety. They stressed the importance of qualified listening and dialogue.

> *I hope, at least, that they listen to me, because in these anxiety attacks* [...] *I passed out a few times or the pressure went up, they gave me a tranquilizer but they didn't listen to me.* (F12).

> *I hope he treats me well and is willing to understand what is going on, not to answer for the sake of answering, but to understand the problem in depth and find the best way to make me feel good again, to heal whatever it is, ease the pain, because I've been to many doctors* [...] *the doctor looks at you, asks what you have and that's it, bye.* (M17).

Talking about sexuality with health professionals, even today, causes embarrassment. The professional is often not prepared to explore the issues surrounding the needs of the homoaffective.

> *When I went to the gynecologist, it was super embarrassing, because I went to do the preventive. It's just that I've never had heterosexual relationships and he didn't ask me anything about it, he went straight to the preventive test and I thought it was very invasive of him not to have asked me.* [...] *not everyone is heterosexual, so it's really important that you know a little about the person's life before.* (F16).

> *I don't think I would have the courage to say I'm a lesbian on first contact* [...] *I don't know if I would speak, I don't know if they would help me* [...] *they would want to know why that was happening and I would not speak, because I would be misunderstood, suffer prejudice.* (F13).

Finally, they highlighted that health professionals need to train and update themselves to assist young homosexuals, as well as must know public policies and put them into practice to meet this population they consider differentiated and at risk.

> *One of the main things is the issue of care, knowing that you are going to get to the health service and you are not going to be repressed for who you are. In fact, you do not know who is the professional who will serve you and what is his conception* [...] *I think that this issue of making you more professional, making professionals have a qualification to serve the public, because it is a differentiated public, they are different from the straight public.* (F10).

> *I expect un update* [...] *The health professional, his duty is to be aware and know the social policies, policies, it is broad, including comprehensive national LGBT health policy* [...] *that they understand that the UHS is for everyone, so that professionals can see this, see that this LGBT population is a population with extreme health risk.* (M4).

The lack of preparation of professionals to meet the demands of young homosexuals draws attention in the testimonies. Sometimes, they signaled an attention with elements that characterize the lack of information on the subject. They long for listening and, in this sense, felt entitled to recommend the search for more information and updating by those who work in the services.

Discussion

When questioning the results of this study, it is found that individuals who adopt behaviors that fall into the LGBTQI+ group become stigmatized and suffer social homophobia, generating prejudice, judgments, oppression, rejection and violence. These ingredients can cause psychic suffering and compromise your mental health, given the humiliations and constraints to which they are submitted daily in intra and extra-family spaces.

Homophobia is internalized by homoaffective and has influence on psychological issues. The possible consequences of internalization are: depression, anxiety, alcohol abuse, low school productivity, among others[10].

Faced with this reality, vulnerability situations were identified in the individual, social and programmatic dimensions. This discussion defends the idea that the three vulnerabilities cannot be discussed in isolation, since it is understood that they are interconnected and are jointly determinant for the susceptibility of individuals to fall ill[4-5].

Individual vulnerabilities are evident in the fact that homosexuals cannot express their knowledge and needs in their favor, since they are silenced by feelings of fear, judgments, prejudices, rejections and family and social oppression. These events can lead to psychic suffering that compromises your mental health. Among the daily difficulties found in

the stories of lives of LGBTQI+ people, there have spaces of domestic sociability that often function as a referential locus of potentiation of vulnerability(ies), overlapping violence(s) and exclusion. This is due to non-acceptance, lack of recognition and respect for sexual orientation and gender identity by the family. Thus, LGBTQI+ young people face a myriad of physical violence, insults, rights violations and existential denial[11].

In this context, social vulnerability coexists, which is reproduced and fed back in the life scenarios of homosexuals, evidenced in the contained invisibility and violence arising from different social segments. It takes place even in health services and culminates with programmatic vulnerabilities, since the LGBTQI+ public feels constrained in seeking health services and professionals to solve their health problems.

In the context of social vulnerabilities, a study[12] indicates the prohibition of possible discrimination caused by gender identity or sexual orientation. In this direction, the support of educational institutions are important, since they can take responsibility for preventing and repudiating situations of prejudice or bullying, improving the indoctrination of sex education. Bullying and prejudice were indicated as the main causes of social vulnerability that interferes with the mental health of young homosexuals.

Even in this scenario, there is a need for the young homoaffective to obtain social acceptance, which is closely related to the formation of positive bonds, capable of providing physical and emotional balance. When this possibility occurs and the differences are respected and understood socially, the psychic stressors decrease dramatically. Nonetheless, when behavior and sexuality are criminalized or judged, they can generate psychic suffering, capable of causing negative self-judgments[13].

Experiences during youth related to cyberbullying, sexual assault, domestic violence and harassment, due to sexual orientation, can lead to victimization capable of causing suicidal ideation[13]. Participants in this investigation also reported suicide attempts due to problems faced, related to the lack of family and social understanding of their sexuality. A policy of tackling the inequities of the LGBTQI+ population requires vigorous strategies, especially the training of health professionals on the sexual and social practices of LGBTQI+, is a fundamental issue for care to be consistent with their health needs[14]. This aspect also converges with the needs observed in the testimonies that resulted from this research. Complementing, several fields of knowledge production and practices perpetuate stigmatizing productions, a reality that requires reflections in the field of health, With a view to building a new paradigm in the teaching process in health courses that considers an academic formation capable of debating gender diversity as a social issue related to the health care process[14].

Information and education on sexuality and its promotion in a positive and respectful way enables people to have pleasure and safe sexual experiences, free from violence and discrimination, so that the sexual right is protected and fulfilled, as formulated by the Department of Strategic Programmatic Actions of the Ministry of Health[15]. Although the Ministry of Health[16] provides for the reproductive rights of people, such as membership, contraceptive methods, family planning and sexual rights, it is observed that, in practice, some rights are not effective. In this study, participants demonstrated that they did not feel subject to their rights as citizens, when they reported that, in everyday life, they fear showing affection in public, such as heterosexual people, such as holding hands in public or revealing their sexual orientation.

In the same vein, it is observed that the sexual and reproductive rights of lesbians, in some situations, are neglected, since M16 reported that, when visiting a gynecologist, felt embarrassed to make an examination for the treatment given by the professional, performed as if for a heterosexual woman. There is a professional look focused more on the prevention of STIs to the male homosexual. Thus, lesbian women receive assistance consistent with that aimed at people with heterosexual behavior. This theme was explored by scholars who describe that

sex education and prevention of STIs are more related to male homosexuality. Lesbian women have low demand for health services, which can increase cervical and breast cancer rates, and may lead to other diseases. Little is discussed about sexual habits, such as the use of gloves in sexual practice as a barrier to STI, due to high levels of contamination[15].

Also noteworthy are the programmatic vulnerabilities, considering that there were demands for health care of young homosexuals, including respect for health services and professionals. In relation to this aspect, a study[17] discusses that it is possible to see the lack of health care focused on different sexualities. The individual needs to be understood as an individual subject. Health professionals, through listening, have the opportunity to promote the physical and mental health of those people, acting based on ethics and not on moral and/or religious perspectives.

Another weakness presented by the young homoaffective was the medicalization associated with emotional imbalances, which portray the biomedical model, as illustrated by the speech of F12 when exposing that pain was mitigated by medication, but that it was not heard and understood as an integral being. There is also the precariousness of care guided by humanization, especially the fact that professionals listen to the complaint, treat the problem, and sometimes the consultation is closed. This makes clear the lack of link between professional and patient, hurting the principles of user embracement and approach to health services, through the longitudinality of care.

With this look, in the expectations of the participants of this study, the desire for humanized care practiced by health professionals, from the perspective of empathy, without judgments and constraints. This demand corroborates the National Humanization Policy[18], which states that health care begins with embracement. Embracement is recognizing what the other presents as legitimate and unique health needs. The embracement takes place collectively, between teams/services and users/population and aims to build social-affective networks, based on trust, able to humanize and value both their users and workers and managers, promoting autonomy and production of health.

Faced with all these confrontations identified in the daily lives of homosexuals, there is a clear search for solutions and quality of life. In this search, they perform self-care, which goes through the practice of physical activities, listen to music, watch serials and programs, maintain a circle of friendships, take care of food and aesthetics and maintain practices of religiosity and spirituality. Friends are considered the first support of the homoaffective, especially when they reveal their sexuality, since it is usually devoid of prejudice and discrimination and guarantees trust and inclusion, which are often not found in the family environment[19].

In this sense, it is necessary to infer the need for a change in the existing paradigms in the theoretical and organizational context of care relations, in the context of the production of physical and mental health care of LGBTQI+ people[11]. The importance of the Family Health Strategy teams, which are the door of preferential access to the Health Care Network, is emphasized. The team needs to be prepared to consider the person in his uniqueness, as well as the social aspects that imply him. Thus, it is necessary to develop comprehensive care, through the planning of public actions for health protection, prevention and control of risk and diseases and health promotion, allowing minimizing inequalities/inequities, in order to avoid social exclusion of groups that may suffer stigmatization or discrimination[20].

In addition to humanizing care, young homosexuals signaled the importance of developing health actions and interventions, such as lectures, support groups, professionalization and continuing education, aimed at health team professionals. They highlighted that health services must know public health policies and put them into practice to improve the quality of care. These requests share with a study[21] that indicates that, in order to qualify health, it is necessary to know what are the fragilities

of the services, to create measurement tools capable of evaluating attitudes and actions carried out by health professionals and develop action plans that promote improvements in care for sexual minorities.

The Ministry of Health[22] continuously seeks to qualify the services and the Unified Health System (UHS) throughout the country to meet its principles and guidelines. The National Comprehensive Health Policy-LGBT inserts the need to improve access to this population, through the training of workers, the structuring of health services and the implementation of practices that address the specific needs of LGBTQI+ people, as well as consider the existence of these people.

Finally, an important limitation of the study was the impossibility of giving voice to the other young homoaffective and not only those who accessed the University.

As a contribution, the study produced knowledge bringing new elements for the understanding and analysis of mental health care to the young homoaffective, especially on their demands facing the need to access the health services of UHS.

Final considerations

The confrontations experienced by young people as a result of their homoaffectivity can interfere with their mental health, which requires care. They are vulnerable in the individual, social and programmatic dimensions and, in this context, physical, verbal and/or psychological violence, integrated with prejudice and oppression of society, imply in developing a collective and qualified work of the Family Health teams. This reinforces that the search for more information is a requirement of the whole society, besides the permanent professional qualification.

There are health impairments in lesbian women and gay men. When one thinks about the health of the male homosexual population, one soon refers to sexual health, awareness about STI, disease prevention and strategies to reduce its transmission. On the other hand, the homoaffective population is neglected, when observing that little is discussed about safe female homoerotic practices, prevention and harm reduction.

Self-care stands out in the process of health production of the studied group, through self-directed actions that contribute to the quality of life. However, in equal measure, the reports on self-harm, search for excessive medicalization, alcohol and other drugs also gained prominence. Healthy self-care should be stimulated by health professionals to assist users in the most humanized and accessible way possible, creating bonds strong enough to stimulate positive health actions, repudiate insufficient self-care and/or harmful to the individual. For this, health services, as well as educational institutions, need to be prepared to address and discuss sexual diversity, in addition to stimulating, implementing and disseminating public health policies in this direction.

In addition to public and private bodies, the importance of social movements, responsible for struggles in the search for rights, is emphasized. If, at present, prejudice and homophobia are considered crime, this is largely due to those who have experienced situations and who have spoken so that others do not suffer prejudice and violence due to their sexual orientation.

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Received: June 4, 2021

Approved: September 5, 2022

Published: October 10, 2022