



Review

Queer and Disabled: Exploring the Experiences of People Who Identify as LGBT and Live with Disabilities

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Abstract: As a minority within a minority, individuals who have a disability and identify as LGBT are at the intersection of multiple stigmatised identities. This brings with it unique challenges, including the possibility of oppression and rejection by both the LGBT and disability communities, which can impact on identity and wider life experiences. While previous reviews have explored issues relating to intersectionality, multiple oppression, identity, acceptance, and sexuality, an overview of the impact on wider life experiences is missing. This narrative review presents empirical findings published since 2000 about the wider everyday experiences relating to attitudes and discrimination, education, employment, finances, health and well-being, support, and intimate relationships among people who identify as LGBT and have a disability.

Keywords: LGBTQIA+; LGBT; disability; health; well-being; intersectionality; minority; discrimination

1. Introduction

The current article provides a narrative review of empirical findings published since 2000 relating to everyday experiences, including attitudes and discrimination, education, employment and finances, health and well-being, support, and intimate relationships of LGBT people with disabilities (LGBTpwD). To give context, the following provides a brief overview of experiences and challenges relating to intersectionality and multiple stigmatisation, acceptance among LGBT and disability communities, as well as self-acceptance and identity.

Society and culture tend to be structured around normative social identities that are heterosexual and able-bodied [1,2]. It has been proposed that identities which do not conform with the normative sexual, gender, and able-bodied identities [3] are perceived as deviant and spoiled identities [4]. As such, those who identify as lesbian, gay, bisexual, or queer, as well as those who are transgender and individuals with disabilities, are seen to belong to stigmatized minority outgroups [2].

1.1. LGBT

The wider LGBTQIA+ community encompasses people who identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other non-normative sexual and gender identities. We define queer as not heterosexual, in agreement with Dilley [5]. Approximately 3.3% of adults in the United States (US) aged 18 and over identify as gay or lesbian, 4.4% as bisexual, and 0.6% as transgender [6]. These proportions are lower in the United Kingdom (UK) where 1.54% of residents aged 16 and over in England and Wales identify as gay or lesbian, 1.28% as bisexual, and fewer than 1% as pansexual, asexual, queer, or other. This equates to 1.5 million people (3.2%) of the population who identify as LGB+ [7], while 0.54%, or approximately 262,000 people, do not identify as cisgender [7,8]. The inclusion of people who identify as intersex, asexual, or pansexual in the wider LGBTQIA+ community is somewhat more recent compared to those who



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identify as lesbian, gay, or bisexual. A wider body of literature therefore exists for the latter groups, spanning back to the 1970s [9–12].

Although this review focuses on the experiences of people who identify as LGBT, articles which included different configurations of subgroups (e.g., LGBTI) within the wider LGBTQIA+ community were also reviewed.

1.2. Disabilities

The United Nations Convention on the Rights of Persons with Disabilities defines disability as any “long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” [13]. As such, disability encompasses a wide range of very different conditions, which may constitute communities within communities. For instance, Mitchell [14] suggests that the deaf community may exist as a minority within the disability community, having its own minority language, history, and social structure, and separate struggles in aspects related to communication and sexuality. While some of these conditions are invisible, others, such as physical impairments, which require a wheelchair, or visual impairments, which may require the help of guide dogs or canes, are more visible.

1.3. Disability and LGBT Rights across Different Contexts

The legal and social circumstances of people with disabilities and those who identify as LGBT vary across different contexts. People who identify as LGBT differ from heterosexual and cisgender norms. As the ‘other’, they have been stigmatised and exposed to prejudice, violence, and discrimination in areas like housing and accommodation, employment, and education [15,16]. During the past decades, the LGBT community has been gaining rights and forms of legal protection to overcome discrimination and inequality [17]. Reporting by the International Lesbian, Gay, Bisexual, Trans and Intersex Association showed the considerable differences in legal protections for people engaging in same-sex relations across the world [18,19]. As of 2020, private consensual same-sex relations were still considered a criminal offence in 69 UN member countries, in 6 of which it was punishable by death and in a further 5 the death penalty was a possible punishment [19]. Even in contexts where legislation has been introduced, LGBT people continue to experience discrimination and hostility [17,20,21]. For instance, the 2010 Equality Act in the UK created a safe space for LGBT people to live without discrimination [22]. Indeed, time-series data from the UK shows that attitudes towards the LGBT community have improved [23], while more recently attitudes towards transgender people have remained relatively stable and positive [24]. However, conversion therapy which seeks to change a person’s sexual orientation or gender identity, remains legal in the UK (although the UK government is in the process of introducing a ban) and around 2% of LGBT people have undergone, and a further 5% have been offered, conversion therapy [25]. Overall, there remains substantial variation across different contexts, which may be associated with the protective legislation in place [26]. While average social acceptance of LGBTI people has increased across the globe since the 1980s, improvements in social acceptance were found in 56 of 175 countries, with no change in 62 and a decline in 57 countries [27]. Partly constrained by the availability of research and partly by the language skills of the researchers working on this study, the literature reviewed below largely relates to the English-speaking world, including research from the UK, US, and Australia. While research from other countries was not actively excluded, searches were restricted to articles in English, meaning that research from other countries which was not published in English was not identified in the searches. There are differences in the extent of legal protection, access to and provision of healthcare, and attitudes which can impact on experiences even in countries which share a language and many cultural aspects. For instance, while the UK, Australia, and US have all implemented laws which make it illegal to discriminate against someone because of their disability, gender, or sexual orientation, the protection afforded by sexual orientation laws in the US are less broad than those in Australia and the UK [19]. There are further differences in access

to healthcare. In the UK, the National Health Service (NHS) provides free at point-of-care healthcare. A prescription charge of GBP 9.65 is payable on all NHS prescriptions unless exempt. In contrast, healthcare in the US is largely private, requiring patients to pay for treatment. As a result, around 65% of the US population have private health insurance [28]. Government-funded health insurance programmes (Medicare and Medicaid) are available for senior citizens, people with disabilities who have received federal disability payments for at least two years, have end-stage renal disease or amyotrophic lateral sclerosis, and some people on low incomes. While this may result in some differences in outcomes, these are likely to be minimal compared to contexts where same-sex relations are illegal, and particularly those where it is punishable by death. However, LGBT research in these contexts is perhaps unsurprisingly limited. Systematic reviews found heightened levels of poor mental health including depression and suicidal ideation among LGBT people of Arab heritage [29] and in South Asia [30], although the prevalence of depression and anxiety were found to be slightly higher among LGBT individuals in Kenya, where same-sex activities are illegal, compared to South Africa, where legal protections are in place [31]. The prevalence of drug and alcohol dependence and suicide attempts were relatively similar. This points to the need for more research into the experiences of LGBT adults with disabilities across the world beyond the English-speaking context.

1.4. A Minority within a Minority

The disability and LGBT communities individually occupy marginalised positions in wider society [2,32]. Thus, being associated with either community carries its own stigma [33]. However, many people pertain to more than one minority group owing to characteristics related to their gender, race/ethnicity, sexual orientation, or even type of disability [34,35]. Individuals who have a disability and identify as LGBT then constitute a minority within a minority [36,37]. Santinele Martino [38] reviews experiences of isolation, marginalisation, and oppression among people who are queer and have a disability under a lens of intersectionality. The author explores the impact of intersectionality on sexuality, intimate relationships, sexual exploration, and acceptance by both the queer and disability communities, noting that there is a lack of empirical research on the everyday experiences and challenges of this minority within a minority.

1.5. Intersectionality and Multiple Stigmatisation

Intersectionality relates to the complex experience of belonging to multiple identities and social groups [39,40]. Intersectionality has its roots in Black feminism [41] and demonstrates how overlapping axes of oppression relating to gender, sexual orientation, race, religion, national origin, and class have an effect on people who belong to more than one minority community [42–44]. According to Collins and Bilge [45], it is of great importance to not only see intersectionality regarding the effect that multiple identities have on one's self, but to explore the impact of multiple identities on power imbalances and inequalities. Being at the intersection of multiple stigmatised identities not only reveals the impossibility of being what is normatively considered 'normal' [46], it also brings about unique challenges [32,47,48] and results in layered oppression [49,50]. LGBTPWd are affected by multiple systems of inequality, including ableism, homophobia, heterosexism, classism, racism, and ageism [49,51]. For instance, lesbian women with disability may experience negative attitudes towards lesbians and disabilities [50], resulting in multiple stigmatisation and oppression [52]. LGBTPWd must contend with ableist [32,53,54] and heteronormative and cisnormative public perceptions, which have either denied or restricted access to their sexual identities [55,56]. Therefore, it is important to understand the experiences of LGBTPWd under an intersectionality-focused lens [49,51].

In addition to multiple oppression, a further challenge relates to negotiating one's position in both community and society [14], as highlighted by a student with disabilities and identifying as LGBT: "It can be really marginalizing to identify in an already marginalized population—to further be kind of pushed out of—that you are not really a part of

that, and you're not really a part of this population." [57]. As a minority within the wider LGBT and disability communities, adults with disabilities who are LGBT may not feel like they fit into either group or feel closer to one than the other group [58]. Indeed, some of Shakespeare's participants reported experiencing homophobia among the disability community and disablism in the LGBT community [58], while Zakarewsky [9] suggests that individuals who are deaf and identify as LGBT face a unique struggle as an 'invisible' minority somewhere between the LGBT and disability communities.

1.6. Acceptance of Disabilities among LGBT Communities

Shared experiences of social rejection may make LGBT people feel connected with individuals with similar backgrounds and experiences [59]. As a result, the LGBT community may show a higher level of connection and acceptance [60]. Nonetheless, very little empirical research has explored attitudes towards and the extent to which people with disabilities are accepted among the LGBT communities. There is evidence that disability is more prevalent among LGB men and women [61]. At the same time, LGB people with disabilities tend to be younger than their heterosexual counterparts [61]. Prevalence rates vary from 35% [62] to 16.8% [25] among LGBT samples in the UK. In comparison, the most recent census data showed that 17.8% of adults in England and Wales reported having a disability, down from 19.5% in 2011 [63]. Elsewhere, prevalence rates of 22.7% have been reported for Australian LGBT respondents [64] and 39% for US transgender respondents, compared to 15% in the general US population (although only 28% of transgender respondents self-identified as having a disability) [65].

A US survey of sexual minority women showed that those with disabilities were less likely to feel connected to the community of sexual minority women than those without disabilities (19% vs. 31%), although similar proportions felt very connected to the wider LGBT community (15% vs. 16%) [66]. A 2017 survey of 5375 LGBT people in England, Scotland, and Wales commissioned by the LGBTQIA+ charity Stonewall found that 26% of those whose activities were limited a lot and 7% of those whose activities were limited a little by disability had experienced poor treatment or discrimination in the LGBT community [67]. Moreover, participants with disabilities described instances of rudeness and being laughed at during Pride events or being denied access to venues due to their disability, while others acknowledge discrimination and the exclusion of members who are trans and/or have additional minority characteristics such as ethnicity or disability among the LGBT community [67]. Similarly, while a gay man with disabilities in a study by Blanchett [68] felt accepted by wider society as a person with disabilities and a sexual being, he did not feel accepted as a gay man by the gay community. In addition to issues relating to the accessibility of LGBT events and venues, acceptance of people with disabilities may be hindered by unhelpful perceptions of disability shared by able-bodied members of the LGBT community. For instance, Jowett and Peel [53] found that those with conditions other than HIV/AIDS or breast cancer felt invisible and excluded from the LGBT community, suggesting that there may be greater acceptance of conditions which are associated with a community. Furthermore, societal perspectives that de-sexualize people with disabilities [69,70] may make it difficult to be accepted into a community based around an inherently sexual identity. Several authors have also highlighted the impact of the idealisation of the physically fit and youthful gay male body on acceptance of men who do not comply with these ideals because they have physical disabilities [2,52,53,58,71]. Although body ideals may be less problematic among the lesbian community, some have described ableist attitudes here too, and pride in 'lesbian strength' may unintentionally exclude women with disabilities [58]. Thus, terminology used to liberate and empower some identities can backhandedly exclude and diminish other identities [1]. In contrast, others have described the LGBT community as a whole, or subgroups within it, as being more accepting and inclusive of difference and disability than society at large due to their own experiences of stigmatisation [53,57].

1.7. Acceptance of LGBT amongst the Disability Community

In addition to experiencing negative attitudes and discrimination due to their disability and sexuality or gender identity within their family, their religious or ethnic communities, and wider society [72], there is some, albeit limited, evidence that people who identify as LGBT may experience rejection among the disability community [73]. For instance, a report on homophobia and discrimination across the European Union describes how a Lithuanian NGO for people with disabilities “refused to rent office space to the Lithuanian Gay League (LGL), on the grounds that they did not want LGBT persons on their premises” [26]. Additionally, LGBT adults with chronic health conditions reported concerns about the heteronormativity and homophobia of support groups for their specific conditions [53]. In some cases, this was attributed to the older age profile of the specific conditions. Overall, however, empirical explorations of attitudes towards LGBT people among the disability community remain limited.

1.8. Self-Acceptance and Identity

Despite the aforementioned challenges, research also highlights the resilience of people with disabilities [74]. Self-acceptance and developing a positive identity may be important factors impacting on resilience and well-being. Accepting a visual impairment, for instance, has been associated with lower levels of depression and better well-being [75], while developing a positive disability identity has been associated with greater life satisfaction [76], disability pride, a sense of purpose [77], and a greater sense of belonging [78], which in itself has been associated with better physical health and mood mediated by self-esteem [78].

Similarly, self-acceptance has been associated with better mental health outcomes among LGBT adults. For instance, lower self-acceptance of sexual orientation has been associated with poorer mental health outcomes including distress, depression, poorer psychological well-being, and higher levels of minority stressors, including lack of acceptance by family and friends, disclosure of one’s sexual orientation to others, and internalising heteronormative beliefs [79]. Among transgender people, high self-acceptance was associated with significantly lower odds of depression (OR: 0.04, CI: 0.01, 0.25) relative to low self-acceptance. While the same was true for LGB people, the difference was less stark (OR: 0.53, CI: 0.36, 0.79) [80].

Qualitative research with 13 LGBTQIA+ participants with disabilities found that self-acceptance, together with advocacy, social support, and a plea for recognition of humanity, were found to increase the resilience of this group [32]. The participants reported that although they could not change the way they were perceived by the outside world, by accepting themselves they were able to deal better with ableism and homophobia, despite the stress and anxiety it caused them.

Several models of LGBT [81] and disability identity development [82–84] have been established, which tend to involve a gradual acceptance of the identity culminating in ‘coming out’ to others. The existing research suggests that developing LGBT and disability identities share some common experiences such as ‘coming out’ and ‘passing’. ‘Passing’ or ‘fitting in’ relates to social mobility and refers to an attempt to become a member of a (higher status) majority group by concealing the stigmatised characteristic, and adopting the negative attitudes of the majority group [85,86]. Whitney [46] conducted structured interviews with five US women aged 25–58 who self-identified as queer (genderqueer, transgender, dyke, and/or bisexual) and disabled (arthritis, PTSD, social anxiety, cancer survivor, osteoporosis, progressive hearing loss, chronic pain, and/or clinical depression). These showed that extant models of both LGBT [81] and disability identities [83] could be applied to their context. Participants described how their realisation of their being different due to their sexual orientation/gender identity and disability often occurred long before coming out as LGBT or disabled, similar to Eliason’s ‘pre-identity stage’. This was followed by a growing awareness of their LGBT and disabilities identities, a phase termed ‘emerging identities’ by Eliason. Identities were further shaped (‘re-evaluation/evolution of identities’) by experiences of oppression (‘experiences and recognition of oppression’) [81].

A growing awareness of oppression and difference marks the first stage ('coming to feel we belong') of Gill's model of disability identity development [83]. Meeting other people with disabilities/who are LGBT and learning about one's own disability prompted a sense of community and better understanding of what constitutes a disability, particularly for those with invisible disabilities such as social anxiety ('coming home'), culminating in acceptance of one's identity ('coming together') and, ultimately, coming out to others [46]. This fluid and often circular process of disability identity development via awareness of oppression and finding a home within a disability community is mirrored by some of Shakespeare's 22 LGB participants with disabilities [58]. For some, learning about and learning to accept one identity also engendered growth, awareness, and acceptance in their other identity [46,58]. Ryan Miller conducted interviews with 25 LGBTQ college students with a range of disabilities (predominantly relating to mental health). These students constructed their identities as (1) *intersectional*, and as such inseparable; (2) *interactive*, with one reinforcing the other positively or negatively; (3) *overlapping*, in terms of the prevalence of conditions such as depression or anxiety among the LGBTQIA+ community and experiences of oppression resulting in greater empathy; (4) *parallel*, whereby students drew analogies between their identities relating to experiences such as 'coming out'; and (5) *oppositional*, whereby they ranked or rejected their identities and modified behaviours to better fit in with one identity [57]. The students used multiple perspectives to navigate their contexts, deal with experiences of multiple stigma and oppression, and find community. Many of Miller's participants reported a sequential process, usually developing their LGBTQ before their disability identity, but there is conflicting evidence relating to the extent to which people embrace these two identities. While Whitney [46] found that some of her female participants felt more positive about their queer than their disability identity, the reverse was true for Beese and Tasker's gay, deaf participants [48].

There may be several reasons for this. For one, public attitudes may be more positive towards the lesbian, gay, and bisexual community than the disability community [46]. This may be due to greater success by the LGBT movement to reframe attitudes and perceptions. While the LGBT community is built around shared activities and lifestyles, Shakespeare [58] proposes that rather than a disability community, it may be more apt to talk about the disability movement, with very few opportunities to engage in shared cultural activities. Furthermore, it has been proposed that stereotypes can be internalised and shared by members of a target group at the implicit level (e.g., women and gender stereotypes) [87]. There is evidence that attitudes and perceptions differ for different types of disabilities. For instance, in Great Britain attitudes have been found to be more positive towards people with physical and sensory (hearing, visual) impairments than towards people with mental health difficulties such as depression or schizophrenia [88,89]. Similarly, disability tends to be associated with being in a wheelchair or visual impairment [77,88] and, although there is some variation, to a lesser extent with conditions such as severe disfigurement, HIV/AIDS, severe depression, and learning difficulties [77,88]. Whether a condition, such as depression, is perceived as a disability may impact on the extent to which people believe that they have a disability and self-identify as having a disability. There is also evidence that people may not self-identify as disabled due to the negative connotations associated with the term, but they do identify as having their specific condition [77]. This may explain why Whitney's participants [46], who had conditions including PTSD, social anxiety, and clinical depression, felt more positive about their queer identities. Moreover, Shakespeare [58] found that some of his participants felt closer to the identity they had developed first. This would have implications on identity development among those with congenital versus acquired disabilities; however, the claim has not been explored empirically. Due to the stigma associated with LGBT and disability identities, some people may choose to conceal and not disclose their LGBT [50,52,55,57] and/or disability identities [50,86] where the disability is not visible.

2. Methods

This article provides a narrative review of the extant literature on the everyday experiences of adults who identify as LGBTQIA+ and have a disability such as a sensory or physical impairment. To obtain access to a wide range of relevant articles, search guidelines for scoping reviews were adapted for this review. A literature search was performed on 7 June 2022 in Ovid (Embase, Journals@Ovid, MEDLINE, PsycInfo, Social Policy and Practice) databases using the following search string:

sensory impair * OR physical impair * OR sensory disab * OR physical disab * OR vis * impair * OR hearing impair * OR mobility impair * OR impair * mobility OR disab * OR blind * OR sight loss OR deaf * OR hearing loss

AND

gay * OR lesbian * OR homosexual * OR queer * OR transsexual * OR transgender OR bisexual *

While no date restrictions were applied to the search, articles published prior to 2000 were excluded from the review due to legislative changes in many contexts, therefore focusing on more recent findings in each life domain. The search was restricted to articles in English only. The initial search yielded a total of 276 articles. Three researchers (AG, TK, NH) reviewed the abstracts and full texts. At both stages, each article was reviewed by one researcher only. After removing duplicates, the titles and abstracts of a total of 178 articles were reviewed and assessed against the eligibility criteria. Articles were included in the review if they reported empirical findings relating to everyday experiences including those relating to health and well-being, health service use, employment, education and finances, attitudes and discrimination, support and intimate relationships of adults who identify as LGBTQIA+ and had a disability. Articles were excluded if they (1) did not report empirical findings, (2) did not relate to the target population of interest, (3) were published before 2000, (4) were not available in English, and/or (5) the full text was not available. Articles were also excluded if they reported findings for people with intellectual disabilities only. The initial objective of this review was to explore the experiences of LGBT people with visual impairment; however, an initial search of the literature did not identify any research on the experiences of this group and the scope of the review was, therefore, expanded to other physical impairments. Physical impairments tend to be more visible disabilities and more difficult to conceal; in contrast, it may be easier for people with some types of intellectual disabilities to pass as non-disabled. Articles which report empirical findings relating to samples with intellectual disabilities only were, therefore, excluded from the review. As noted, disability encompasses a wide range of conditions which may impact differentially on these experiences. A body of research has focused on LGBT adults with intellectual and learning difficulties [73,90–92]. Although the current review focuses on physical impairments as the more visible disabilities, it is not always possible to disaggregate findings where samples include people with different types of disabilities. In addition, a search of the grey literature was conducted which included research reports produced for government and charities.

3. Attitudes and Discrimination

Despite the introduction of legislation, such as the Disability Discrimination Act in 1995 and the Equality Act 2010 in the UK, people with disabilities [77,93] and those who identify as LGBT [25,65] continue to experience overt and covert prejudice, discrimination, and social exclusion. For people with disabilities, this may include being ignored, treated like a nuisance, talked to in a patronising way, stared at, called names, or physically attacked; not being believed that they have a disability; people not understanding their needs, refusing to make reasonable adjustments, incorrectly assuming that they do not work because of their disability, expecting less of them, being awkward around them, or acting in an aggressive or hostile manner [94]. Attitudes towards disability may be shaped by media portrayals of people with disabilities, direct or indirect personal experiences of disabilities, family [77], and/or underlying models of disability, which construe disability as a medical

condition to be treated and cured (medical model) [77], caused by environmental and attitudinal rather than personal barriers (social model) [77,95,96], or a personal tragedy to be overcome (charity model) [77,97]. Associations of disabilities with disease may lead to pressures to achieve normalization through medical interventions and therapies, which can be more dangerous than beneficial [4] and trigger evolved responses such as disgust, anxiety, and avoidance [98].

As indicated in Section 1.3, despite improvements, attitudes towards people who identify as LGBT, and legislation to protect them, vary substantially across different contexts [26]. For instance, the Eurobarometer survey shows that attitudes tend to be substantially more positive in Nordic and Western European countries such as Sweden, Denmark, and the Netherlands than Eastern European countries such as Romania, Bulgaria, and Latvia [26].

Experiences of Discrimination

The 2012 Private Lives 2 survey, which explored health and well-being among a sample of 3853 LGBTI Australians, found that respondents were more likely to have experienced harassment or violence in the past year if they had a disability (46% vs. 33% without disability). This included verbal abuse (32% vs. 24%), threatening emails or graffiti (11% vs. 5%), harassment (21% vs. 14%), and threatened or actual physical assault such as being punched, kicked, or beaten (13% vs. 8%) [64]. Similarly, a survey of US sexual minority women found a higher prevalence of discrimination among those with disabilities ($n = 52$) than those without disabilities ($n = 74$), including being statistically significantly ($p < 0.01$) more likely to be called names or insulted (49% vs. 22%) and have people act as if they were better than them (73% vs. 54%) [66].

A similar pattern was found among the transgender community. The 2015 US Transgender Survey showed that compared to all respondents, transgender adults with disabilities were more likely to have experienced discrimination (i.e., unequal treatment or service, verbal harassment, and/or physical attacks) (69% vs. 58%), including in retail stores, restaurants, hotels or theatres (39% vs. 31%), public assistance or government benefits offices (21% vs. 17%), courts (19% vs. 13%), and social security offices (16% vs. 11%). Additionally, respondents with disabilities were more likely to have experienced sexual assault (61% vs. 47%) and police mistreatment (68% vs. 58%) [65]. Perhaps unsurprisingly then, 70% felt uncomfortable asking the police for help compared to 57% of all respondents.

The findings show that, compared to LGBT adults without disabilities, LGBTPWd are at increased risk of negative attitudes and discrimination across a range of contexts, including public spaces, where legislation prohibits discrimination based on disability, sexual orientation, and gender identity. This suggests that public and private organisations may benefit from training to ensure they are aware and implement legislation correctly. Almost half of LGBTPWd in Australia and over two thirds of US transgender people with disabilities had experienced some form of discrimination, with clear implications for the mental health of these individuals. This also highlights the gap between increasingly positive attitudes towards LGBT and disability communities and the everyday experiences of LGBTPWd. Exploring attitudes specifically towards LGBTPWd may be required to understand the motivation behind instances of prejudice and discrimination. The prevalence of sexual assault and police mistreatment among US transgender adults with disabilities is of concern, as is the lack of trust in law enforcement bodies which may prevent LGBTPWd from reporting harassment and assault. One reason for the disproportionate impact of discrimination on LGBTPWd may be a lack of representation. As indicated earlier, attitudes are informed by media representations. Although overall representation of LGBTQ characters on TV has improved, the prevalence of characters with disabilities among them (4.5%) remains well below the proportions found in the LGBT community [99]. The lack of LGBT characters with disabilities may result in attitudes being formed around misconceptions and stereotypes.

4. Education, Employment, and Finances

There is evidence of lower educational attainment and employment rates among people with disabilities [100]. In the context of education, inadequate support and non-inclusive teaching may impact on educational attainment. For instance, sex education for students with disabilities is largely missing, as is access to diverse materials which go beyond heteronormative information about sex and relationships [68], leaving them poorly prepared for intimate relationships. Research from the UK suggests that Special Educational Needs and Disabilities (SEND) are often identified late and/or inadequately supported, particularly in large classes, while learning is improved among those who are referred to a Pupil Referral Unit (PRU) and, thus, benefit from smaller class sizes and support from educational specialists [101]. In the context of visual impairment, there is evidence of education level impacting on employment outcomes [102,103]. People with disabilities who leave school early may have difficulties in applying for and gaining jobs due to low literacy, inaccessible application forms, and a lack of support with writing curriculum vitae, applications, and cover letters [101]. This is of concern, because, in addition to providing financial stability, employment has been associated with a range of positives, including self-worth, reducing social isolation, and (financial) independence among people with disabilities [72]. Negative employer attitudes and prejudice, including incorrect assumptions relating to their abilities, concerns about time off work, and a reluctance to make workplace adaptations, have been identified as the main barriers to employment among people with disabilities [72].

Furthermore, there is evidence of heteronormativity and discrimination in schools, which can leave LGBT students unprepared for adult life and workplaces. In the context of education, discussions around sexual orientation and gender identity remain largely absent and, where they take place, insufficient to prepare LGBT people for adult life. Although, younger people generally reported better experiences, suggesting that education and attitudes are improving [25]. In addition, around one in five current students had been 'outed' without their permission and/or verbally harassed or insulted. These incidents were largely not being reported mainly because the incident was not considered serious enough, happened all the time, or students felt that nothing would change [25]. As such, the school environment may exacerbate the stress LGBT students experience relating to stigmatisation, lack of acceptance, and isolation elsewhere [68]. Similarly, at least one in five LGBT adults have had a negative experience in their workplace due to being LGBT in the past year, including being 'outed' without their permission (11%), inappropriate comments or behaviours (11%), and/or verbal harassment or insults (9%) [25].

4.1. Education

The Australian Private Lives 2 survey found that educational attainment was lower among LGBTI respondents with disabilities: 41% had completed year 12 compared to 56% of respondents without disabilities [64]. However, although US sexual minority women with disabilities were slightly more likely to have completed fewer years of college than those without disabilities (42% vs. 31% less than 4-year college degree), the differences in educational attainment were not statistically significant ($p = 0.109$).

Qualitative research carried out by the UK LGBTQIA+ charity Stonewall provides an insight into the impact of being LGBT and having disabilities on education through the example of a young woman who, despite her visual impairment, preferred to sit at the back of the class because of anti-LGBT bullying which had left her feeling anxious and ashamed [101]. Being unable to see the board, she could not keep up in class and left with few qualifications. Others reported leaving education, training, or work because of their health condition or not getting the results they needed to continue education. Additionally, a qualitative study with eight LGBTQ students with disabilities examined problems relating to discrimination, the intersection of disability and queerness in schools, and participation in extracurricular activities [104]. Although only three of the eight students had experienced homophobic bullying, all believed that homophobia existed in schools. Furthermore, they

reported that their disability made them a target for bullying and peer aggression, and fearful to stand up for themselves.

Among people who were 'out' or perceived as transgender at primary school, having a disability was associated with a greater prevalence of negative experiences, including being verbally harassed, attacked, or expelled, compared to those who did not have disabilities (82% vs. 77%) [65]. These negative experiences may result in a reluctance to disclose an identity in the context of school. A national LGBT survey found that only 10.3% had not disclosed their LGBT identity to any other students, but 52.8% had not disclosed their LGBT identity to any teaching staff and 61.2% not to any non-teaching staff [25]. Miller suggests that LGBTQ students with disabilities often make decisions on disclosing their identities to other students and school staff based on previous experiences to avoid microaggressions [105].

4.2. Employment

The 2012 Private Lives 2 survey found higher unemployment rates (18.7% vs. 4.3%) and lower full-time employment rates (31% vs. 52.3%) among LGBTI Australians with compared to without disabilities [64]. Similarly, US sexual minority women with disabilities were statistically significantly less likely to be in full-time work (18% vs. 47%) and more likely to be disabled/unable to work (28% vs. 5%) than those without disabilities [66]. Research with a larger sample of US sexual minority women replicated statistically significant differences in full-time employment (21% vs. 52%) and being disabled/unable to work (37% vs. 5%) [106].

The 2015 US Transgender Survey showed that transgender adults with disabilities were also more likely to be unemployed (24%) than all transgender respondents (15%) and the US general population (5%) [65]. They were further more likely than all respondents to have lost a job (59% vs. 53%), to have experienced employment discrimination in the past year (being fired, not hired, denied a promotion) (75% vs. 67%), to have taken steps to avoid workplace discrimination (81% vs. 77%), to stay in a job for fear of discrimination elsewhere (30% vs. 26%), or to have quit a job to avoid discrimination (21% vs. 15%) [65]. Gender identity was the most common reason given for not being hired (39%), denied a promotion (49%), and fired (43%), while disability was cited less often (7%, 6% and 15%, respectively) [65].

4.3. Finances

Eliason, Martinson [66] found that sexual minority women with disabilities ($n = 52$) had statistically significantly ($p < 0.01$) lower mean household income (USD 42,545 vs. USD 77,709) than those without disabilities ($n = 74$). Additionally, LGBTI Australians with disabilities had lower income than those without disabilities (52% vs. 30% earned less than AUD 600 per week) [64].

Statistically significant differences in annual household income were also found among US transgender adults. Annual household income was significantly higher among those with no disability (USD 61,033) than those with physical (USD 46,112), socioemotional (USD 39,856), and multiple disabilities (USD 34,375) [107]. US transgender adults with disabilities were also more likely to have a household income of between USD 1 and USD 9999 per year (21% vs. 12% of all respondents and 4% of US general population), live in poverty (45% vs. 29% of all respondents and 12% of US general population), receive support from a public food assistance programme (29% vs. 15% of all respondents), and to have been evicted from their home (8% vs. 5%) [65]. Gender identity was the most common reason given for discrimination, including for being refused access to shelters during periods of homelessness [65]. The 2017 Stonewall survey showed that LGBTPwD in England, Scotland, and Wales were around 2.5 times more likely to have experienced homelessness than those without a disability (28% vs. 11%) [67].

The existing evidence highlights the impact of disability on education, employment, and finances, as well as the emotional impact of perceived and actual experiences of dis-

crimination and bullying in the context of school. Educational and employment outcomes tended to be poorer and employment rates lower among LGBTPwD, with at least one person leaving education due to a combination of homophobic bullying and a lack of support for their disability. This is of concern because of the potential impact of poor educational attainment on employment prospects in later life, which in turn may impact on feelings of social isolation and self-worth, and household income. Smaller class sizes and support from educational specialists may help to overcome difficulties relating to disabilities [101], while better provision of sex education and more inclusive sex-related information may help better prepare students who are LGBT and have a disability [68]. More importantly, integrating inclusive sex education into the curriculum may 'normalise' non-heterosexual orientations and non-cisgender identities and, thus, improve the school experiences of LGBT students with disabilities. In contrast, local laws in several US states prohibit positive discussions of same-sex relationships in schools [19]. For instance, same-sex relationships can only be discussed in the context of sexually transmitted diseases in South Carolina [19]. The co-occurrence of lower income and employment rates among different cross-sectional samples highlights the need for longitudinal research which explores how experiences interact and impact at different stages across the lifespan. For instance, the impact on retired LGBTPwD has not been explored and neither has the impact of ethnicity on employment among LGBTPwD. Lower employment rates among LGBTPwD relative to those without disabilities may not be entirely unexpected because some conditions may prevent and preclude people from working or working full-time, both by necessity or by choice. However, considering the presence of laws protecting people with disabilities from employment discrimination in the UK, US, and Australia, where research was available, employment opportunities should be available for those who want to and can work. Future research will need to explore differences among people with disabilities who are LGBT vs. heterosexual/cisgender to assess the impact of sexual and gender identity on employment and educational outcomes. This may help to identify which employer attitudes need to be targeted to increase employment outcomes among LGBTPwD. Finally, experiences of homelessness and a lack of access to homeless shelters due to one's gender identity requires urgent attention to ensure LGBTPwD are adequately supported when they are at their most vulnerable.

5. Health and Well-Being

Identifying as LGBT has been associated with poorer physical and mental health outcomes [26,32], possibly due to an increased risk of minority stress [108]. The incidence of psychological distress among transgender adults is also high and has been associated with an unsupportive family environment, discrimination in the context of work, physical violence, and sexual abuse [65,109]. Additionally, disabilities such as visual impairment have been associated with poorer mental and physical health outcomes, psychosocial well-being, and sleep quality [110–116].

5.1. Mental and Physical Health Outcomes

There is some indication of poorer physical and mental health outcomes among LGBTPwD. Among middle-aged to older adults with hearing impairment, identifying as LGBTQ was found to be associated with an increased risk of comorbidity, depression/anxiety disorder, lung disease (including asthma, emphysema, chronic bronchitis), and arthritis [117]. Identifying as non-binary was found to increase the risk of being diagnosed with depression or anxiety by 80% among adults with hearing impairment, but there were no differences for any other health conditions [118].

There is also evidence that having a disability is associated with poorer physical and mental health outcomes among LGBT adults. Two survey studies compared a range of physical and mental health indicators in US sexual minority women with and without disabilities. Eliason, Martinson [66] found that those with disabilities ($n = 52$) were statistically significantly ($p < 0.01$) more likely to report poorer health, a range of physical and mental

health conditions, and limitations than those without disabilities ($n = 74$). Participants with disabilities were significantly more likely to have arthritis, asthma, COPD/lung disease, diabetes, PTSD, other anxiety disorders, and drug dependence, but less likely to have high cholesterol than those without disabilities. In addition, they were less likely to feel energetic and more likely to report limitations on moderate activities, climbing stairs, achieving accomplishments, and the kind of work and activities they could do. Disability was further associated with significantly poorer self-reported health (55% rated their health as poor or fair vs. 23% among those without disabilities), physical health (mean PCS score of 32.2 vs. 45.8), and mental health (mean MCS score 42.1 vs. 46.3) [106]. Women with disabilities also had a higher mean BMI (40.6 vs. 34.3) and waist circumference to height ratio (0.71 vs. 0.64) than those without disabilities but they were less likely to drink more than seven alcoholic drinks per week (7% vs. 9%). Encouragingly, women with disabilities experienced similar if not better benefits (increased fruit and vegetable consumption and physical quality of life) than those without disabilities following a group health intervention specifically addressed at increasing healthy lifestyle choices in sexual minority women [106].

Poorer self-reported health and higher BMI were also found among LGBTI respondents with disabilities in the Australian Private Lives 2 survey: 3 in 10 reported very good or excellent health compared to almost 7 in 10 without disabilities, and 1 in 10 reported poor health compared to just under 1 in 100 respondents without disabilities [64]. LGBTI people with disabilities were less likely than respondents without disabilities to fall within a normal BMI range (32% vs. 45%) and more likely to be obese (37% vs. 23%). Furthermore, LGBTI people with disabilities had poorer mental health, as assessed by the mental health subscale of the SF-36 (60 vs. 72), and an increased risk of mental health problems, as assessed by the K10. They were more likely to self-report anxiety and treatment for anxiety (52% vs. 23%) and frequent ('often') episodes of intense anxiety in the past year (27% vs. 10%). Over 4 in 10 reported drug use for non-medical purposes in the past year, nevertheless, this was similar for those with and without disabilities (44% vs. 45%).

In contrast, a 2017 online survey of 5375 LGBT adults in England, Scotland, and Wales [62] found that LGBTPWd were more likely to have experienced some form of addiction (19% vs. 7% of respondents without disabilities), to have felt that life was not worth living at some point in the past year (59% vs. 31% of people without disabilities), and to have self-harmed (28% vs. 11% of people without disabilities and 6% of adults in general). In addition, 8% had attempted to take their own life in the past year.

Poorer mental health was also found among transgender people who self-identified as having a disability in the 2015 US Transgender Survey [65]. Compared to all transgender respondents and the US general population, they were more likely to report having seriously considered suicide in the past year (12% vs. 7% and 0.6%, respectively) and attempted suicide across their lifetime (54% vs. 40% and 4.6%).

5.2. Health Service Use

Considering the potential for poorer physical and mental health outcomes among LGBTPWd, trust in and availability of appropriate health services may be vital. However, research from the US [20], UK [25], EU [26], and Turkey [21] shows that, despite legislation, LGBT people continue to experience discrimination, including in the context of healthcare, impacting on the use of health services. According to the 2017 UK National LGBT survey [25], at least 16% of LGBT people who accessed or tried to access services provided by the NHS had a negative experience due to their sexual orientation, and at least 38% due to their gender identity. Furthermore, when accessing mental health services, 51% of LGBT people mentioned that the wait was too long, 27% felt worried, anxious, or embarrassed about attending these services, and 16% reported that their GP was not supportive. Moreover, 80% of transgender respondents declared that accessing gender clinics was not easy and the wait was too long. Longer waiting times for gender clinic appointments have been found to have a negative impact on mood, suicidal ideation, and quality of life among transgender people who are already at increased risk of depression,

self-harm, and suicidal ideation compared to the general population [119]. In response to these issues, the NHS has adopted the *LGBT+ action plan priorities* [120] to reduce health inequalities and improve access and experience for LGBT people. This involves increasing sexual orientation and gender identity monitoring and providing training to their staff to increase awareness and understanding of LGBT communities. Improving access and treatment experiences may be particularly important for LGBTPWd, who may require health services to manage their disability and comorbid conditions.

5.3. Use of Health Services

The 2012 Australian Private Lives 2 survey showed that LGBTI respondents with disabilities were more likely than those without disabilities to use health services such as their GP (83% vs. 73% had a regular GP; 19% vs. 3% had seen their GP 12 times or more in the last year), counsellors, psychologists or social workers (61.6% vs. 39.9%), and psychiatrists (28.4% vs. 7.4%) [64]. But respondents with disabilities were less likely to have ever had an HIV test (59% vs. 65%), a pap test in the past 2 years (47% vs. 53%, among female respondents), or a mammogram screening (54% vs. 58%, among females aged 50–69).

5.4. Barriers and Facilitators to Health Service Use

One barrier may be cost [109]. For instance, transgender people with disabilities (42%) were more likely to not have seen a health provider when they needed to because of cost compared to 33% of all respondents [65]. Similarly, sexual minority women with disabilities in the US were found to be statistically significantly ($p < 0.01$) more likely than those without disabilities to have public health insurance (54% vs. 20%), which may limit their access to some treatments and health services [66]. Participants with disabilities in the Australian Private Lives 2 survey were also less likely to have private health insurance than those without disabilities (51% vs. 61%) [64].

Hanjorgiris, Rath [52], O'Toole and Brown [121], and Hunt, Matthews [33] discussed the barriers to effective mental health support for gay men and lesbian women with disabilities. This may be particularly important because of the poorer mental health outcomes noted earlier. Additionally, several of Hunt et al.'s participants reported depression associated with their disability which was not always addressed adequately by their counsellor. Barriers included a lack of cultural competence among mental health professionals (i.e., an understanding of the specific reality and needs of these client groups) [52,121], experiences of discrimination and bias by counsellor and/or office staff, as well as accessibility issues relating to facilities, paperwork, assessments, and fee structures [33]. Perceived homophobia and transphobia [25,65,122], negative experiences, and discrimination in health and social care settings may act as additional barriers to wider health service use among LGBTPWd [109].

5.5. Experiences of Health Service Use

A 2008 online survey which included qualitative as well as quantitative questions showed that LGBT adults with chronic health conditions experienced homophobia in the context of their healthcare, including being told by medical professionals and carers in their home about their anti-LGBT views [53]. Similarly, the 2017 Stonewall survey found evidence of continuing discrimination and negative attitudes from healthcare staff in the UK: 34% of LGBTPWd reported inappropriate curiosity from staff, 20% reported unequal treatment by staff, and 15% reported being outed without their consent in front of other staff or patients by healthcare staff [62]. In addition, 8% reported being pressured to access services to change or suppress their sexual orientation and/or gender identity when accessing healthcare services (compared to 5% of all respondents) and 33% reported a lack of understanding of specific lesbian, gay, and bi health needs (compared to 25% among all respondents). There is further evidence of poorer access to and provision of healthcare

services: around a fifth of LGBTPwD had experienced difficulties accessing healthcare (19%) and had avoided treatment for fear of discrimination (20%) because they were LGBT [62].

Findings from the 2015 US Transgender Survey showed that 42% of transgender adults with disabilities had had at least one negative experience with healthcare providers in the past year compared to 30% of transgender adults without disabilities [65]. Secondary analysis of these data showed that the former were statistically significantly more likely to have experienced discrimination when trying to access mental health centres (17.3% vs. 6.2%), rape crisis centres (7.8% vs. 3.3%), domestic violence shelters (9.9% vs. 3.5%), and drug treatment programmes (4.7% vs. 2.0%) [107]. Experiences of discrimination in all places were lowest among those who had physical disabilities and tended to be highest among those who had multiple or learning disabilities. Logistic regressions showed that being older and having a higher income consistently reduced the likelihood of discrimination, while being Latino was associated with a higher likelihood of discrimination in all sites. Additionally, transgender adults with multiple disabilities had between 3.00 (rape crisis centre) and 4.08 (mental health centre) times the odds of experiencing discrimination than those without disabilities. Moreover, transgender adults with disabilities had around twice the odds of experiencing discrimination when trying to access mental health centres (OR: 2.54, CI: 1.77, 3.65) and domestic violence shelters (OR: 1.84, CI: 1.01, 3.36) than those without disabilities, but there were no statistically significant differences for rape crisis centres and drug treatment programmes.

Hunt, Matthews [33] conducted qualitative interviews with 25 lesbian women with disabilities which explored their experiences of counselling. Satisfaction with counselling was mixed and dissatisfaction was associated with prior expectations of counselling not being met. Good counselling skills, ethical and professional behaviour, cultural awareness, and self-awareness all impacted on perceptions of the counsellor's overall effectiveness, while the counsellor's awareness and understanding of sexual orientation, disability, and/or both impacted on the counselling experiences. Although, most participants were flexible about the counsellor's own identities. Participants advocated for themselves by educating counsellors about their disability, screening the counsellor's attitudes towards their sexual orientation prior to making the first appointment and/or changing counsellors. In some cases, counsellors advocated for participants, helping them navigate their wider healthcare. Not all participants felt comfortable disclosing their sexual orientation, particularly where counsellors were known to have strong religious beliefs and a negative reaction was expected.

There may be a reluctance to disclose one's sexual or gender identity to health and social care providers for fear of discrimination [52]. Adults with hearing impairment were found to be significantly more likely to disclose their LGBTQ status to their healthcare provider if they felt accepted as LGBTQ by those close to them, were cisgender men, were older, and the healthcare provided involved patient-centred communication [123]. Disclosing their LGBT status to health and social care professionals may be important to ensure appropriate support can be provided. A UK study which explored the experiences of LGBTQI+ adults with disabilities using self-directed social care support found that participants did not receive support from their personal assistant with LGBTQI+ activities because they had not disclosed their status to their personal assistant (40%), did not feel comfortable receiving help from their personal assistant with this (40%), or the personal assistant had refused to help with this (20%). Over half never or only sometimes disclosed their LGBTQI+ status to their personal assistants and under a third felt comfortable discussing their needs as an LGBTQI+ person [124]. Moreover, sexual orientation and gender identity did not always form part of assessments by the local authority and some participants were concerned that disclosing their status may impact on the care provided to them if the assessor held strict religious views. Indeed, participants described experiences of abuse, discrimination, and being outed to family members without consent, at times resulting from the strict religious views of personal assistants and local authority staff [124]. Due to reliance on support, abusive situations may have been prolonged. Despite these negative

experiences, the use of personal assistants provided LGBTQI+ adults with disabilities with a sense of control over their care, choice, and power [124].

Positive experiences with healthcare professionals among LGBT adults with chronic health conditions were associated with location ('living in a queer area'), privilege (being an affluent, white, male), and seeking out healthcare professionals who were themselves LGBT [53]. In addition, Hunter, Dispenza [32] suggests that rehabilitation professionals can foster self-acceptance, and thus resilience, by supporting and affirming their client's sexuality, gender, and disability identities.

Existing research shows that LGBTPWd are at increased risk of poorer physical and particularly mental health outcomes, including suicidal behaviours, potentially as a result of being at the intersection of these communities. This makes access to and use of health services vitally important. However, the evidence suggests that LGBTPWd continue to experience prejudice and discrimination in the context of health and social care services, despite efforts by national health services to reduce health inequalities. These may involve increasing cultural competence and understanding of sexuality-, gender-, and disability-specific issues among services. This may have a particular impact on older LGBTPWd, who may require more health support than their younger counterparts. Few articles have focused on facilitators of service use and the effectiveness of interventions to improve health outcomes and access to services. The success of a health intervention specifically addressed at sexual minority women among those with and without disabilities is encouraging and suggests that tailored information and programmes may help reduce some of the health inequalities experienced by LGBTPWd. Considering the need for medical support, lower household income among LGBTPWd is a particular issue where healthcare is not free and there is some evidence that it may prevent LGBTPWd from accessing services when they need them. Moreover, the evidence presented here relates to the US, UK, and Australian contexts where being LGBT is not illegal. Urgent research is required to identify how LGBTPWd, in contexts where their sexual orientation or gender identity is illegal, access health services and support for their disabilities and mental health difficulties.

6. Support

Despite the challenges noted in areas such as employment, education, and healthcare, limited research has explored the availability and appropriateness of support for LGBTPWd. While formal support may be sought from health and social care services, charities or support groups, family [72], friends, and the wider LGBT and disability communities [53] are an important source of informal support.

6.1. Formal Support

The previous section has highlighted some of the challenges encountered by LGBTPWd in the context of health and some social care services, including experiences of prejudice and discrimination by healthcare professionals and in-home carers or personal assistants. Additional support may be sought from charities, support groups, or day centres for people with specific disabilities. In addition to advocating for LGBT rights, LGBT charities may provide practical and emotional support, for instance, by helping members apply for gender recognition certificates or dealing with instances of discrimination or harassment [25], while disability charities may provide rehabilitation, emotional support, and information about a health condition. There is concern that service providers do not recognise diversity within the disability community [72]. For instance, qualitative research with 103 people with disabilities across England showed that day centres and voluntary groups were perceived as a 'lifeline', providing both support and social activity [72]. Nevertheless, both were perceived as not being inclusive by lesbian or gay participants. Nonetheless, charities and support groups may only exist for more common health conditions and impairments and the information provided by them may cater to a majority subgroups within it [53]. Yet, in the case of smaller subgroups (i.e., less prevalent sexual identities or disabilities), existing support networks may not be in place and people may be required to

set up their own support groups [53]. Furthermore, information provided by these groups may be heteronormative and, thus, cater for the majority subgroups only [53]. Perceptions of support groups as being heteronormative and hostile towards LGBT people will impact on the extent to which people will feel comfortable to be themselves (come out) and in turn benefit from the group [53]. For instance, the previously mentioned refusal by a Lithuanian disability NGO to rent office space to the Lithuanian Gay League and their reasoning that they did not want LGBT people on their premises [26] will do little to make Lithuanian LGBTPwD comfortable to ask for support.

6.2. Social Support

Evidence has highlighted the importance of social networks in providing informal support where formal mental health support, for instance, is not sought [125]. Indeed, social support, including advocacy and affirmation by individuals, organisations, social media platforms, friends, and family members, was found to increase resilience among LGBTPwD [32]. The availability of social support was contingent on coming out to friends and their wider network [71]. Overall, the notion of ‘coming out’ is routinely considered as a means for individuals to preserve their relationships with family, friends, and strangers [126]. Yet, Hunter, Dispenza [32] found that disclosing a LGBT identity may result in punishment, including “the deliberate removal of financial, familial, and/or social support and resources. . . , with the understanding that doing so would likely harm the participants’ mental and/or physical health” (p. 37). People might, therefore, choose to conceal their identities from parents [55], family [32], carers/co-workers [122], or others who they think will not accept them [55], thus reducing their access to social support. According to Miller [127], LGBTQ students with disabilities used social media platforms to connect with people from the same communities, as they found it easier to manage their online presence and come out online.

Among US sexual minority women, satisfaction with the support received from social networks was lower among those with than without disabilities (29% vs. 40%) [66]. While family can provide an important source of social support for people with disabilities, there may be concerns about being a burden, the impact on relationships, and dependence [72]. Several authors have also noted that, unlike ethnicity, disability, sexual orientation, and gender identity are not necessarily shared by family or their immediate social network, leaving LGBTPwD without role models and a space to share experiences [48,52,53,58,72]. As a result, social groups, specifically those consisting of other people with similar disabilities who are LGBT, may be particularly important not only for identity development as seen earlier, but also to help overcome feelings of difference and social isolation from the wider community and provide a space to feel safe, understood, equal, validated, and empowered [53,58]. For instance, being able to communicate with other gay men by signing allowed deaf gay men to be their authentic selves and promoted open communication [48].

Social identity can provide a sense of belonging and community, as evidenced by one of Jowett and Peel’s participants: “Probably the most support that I get from the LGBT community is a sense of belonging. I identify as being a member of the LGBT community more than I identify with being a member of my chronic illness community.” [53]. However, some of Jowett and Peel’s participants described being abandoned and socially isolated from the LGBT communities as their chronic illness developed [53]. For one participant this was exacerbated by living with their heterosexual family, thus losing all connection with their LGBT community.

Formal and social support can play an important role in the development, self-acceptance, and general well-being of LGBTPwD. Nonetheless, the existing evidence suggests that diversity may not always be recognised in formal support provided to people with disabilities, creating an unwelcoming and potentially hostile environment for LGBTPwD. This may impact on the extent to which LGBTPwD use and benefit from formal support services and, therefore, place greater onus on informal support structures including family, friends, and communities based around an identity. The benefit of being part of

a community of LGBT people with similar disabilities is evident, allowing LGBTPwD to be fully themselves, to feel safe, understood, and empowered. Yet, as indicated, existing support groups or networks may not always be in place for less prevalent sexual identities or disabilities, putting the responsibility on LGBTPwD to set up and run their own groups. Research in the context of visual impairment showed that quantity and quality of social support were associated with mental health and well-being in adults with visual impairment [128–131]. Increasing opportunities for LGBTPwD to meet their peers and acceptance within the LGBT and disability communities as well as wider society may be important to ensure LGBTPwD have access to a wide and diverse support network, particularly where they feel different from their immediate family and friends because of their sexual orientation, gender identity, and/or disability.

7. Intimate Relationships

As highlighted in earlier sections, people with disabilities are often perceived as being asexual [58,69,70]. Indeed Fraley, Mona [71] note the disregard of sexual rights in the initial movement for disability rights. As a result, sexuality, particularly non-normative sexuality, may be suppressed. The literature suggests that this is the case for many young lesbian, gay, or bisexual people with disabilities, who, both for reasons pertaining to age and disability, have had their sexuality ignored or suppressed by parents, teachers, and service providers [68] or refuted as a phase [54]. Fraley, Mona [71] suggest that sexual expression is also impacted by the disability being fetishised and negative beliefs about sexuality, including the belief that people with disabilities are limited in the extent to which they can experience or give sexual pleasure. Where sexual functioning and desire are impacted by disability, this may cause issues in couples [71]. Creativity and experimentation, communication, and obtaining help with sexual expression, i.e., through sexual surrogates or personal assistance services, are proposed as strategies to overcome these.

Disability can also impact on existing relationships and form a barrier to making new ones because of a tendency to see the disability and not the person [72]. Fraley, Mona [71] discussed barriers and strategies to establishing romantic and sexual relationships specifically among LGB people with disabilities. These reflected structural barriers relating to the accessibility of venues/events and communication difficulties (i.e., for those relying on sign language), as well as attitudinal barriers relating to ableism and the focus on physical attractiveness among some LGB subgroups, as discussed in earlier sections. The latter may impact on the confidence and ability of those with disabilities to find partners. The literature further suggests that people with disabilities are perceived as ‘unfit’ sexual partners [132], incapable of having and managing sexual identities [132] or forming and making decisions about sexual relationships and sexual activity [68]. For those who can, dynamic sexual activity is considered too much for their fragility [50]. Such misconceptions can have a negative impact on the sexual self-beliefs of people with disabilities [71,133,134], while negative self-perceptions about one’s body and sexual desirability may impact on the extent to which people with disabilities seek sexual relationships [71]. Romantic partners are found through social networks, at disability or LGB-specific events, or online, while sexual partners are found in bars and on dating sites, with some using sex workers [71]. The latter requires adequate safety measures to be in place.

Despite these challenges, Eliason, Martinson [66] found no statistically significant differences between US sexual minority women with and without disabilities in terms of their relationships or sexuality. Although, sexual minority women with disabilities ($n = 52$) were statistically significantly ($p < 0.01$) more likely to not be living with a partner (16% vs. 7%) and to have a partner who was transgender (10% vs. 0%) than those without disabilities. However, in addition to being less likely to be living with a partner (32% vs. 48%), Eliason, McElroy [106] found that the sexual minority women with disabilities in their sample were also significantly more likely to be single than those without disabilities (61% vs. 50%).

There is evidence that intimate partner violence and sexual violence are more prevalent among women and men with than without disabilities [135,136]. Likewise, transgender people are about 1.7 times more likely to experience intimate partner violence than cisgender people [137]. Research from Great Britain found that 15% of LGBT people with disabilities had experienced domestic abuse in the last year [67]. This is considerably lower than the proportions reported for women with disabilities (33.2%) [135], but it is slightly higher than the proportion of men with disabilities who had experienced lifetime sexual violence (13.9%) [136]. It is also substantially lower than the proportion of US transgender adults with disabilities who had experienced intimate partner violence, including financial, physical, or emotional harm (61% compared to 54% of all transgender respondents) [65]. This is substantially higher than the median lifetime prevalence for physical (37.5%) and sexual intimate partner violence (25%) [137].

Sexuality, sexual expression, and challenges relating to intimate relationships have been relatively well explored elsewhere [38,71]. When it comes to relationships, the evidence shows that unhelpful attitudes and misconceptions impact on the extent to which LGBTPWd are seen and see themselves as desirable partners. LGBTPWd navigate these as well as environmental barriers, such as the accessibility of venues and events and communication difficulties, to find romantic and sexual relationships through social networks, dating sites, and bars. While research has explored barriers and relationship status, it has not focused on relationship satisfaction. It is, therefore, unclear how satisfied LGBTPWd are in their relationships. Of concern is the higher prevalence of domestic and sexual abuse among LGBTPWd, particularly among those who are transgender. This requires urgent attention to identify measures which can be put in place to protect LGBTPWd from intimate violence.

8. Limitations

The LGBT community consists of a wide range of diverse subgroups relating to different sexual and gender identities whose experiences may differ substantially. To account for these differences, future work may need to focus on individual subgroups within the LGBT community, e.g., those who identify as asexual or intersexual. Likewise, there is a great deal of variation among the disability community based on the specific underlying health conditions and impairments. Although the review set out to explore the experiences of people with physical impairments, which tend to be more visible, it was often difficult to restrict findings to this group or disaggregate different types of disability and LGBT subgroups in some articles. Future work could focus on the experiences of people with one specific condition, e.g., hearing impairment. In addition, factors such as the onset and severity of, as well as differences in attitudes towards, individual conditions may also impact on experiences, as has been shown to some extent in this article, and may need to be taken into consideration, particularly in larger samples. This review did not take into consideration membership of other stigmatised groups relating to ethnicity and age, for instance, which may have impacted on experiences. It must be noted that some of the research reviewed here did not specifically focus on the experiences of LGBTPWd and, therefore, did not provide findings for all variables for this subgroup. For instance, the US Transgender Survey only reported findings for subgroups if these were more affected. As such, areas where transgender adults with disabilities did the same or better may be missed, painting an excessively bleak picture of what it is like to be transgender and have a disability. Finally, attitudes and legal protections vary across different countries and, therefore, result in very different experiences and needs for LGBTPWd in these contexts.

9. Conclusions

This narrative review set out to provide an overview of existing empirical findings relating to the everyday experiences of LGBTPWd. While detailed evidence was available for the US, UK, and to some extent Australia, more research is required to explore their experiences in other contexts, particularly those where attitudes are more negative and laws

to protect those with disabilities and non-normative sexual orientations and/or gender identities are missing. Overall, the empirical data showed that LGBTPwD have poorer experiences and/or outcomes across a wide range of life domains, including education, employment, finances, health, and intimate relationships than those without disabilities, despite legislation to protect them from discrimination in place in the US, UK, and Australia. Applying an intersectional lens, this may reflect the complex impact of belonging to multiple stigmatised identities. Future research should explore how these are linked. For instance, longitudinal research could explore how experiences at school impact on employment prospects and household income, and how these impact on health outcomes. Furthermore, LGBTPwD continue to experience higher levels of discrimination and harassment than their non-disabled peers across a wide range of contexts, including public services and in countries where protective legislation has been introduced. This highlights the need to supplement legislation with active efforts to improve attitudes, especially among employers, educators, and healthcare providers, to ensure this minority within a minority is afforded equal access and opportunities. Further research is also required to explore the impact of being LGBT among the disability community. The findings show that there is still some way to go to change attitudes and ensure LGBTPwD are accepted by their respective communities and wider society. It may be particularly pertinent to increase acceptance among the disability and LGBTQIA+ communities, which provide a sense of belonging and social support, thus increasing resilience and self-acceptance. At the same time, research could explore the extent to which older LGBTPwD, or those from minority ethnic communities, or lower classes, are accepted within the LGBTPwD community.

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