12 Not by Convention: Working with People on the Sexual and Gender Continuum

Jeremy A. Wernick, Samantha M. Busa, Aron Janssen, and Karen Ron-Li Liaw

Introduction

The Continuum Approach: Battle Cry for a New Generation of Clinician-Activists

We chose the title of this chapter with clear intent. How many LGB, LGBT, and LGBTQ scholarly works have you read in the pursuit of understanding of how gender and sexuality develop through the lifecycle, affect physical and mental health and well-being, and impact social discourse, policy, and law? In January 2017, the *National Geographic* published a Special Issue entitled, "Gender Revolution," highlighting how resilient our younger generations are in moving beyond traditional, dichotomous categories and living life on the gender and sexual continuum.

The topics covered in the Special Issue reflect just how far ahead youth raised during this "gender revolution" are in understanding and living on the spectrums of gender and sexuality. From school-age childrens' insight into the limits placed on them based on their gender to the stigma associated with paid paternity leave, the Special Issue illustrates how our social attitudes toward gender and sexuality have a meaningful impact across generations and cultures. Rethinking gender in a rapidly evolving social climate driven by social media and increased visibility for gender and sexual minorities requires shifts to our knowledge base as providers. The "Discussion Guide for Teachers and Parents," provided by the Special Issue, opens with a "primer" of relevant definitions and helpful questions to clarify how complex the development of gender and sexual identity is universally [1, 2]. It is no surprise that readers are encouraged to consider how culture, language, region, biology, and numerous other factors contribute to the many self-defining labels created by young people to capture the vast range of sexual and gender expression and identification.

We wrote this chapter with "all of the above" in mind and hope that you find the following principles and pearls, in some way, applicable to every patient encounter, team meeting, research protocol, and your own evolving perspectives. The chapter begins with an introduction to seven guiding principles for working with people on the sexual and gender continuums, followed by a brief review of key historical periods within our field and DSM-5 changes. The chapter explores developmental considerations, assessment within

J. A. Wernick (✉) · S. M. Busa · K. R.-L. Liaw
Department of Child and Adolescent Psychiatry, NYU Child Study Center, New York, NY, USA
e-mail: jeremy.wernick@nyumc.org

A. Janssen
Pritzker Department of Psychiatry and Behavioral Health, Ann and Robert H. Lurie Children's Hospital of Chicago, Chicago, IL, USA

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a biopsychosociocultural framework, comorbid medical and mental health concerns, the impact of minority stress, and considerations for those who are multiple minorities. Finally, we offer clinical pearls to consider in treatment and special considerations for gender variance.

Seven Guiding Principles

1. Gender and sexuality exist in continuums with infinite possibilities, not in discrete, mutually exclusive categories, such as male vs. female vs. transgender and heterosexual/straight vs. homosexual/gay/lesbian vs. bisexual vs. asexual.
2. The gender and sexuality continuums are separate, yet interrelated realms. For example, consider a trans-man (female to male transgender person) who is married to a woman and self-identifies as heterosexual. The basic concept of sexual orientation relies, by definition, on gender considerations. This individual may have identified as lesbian in adolescence and following his gender reassignment now identifies as straight.
3. The gender continuum breaks down into separate, but not mutually exclusive, masculine and feminine continuums. Each individual, regardless of biologic sex, may embody a combination of male- and female-stereotyped traits, behaviors, roles, and identifications.

   For example, a biologic male, who is a husband and a father, may play a more nurturing, emotionally expressive role within a family, while his biologic male partner may play a more assertive, analytic role. Consider the balance of masculine- and feminine-stereotyped traits embodied by a lesbian, scientist mother, who leads a research program but has chosen a flexible work schedule, so that she can be home for school pickup and family activities.
4. Sexuality is composed of three distinct realms: orientation and attraction, behavior, and identity. These three realms are interrelated but not always aligned.

   A man, who is attracted to and has sex with both women and men, may identify as heterosexual. A woman, who is attracted to both men and women and is married to a woman, may identify as lesbian in her twenties but make a conscious decision not to label herself during the rest of her adulthood.
5. Gender may develop based upon biologic sex, but this is not always the case (i.e., transgender, intersex, androgynous individuals). Gender can be broken down into gender identity, roles, and presentation as well as other realms of gender expression both within and outside of the context of culturally defined norms.
6. There are biological, psychological, social, and cultural influences at play in gender and sexual developmental trajectories. The strength and salience of these influences fluctuates as one moves through the lifecycle.

   For example, biological influences such as genetic factors and hormonal influences play a strong role during prenatal and pubertal development. Social factors, such as family and peer relationships, robustly shape behavior during the preschool and school-age years.
7. Each individual is unique and composed of multiple identities that exist within and interact with other sociocultural realms, such as socioeconomic status, geographic region, race and ethnicity, religious and spiritual affiliation, and gender and sexuality, among others.

Figure 12.1 offers a simple visual scale to use in clinical encounters. Across the top of the figure, there are two continuums, male/masculine and female/feminine, with intensity scales ranging from 0 to 10. Below, there are four realms of assessment—gender identification, gender role and expression, sexual attraction, and sexual behavior—to inquire about during the course of your work with each client. Each of these realms will be explained further in subsequent sections. The integration of these four realms makes up one's consolidated sexual and gender identity.

Throughout the chapter, we will be utilizing the cases of BA and SL to illustrate key concepts

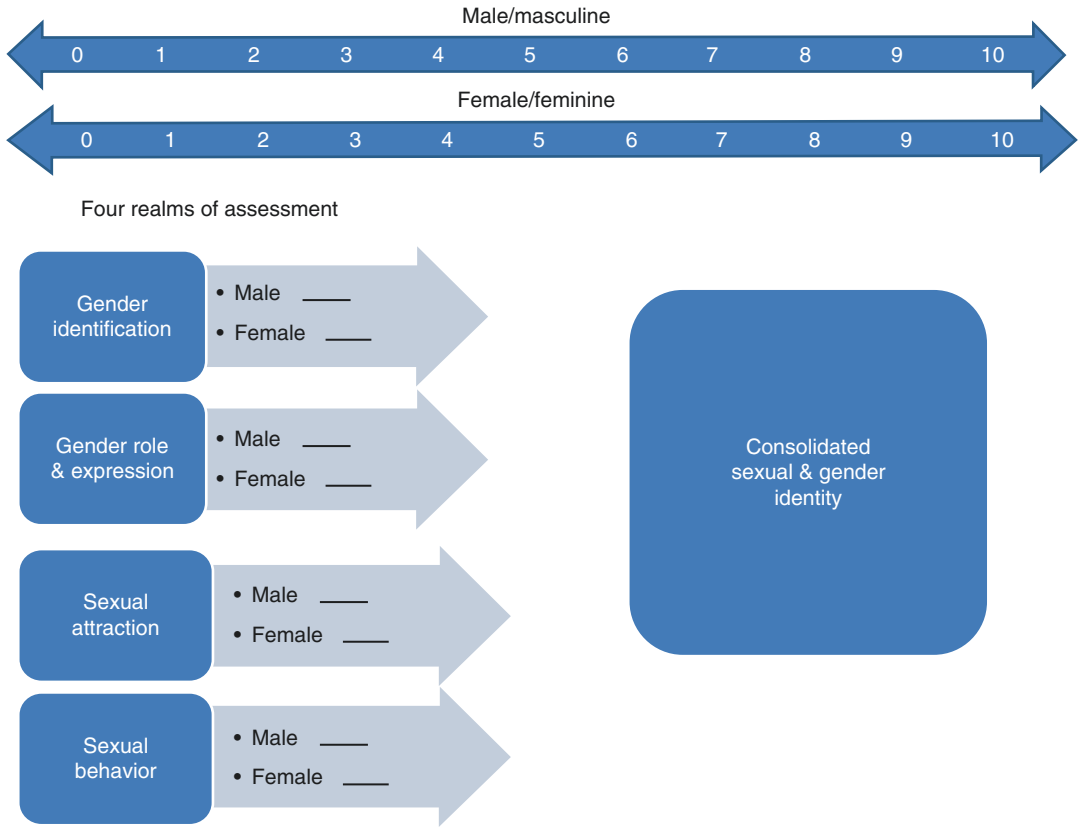

Fig. 12.1 Gender and sexuality assessment tool

and provide recommendations for assessment and treatment.

BA, a 13-year-old assigned female at birth, presents for an initial psychiatric assessment after increased anxiety and panic attacks in the context of anticipating the start of a new high school. Three months into treatment, BA reports that while they are uncomfortable attending a new school, they also are intensely uncomfortable in their body, expressing that they identify as agender.

SL, a 17-year-old assigned female at birth, presents for an initial psychiatric assessment after recently disclosing to his mother and father that he prefers male pronouns, would like to start using a gender-neutral name, and is interested in starting hormone therapy to present as more masculine in college. SL meets weekly with a psychologist to address symptoms of social anxiety and depression, as well as intermittent non-suicidal self-injurious behaviors (NSSIBs). SL and his parents expressed concern about his current therapist's lack of sensitivity to the possible impact of Gender Dysphoria on his current mental health challenges.

Historical Context

The field of medicine has a checkered and storied past when it comes to understanding sexual orientation and gender identity. As far back as the late 1800s, physicians such as Magnus Hirschfeld began to conceptualize sexual orientation and gender identity as biological variance rather than as criminal. Meanwhile, contemporaries such as Karl Westphal argued that homosexuality was an illness that should be treated [3]. Physicians and psychologists argued among each other and the prevailing theories began to evolve and change over time. Freud brought attention to psychosexual functioning and to the concepts of sexual orientation and gender identity. His ideas about sexual orientation and gender identity changed over time and had a profound impact on theories to come. In answering a letter written by a mother hoping for Freud to cure her son of homosexuality, he wrote:

> Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc.)… By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies which are present in every homosexual, in the majority of cases it is no more possible. [4]

The disagreement within the psychiatric community about homosexuality was not a surprise, nor was it surprising that the prevailing views perceived both variations in sexual orientation and gender identity as illness. The concept of identity as pathology persisted, and by the time the first edition of the DSM was released, homosexuality was classified as a sociopathic personality disturbance (Table 12.1). The time from the 1940s, after the release of the DSM to the 1970s, with the revision of the DSM-II, was an era of great social and academic change. Alfred Kinsey brings light to the notion of sexuality as a continuum and exposes a much higher prevalence of homosexual behaviors than was thought [5]. Evelyn Hooker publishes "The adjustment of the male overt homosexual" and with her elegantly designed study challenges the notion that gay men have more psychopathology than heterosexual men [6]. Gay men and lesbians begin to organize and advocate for their rights, and the 1969 Stonewall riots bring momentum and publicity to the gay rights movement. Concurrently, Bieber and Soccarides set forth the theory of causality of homosexuality as a domineering mother and absent father (Bieber) or as a result of incapacitating childhood trauma [7, 8]. They argue for therapeutic cures for homosexuality, the techniques of which formed the basis for what is now referred to as reparative therapy. Gay men and lesbians began to picket the American Psychiatric Association Conferences and argue fiercely that they are not psychiatrically ill by nature of their sexual orientation. By 1973, the DSM-II is revised to remove homosexuality and replace it with sexual orientation disturbance. However, it is not until 1987 that it is removed completely. Meanwhile, variation in one's gender identity is similarly considered pathology and is currently classified under the diagnosis of gender identity disorder.

DSM-5 Changes

Similarly to how visibility of lesbian, gay, and bisexual people helped to change the medical culture's views of sexual orientation, the increasing visibility of transgender and gender-variant individuals continues to move the field away from pathologizing identities. As a result, significant changes were made to DSM-5 in 2013, and gender identity disorder was removed and replaced with gender dysphoria. In order to avoid stigma and create a more appropriate diagnostic label, the change to "gender dysphoria" highlights the distress that often but does not always come with variability in gender identity. Gender dysphoria is described as "a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration…" [9] and requires clinically significant distress or impairment. As such, while many gender-variant individuals go through a period of dysphoria as a part of development, it is this dysphoria rather than the development itself that is pathologized. The topic of gender variance in childhood continues to be quite controversial and is reflected in the stricter diagnostic criteria for this diagnosis in children than in adults (six positive criteria are required for children as opposed to two for adults).

While changes to DSM-5 attempted to reduce the stigmatization of gender diverse individuals and allow for consistent recognition of these identities in healthcare settings, capturing the complexity and variability of gender and sexuality identity remains a challenge. Despite ongoing controversy and disagreement about the change to gender dysphoria, there is a clear progress in the 60 years since the DSM classified LGBTQ individuals as sociopathic. By examining our

Table 12.1 Sexual orientation and gender identity in the DSM

	DSM-I—1952	DSM-II—1968	DSM-IIR—1973	DSM-III—1980	DSM-IIIR—1987	DSM-IV—1994	DSM-5—2013
Sexual orientation	Sociopathic personality disturbance along with psychopathy: sexual deviation	Sexual deviation: homosexuality	Sexual orientation disturbance	Ego-dystonic homosexuality	Removed from the DSM	N/A	N/A
Gender identity	N/A	Sexual deviation	Sexual deviation	Transsexuality (adults); atypical GID (children)	Transsexuality (adults); GID-NOS (children)	Gender identity disorder	Gender dysphoria

field's interface with sexual orientation and gender identity, we can begin to understand a provider's role in both the potential of creating and/or eradicating stigma and bias and work toward a more open understanding of people on the sexual and gender continuum.

Developmental Considerations and Basic Definitions

As mental health professionals, we are trained to think in a way that incorporates the various influences on a person's life. Biologic and maturational processes, psychological factors, and social and cultural influences all play an important role in the development of gender and sexuality through the lifecycle. Developmental trajectories for gender and sexual minorities likely share more similarities with the general population than differences. However, those areas of difference are also important to highlight given their potential impact on the therapeutic alliance, reluctance or willingness to seek treatment, and physical and mental health outcomes. In this section, we will cover fundamental concepts and stages of life, which play a pivotal role in gender and sexual development.

Gender Development

By the age of 2 or 3 years old, most children have developed a sense of *basic gender identity* and have labeled themselves as boys or girls. Somewhat later, these children develop *gender stability*, meaning that they perceive their gender as being *stable over time*. That is, they predict that boys grow up to be men, and girls grow up to be women. By age 5–7, children typically develop an understanding of *gender consistency*, which allows them to realize that one's gender is also *stable across situations* [10]. Though *basic gender identity* develops during toddlerhood, a deeper understanding of *gender identity*, one's awareness of one's gender and its implications, continues to evolve throughout the lifecycle. The meaning and salience of one's maleness or femaleness transform throughout the preschool years, latency, adolescence, and young adulthood, as well as in the context of intimate relationships, committed unions, parenthood, and later life. One's *gender role*, or one's outward presentation and behavior, is often categorized as either typically male or typically female and also continues to change through the lifecycle. Family, peer, and prevailing societal norms and expectations all play a powerful role in shaping outward manifestations of gender as well as internal conceptions of the self [3, 11].

Biological contributions to gender development include genetic factors and hormonal influences. Money and Ehrardt's biosocial theory describes how genes and hormones influence children's physical development, including their genitalia and secondary sex characteristics, which then in turn influences how they perceive themselves and how others perceive them [12]. Biology also influences gender role development as children typically present with play that often falls more typically in one gender or another. Boys tend to prefer more rough and tumble play, and girls more imaginative and social/relational play [13, 14]. By no means is this a hard and fast rule, as many of us recall or were "tomboys" or "girly boys" growing up, and these early tendencies and preferences do not necessarily dictate future adult gender identity and roles.

The biosocial theory describes a number of critical biological and social episodes or events, such as inheriting either an X or Y chromosome from one's father at the time of conception, the formation of female or male differentiated gonads (ovaries or testes) by week 8 of gestation, and the subsequent secretion or non-secretion of prenatal sex hormones, which impact sex differentiation and gender development. Prior to week 6 or so of development, male (XY) and female (XX) embryos are the same except at the genetic level. Both have the capacity to form either male or female reproductive systems. Around week 8 of embryonic development, the secretion of testosterone and Mullerian inhibiting substance (MIS) by the testes of a male embryo stimulates the development of the male reproductive system

and, simultaneously, inhibits the development of the female reproductive system. In the case of a female embryo, the absence of testosterone and MIS leads to the development of the female reproductive system, which is the default state in nature. Around 3–4 months after conception in a male embryo, the ongoing secretion of testosterone leads to the growth of a penis and scrotum. In a female embryo, the uterus, cervix, and vagina develop in a programmed fashion without hormonal control.

Hormones play a particularly prominent role in gender development during the prenatal and pubertal periods. During these sensitive periods of development, exposure to androgens (male hormones) or estrogens (female hormones) may differentially influence one's physiology, chemical processes, and morphology and determine the body habitus, secondary sex characteristics, and, to some extent, brain organization and lateralization of cognitive and language functioning [15]. The combination of biologic and social forces, ultimately, impact gender-related behaviors, roles, and identity. Much of what we have learned in this field comes from work with patients who have genetic and hormonal syndromes, such as Klinefelter syndrome (47 XXY), androgen insensitivity, and congenital adrenal hyperplasia, among others.

Within psychology, many theories have been proposed to explain the process of gender development and differentiation. Given the scope of this chapter, we will highlight a few key conceptual trends. Halpern's model offered a perspective on how nature and nurture might jointly influence the development of many gender-typed attributes, such as spatial skills in males and language abilities in females. Halpern asserted that specific early experiences affect the organization of the brain, which in turn influences one's responsiveness to similar experiences in the future. For example, due to social conventions and gender norms, boys who receive more opportunities to engage in spatial reasoning and explore a wider variety of spatial experiences may develop a rich array of neural pathways in the brain's right cerebral hemisphere that serve spatial functions, which in turn may make them even more receptive to spatial activities and acquiring spatial skill. In contrast, girls may develop a richer array of neural pathways in areas of the brain's left cerebral hemisphere serving verbal functions, thereby becoming even more receptive to verbal activities and acquiring verbal skills [12].

According to the social learning theory, children acquire their gender identities and gender role preferences through differential reinforcement and observational learning. Through differential reinforcement, children are encouraged or rewarded, implicitly or explicitly, for gender-appropriate behavior and discouraged or punished for gender-atypical behavior. Through observational learning, children adopt the attitudes and behaviors of a variety of same-sex models [10]. Numerous studies have shown that even before the age of 2 and before children have acquired their basic gender identities, parents are already differentially reinforcing their children's interests and behaviors by rewarding those that are gender-appropriate, such as praising a boy who is playing with trucks and blocks, and discouraging those that are gender-atypical, such as admonishing him when playing with dolls or dressing up [12].

Social and cultural factors begin to influence the complex and lifelong process of gender development even prior to birth. What color will the baby's room be painted? What name have the parents chosen? Why does the infant clothing color palette shrink to pink and blue? Without gender-specific colors, clothing, hairstyles, and names, we would be hard-pressed to distinguish between baby boys and girls through their first year or two of life (and arguably up until puberty). The socialization process continues with parents tossing their baby boys into the air and cuddling their baby girls on their laps. Early in life, parents and caregivers certainly provide the strongest social influence on gender development, but during the preschool years and beyond, peers and siblings begin to exert a more significant influence. Popular culture and media also play powerful roles in shaping our ideas about gender roles and expectations, limitations and possibilities, and models for identification.

There are vast differences across cultures in what people expect of boys and girls. In Tahiti, few distinctions are made among males and females; even the national language lacks gender pronouns, and most names are used for both boys and girls. Anthropologist Margaret Mead found varying patterns of masculine and feminine traits in the members of three different "primitive societies" living in New Guinea. According to Mead's observations, the Arapesh and Mundugumor both made limited distinctions between males and females; however, gender expectations varied enormously between the two. The Arapesh idealized stereotypically feminine traits, such as cooperation, sensitivity, and submissiveness. On the other hand, Mundugumor men and women revered aggression, violence, and stoicism, which are typically regarded as masculine traits. Finally, in the third society Mead observed, the Tchambuli, women were expected to be dominant and exhibit a limited amount of emotion and men were regarded as more dependent, emotional, and irresponsible. Mead points out that the Tchambuli's gender expectations are the opposite of those found in Western cultures [12, 16].

In the Native American/First Nation culture, individuals may identify as being *two-spirits*, which refers to people who are either biologically male and fulfilling the social role of a woman or biologically female and fulfilling the social roles of a man. Native Americans dissociate physical or biological traits from gender within the two-spirit identity and, instead, emphasize the role of spirituality in creating gender. Two-spirits are considered as having embodied both male and female spirits [17–19]. In some Native American communities, these two-spirits are revered and celebrated for their superior spiritual status and ability to see through both the male and female perspective. That being said, this celebration is not always the case [18, 20]. Regardless, the two-spirit identity exemplifies the ways different social and cultural forces like spirituality can shape gender expression and identity.

In Kosovo, homosexual Gypsy musicians use music to negotiate the arbitrary boundary between male and female genders. Cultural forces like religion and socioeconomic conditions shape the ethnomusical experiences in this society [21]. Male musicians may perform for the public accompanied by instruments, whereas women are typically restricted to private domains with female audiences. *Talava*, a specific type of Gypsy music that originated in the female domain, is performed in public by homosexual men who dress and behave like women. Based on their unique behaviors and established social standing, one can argue that these individuals inhabit a third gender space within the local culture [21].

Sexual Development

Empirical research reveals that human beings are sexual beings throughout the lifecycle with sexuality manifesting itself in diverse and complex ways at different points in time. DeLamater and Friedrich assert that the capacity for a "sexual response," as manifested by erection and vaginal lubrication, is present from birth. These physiologic responses as well as infant exploratory touching of their genitals can be seen within the first 2 years of life. Around age 2.5–3 and sometimes earlier, the rhythmic manipulation associated with adult masturbation can appear and is a natural form of sexual expression. Between the ages of 3 and 7, there is marked increase in sexual curiosity and exploration, such as "playing house" and "playing doctor" with similar-aged peers. Through the elementary school years, ages 6–9, sexual play becomes increasingly covert as children become aware of cultural norms.

During preadolescence, ages 8–12, children tend to socialize and learn about sexuality with same gender peers. This social organization changes dramatically during adolescence as teens progress through puberty. During puberty, there is sudden enlargement and maturation of the gonads and genitalia, development of secondary sex characteristics, and surge in sexual interest due to increases in testosterone levels and a growing capacity for adult sexual interactions. The process of achieving sexual maturity continues through adulthood through committed

and/or noncommitted intimate relationships. Later in life, women may undergo physical and emotional changes associated with menopause as men progress through andropause. These changes, however, do not preclude older people's ability to engage in satisfying sexual activity in all forms [22].

Sexuality can be broken down into three domains: sexual attraction and orientation, sexual behavior, and sexual identity. *Sexual orientation* refers to the predominance of erotic thoughts, feelings, and fantasies one has for members of a particular sex. This also includes the intensity of one's sexual attraction toward members of the same or opposite gender and with whom one tends to fall in love. *Sexual orientation* may be fixed at birth or an early age and is considered to be "immutable, stable, and resistant to conscious control" [23]. Based on our current body of research, the origins of sexual orientation are likely multifactorial and require further investigation.

Sexual behavior refers to the sexual activities in which an individual engages. What constitutes "sex" depends on whom you ask. Traditional definitions of "sex = intercourse" do not hold true for many groups, such as teenagers, women, and men who have sex with men (MSM), among others [24]. Does only penile-vaginal intercourse count as "sex"? What about oral and anal sex, mutual masturbation, and use of sex toys? Are these considered "sex" as well? When working from a continuum approach, we should be as specific as possible when inquiring about our patient's sexual orientation and behaviors while taking an open, nonjudgmental stance, so that every patient feels comfortable answering us honestly.

Sexual identity, or how a person labels their sexuality, represents an amalgam of one's sexual feelings, fantasies, attractions, behaviors, and romantic relationships. Sexual identity is one of the many dimensions of an individual's identity, or sense of self—who one is and how one fits into society. In contrast to more visible realms of identity, such as age, gender, race, and ethnicity, *sexual identity*, like spiritual and religious affiliation, socioeconomic status, and occupation, is largely invisible. Many theorists, including Erik Erikson, Sigmund Freud, and Vivienne Cass, have written extensively on the topic of sexual identity and proposed an array of stage models [24].

Within Erikson's psychosocial theory of development, the stages of adolescence and young adulthood bring important challenges in developing a core sense of personal and social identity and achieving intimacy or "genuine mutuality and love" [25]. According to Cass (1979), who set the standard for homosexual identity development, sexual identity is a universal developmental process that unfolds in a predetermined sequence through six stages: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis [26]. Though stage models allow us to better conceptualize and categorize human experience, there have been a number of critiques with regard to their universality, applicability, accuracy, and ability to capture the unique features and range of diversity found within real-life experience [24].

In light of these critiques, Savin-Williams [24] proposed utilizing a "differential developmental trajectories" framework to better reflect the diverse, unpredictable, and ever-changing lives of contemporary, same-sex attracted teens. Within this framework, Savin-Williams lays out four basic tenets:

1. Similarities: Same-sex attracted teenagers are similar to all other adolescents in their developmental trajectories. All are subject to the same biological, psychological, and social influences. He warns against exclusively focusing on sexuality as it runs the danger of misattributing normal adolescent experiences to sexual orientation.
2. Differences: Same-sex attracted teenagers are dissimilar from heterosexual adolescents in their developmental trajectories. Perhaps due to unique, biologically mediated constitution and cultural *heterocentrism* (negativity toward sex-atypical behavior, temperament, and interests), same-sex attracted young people's psychological development is different from that of heterosexuals.

3. Heterogeneity: Same-sex attracted teenagers vary among themselves in their developmental trajectories, and this can be similar to the ways in which heterosexual teens vary among themselves. The interaction of sexuality with gender, ethnicity, geography, socioeconomic status, and cohort results in distinctive trajectories among teens.
4. Uniqueness: The developmental trajectory of a given person is similar to that of no other person who has ever lived. Given the profound diversity inherent in individual lives, general descriptions of group-mean differences and similarities may be irrelevant when applied to a specific individual.

Although it is likely that there are more similarities than there are differences in the developmental trajectories of gender and sexual minorities as compared to the general population, there are some key areas of difference that are important to keep in mind when working with people on the gender and sexual continuum. The first is that many gender and sexual minorities recall "feeling different" from their peers beginning around 7 or 8 years of age. Often, this feeling is a result of gender-"atypical" or gender-"nonconforming" behavior. As many as two-thirds of adult gay men and women recall some gender-atypical behaviors or preferences as children [13]. In the United States, "tomboys," or girls who prefer boys' toys, games, clothing, and playmates, tend to have fewer problems with social adaptation than "sissy boys," or boys who prefer girls' toys, activities, dress, and playmates, as evidenced by our socially constructed labels for these two subsets of children [3].

Notably, children who display gender role behaviors that are more typical for the opposite sex will sometimes come to the attention of their parents, peers, or communities for violations of typical gender role behaviors. Gender identity and gender role behaviors often align, but not always. Many children with cross-gendered behaviors impactful enough to qualify for a diagnosis of gender identity disorder grow up to have persistent gender-nonconforming identities, but a vast majority of those children as they grow will no longer identify with the gender of the opposite sex of which they were born. Interestingly, a majority of these children with gender identity disorder (as defined by the DSM-IV) will later in life identify as being gay, lesbian, or bisexual [27, 28].

Another unique aspect of the developmental trajectory for sexual minorities is the process of *coming out*. Coming out involves becoming aware of and acknowledging one's own sexual identity (coming out to oneself) and disclosing that identity to others (coming out to others). It is a lifelong process that parallels one's development throughout the lifecycle. During childhood and adolescence, *coming out* might mean having a first same-sex crush, feeling different, or asking oneself, "Am I gay?" Later in adolescence or during young adulthood, *coming out* includes first same-sex intimate experiences, relationships, and telling friends and/or family. Although every individual uniquely identifies on the sexuality continuum, those who identify as a sexual minority must make decisions every day about whether or not to disclose their sexual identity, particularly during times of major life change, such as moving to a new town or starting a new school or job [3]. Younger generations seem to be coming out at earlier ages and often feel no need to label themselves at all. Older generations, who came of age during more conservative times, may have gotten married to opposite sex partners, had children, and begun the process of *coming out* much later in life. There is likely a similar but somewhat different process of coming out for gender minorities. The process may start earlier in life during childhood or adolescence and may be complicated by the need to make important decisions about puberty suppression in conjunction with their legal guardians and medical and mental health providers.

The Group for the Advancement of Psychiatry's online LGBT Mental Health Syllabus serves as a rich resource in exploring the unique issues facing same-sex couples and individuals through adulthood, including variations in intimate relationships, civil unions and marriage, parenting, and aging [3]. Although the US Supreme Court ruled in 2015 that the

Defense of Marriage Act (DOMA) and its restriction of the federal recognition and definition of "marriage" to only include opposite-sex couples was unconstitutional, the variability of nondiscrimination policies within individual states continues to obscure the rights of same-sex couples and perpetuates systematic discrimination against the LGBT community [29]. Despite barriers to reducing anti-LGBT rhetoric societally, the legalization of same-sex marriage had a significant impact on the visibility and normalization of sexual minority identities in the United States. Notably, the Youth Risk Behavior Surveillance System (YRBSS) sampled more than 700,000 high-school students and found a significant decrease in the rate of suicide attempts among sexual minorities living in states with policies recognizing same-sex marriages [30]. The American Academy of Pediatrics (AAP), American Medical Association (AMA), American Psychological Association (APA), American Psychiatric Association (APA), and National Association of Social Workers (NASW), among other professional organizations, explicitly support and recognize the positive impact policies that support same-sex marriage have on the rights, benefits, and long-term security of children in the United States [31].

Assessment

Assessment Overview Within a Biopsychosociocultural Framework

At all ages and in every culture, every person has a gender identity, and as cognitive and physical development progresses, every person develops a sexual orientation as well. The details, meaning, and impact of those identities can fluctuate over time, and there is a great deal of evidence to suggest that sexual orientation and gender identity are on a spectrum. However, if we are not able to sensitively ask the questions, our patients will never provide us with the answers that can help inform a comprehensive treatment plan targeted to each patient's individual needs. A thorough and thoughtful assessment can capture the specifics for each individual and help to avoid the unfortunate experience of bias that many LGBTQ patients face in their medical care. But before an assessment can be completed, a person must first seek care.

Because of accrediting organizations, enthusiastic students, trainees, and faculty as well as in response to the pressure from LGBTQ rights organizations, most training programs include some form of training on sexual and gender minorities. Yet despite the increase in training, LGBTQ individuals continue to experience significant bias in their doctor's offices. In a recent large national survey of transgender individuals, 24% of all respondents were denied equal care at a doctor's office or hospital and nearly 19% of respondents were denied care altogether. In addition, over one-quarter of respondents were verbally harassed at their doctor's office. Not surprisingly, those surveyed were less likely to seek care in part because of a legitimate fear of harassment [32].

Much can be done to set the scene prior to the healthcare professional even meeting the patient to reduce a person's fear of bias or discrimination. Review your intake documents and electronic medical records from the viewpoint of an LGBTQ individual. How does a transgender man identify gender when given only the option of male or female? How do same-sex parents differentiate themselves when given the option of mother or father? When a person has legal documents identifying them as one gender but they identify as the other, how do you ensure their preferred name and pronouns are used? Are there gender-neutral bathrooms available for use? Are there questions about sexual orientation in the documents, and are they asked in such a way that allow for the large spectrum of responses? For many patients and families, an early opportunity to create an environment that is respectful and affirming of the needs of LGBTQ patients is with front-desk staff. Training front-desk staff about the unique healthcare needs and barriers of LGBTQ patients and families can improve the extent to which institutions provide responsive healthcare experiences consistently. *Affirmative Care for Transgender and Gender Non-*

Conforming People: Best Practices for Frontline Health Care Staff is a valuable training resource developed by the National LGBT Health Education Center [33]. By giving LGBTQ patients and families a space for their identities to be acknowledged, you are already improving their care and potentially alleviating fears of possible bias and discrimination. When meeting the patient for an initial assessment, it is vital not to make assumptions and to stress confidentiality. A curious stance with open-ended questions is recommended to allow patients the flexibility to answer honestly about their gender and sexual development. It can be tremendously helpful to display materials that identify you as someone comfortable speaking with sexual or gender minorities, or alternatively, it can be helpful to normalize a wide range of identities and behaviors. Often, questions are directed either at identity or at behavior, but not at both. Identity does not equal behavior, and a person telling you they are heterosexual in no way completely defines their sexual behaviors or fantasies. Only by asking about identity and behavior as well as the meaning of both will you start to get a clearer picture of your patient's internal sense of gender identity and sexual orientation. Literature suggests that neither sexual orientation nor gender identity is a choice and that there are clear biological influences on the development of sexual orientation and gender identity. For example, twin studies investigating homosexuality [34, 35] showed higher rates of concordance among monozygotic twins (52% for gay men, 48% for lesbians) than for dizygotic twins (22% for gay men, 16% for lesbians) and for adoptive siblings (11% for gay men, 6% for lesbians), thus making a clear argument for a strong heritable component of homosexuality. However, how one expresses those identities does involve a degree of volition and is influenced by one's psychological, social, and cultural influences. This is as true for identities considered more normative than for identities less typically a part of the norm.

The process of "coming out" is primarily an experience thought to be limited to those with variations in their gender expression or sexual orientation, but everyone proceeds through identity development around their sexuality and gender, and often exploratory behaviors and thoughts in youth are not reflected by later identity consolidation in adulthood. Regardless if one identifies as gay, straight, bisexual or asexual, *cis-gendered*, *transgendered*, or *genderqueer*, at a certain point, a sexual orientation and gender identity are established, and frequently those early exploratory thoughts, fantasies, or experiences are forgotten. In one study, men reported same-sex experience rates of approximately 3% for the past year and 7–9% since puberty, and for women, approximately 1% in the past year and 4% since puberty [36]. These numbers reflect sexual behavior only and do nothing to quantify identity or fantasies, nor are these numbers predictive of later identity. They capture behaviors but miss out on the fuller picture of the diversity of gender and sexual expression.

As a society, we are much more comfortable with identifying folks on opposing poles than as on a spectrum. This stressor becomes very clear in work with bisexual or gender-queer individuals, those who choose to identify on a place on the gender and sexuality spectrum that places them apart from the current norm. By identifying in such a way that may be more internally consistent but less societally sanctioned, people are exposed to more bias and discrimination [37]. Those identifying as somewhere in the middle between gay and straight, man or woman, are often the most misunderstood, and a good assessment is the first step to understanding.

By thinking in a continuum approach, you are not limited to rubrics based on one identity or another. Every person, no matter their orientation or behavior, has biopsychosocial and cultural influences that define and modulate their gender and their sexuality. As such, age-appropriate assessment of psychosexual development should be done for every patient, and ideally, any assessment would be structured such that the provider can better understand the role that these biopsychosocial and cultural influences have played in their patients' lives.

There is not good data on the prevalence of gender variance, with most of the data coming either from the specialized gender clinics or patients presenting for cross-hormone treatment or sexual reassignment surgery. Numbers range from approximately 1 in 1000 to 1 in 20,000 individuals [38, 39], and these numbers do not account for those individuals that have an identity that fits somewhere along the gender spectrum that do not seek any treatment.

Psychologically, one must understand how one integrates their gender and sexual orientation into their identity. Have they fully formed their identity? Does it align with their behaviors? Does it bring pride, shame, or indifference? What is the impact of their identity and behavior on their mental health (substance use, depression, suicidal ideation) or in their relationships—romantic, sexual, or otherwise? Often those with gender-nonconforming identities or behaviors or those with same-sex interests are forced to keep their identities and experiences a secret—from their peers, from their families, and even from themselves. How does holding on to that secret impact their development and their functioning? There is no evidence to suggest that LGBTQ individuals use any separate defense mechanisms to address their challenges [40]. However, for those with sexual identity and/or gender identity that is not safe to be expressed, they often miss out on developmental experiences they see their peers engage in.

Socially and culturally, inquiries can lead into multiple social milieus. For example, what are the family beliefs about sex, gender, and sexuality? What are the community and/or religious views about gender and sexuality? Does the patient face bias? Is he or she safe to express his or her identity? What are the cultural values and mores of the social group? Do you know people that are going through a similar developmental trajectory? Asking these types of questions will help a provider to understand the context through which his or her patient conceptualizes their gender and sexuality and helps to later guide the treatment plan.

Comorbid Medical and Psychiatric Concerns

From the LGBT Mental Health Syllabus [3]:

> [Those living on the gender and sexual continuum] are people first and foremost, with the same primary care issues and needs as others across the lifecycle. [This] community is highly diverse, and any discussion of health risks and behaviors runs the risk of overgeneralization or even stereotyping, leading to questionable assumptions.

Our knowledge base with regard to medical and mental health concerns facing gender and sexual minorities is limited by two key factors:

1. There have been significant methodological challenges in conducting research on a group that is subject to bias and discrimination, both within society and within the medical system.
2. Until recently, those living on the gender and sexual continuum have not been included or adequately identified and characterized within important population health-based studies.

That being said, what follows is a review of key health issues to consider in your work with all patients on the continuum keeping in mind that risk is conferred by gene–environment interactions and behavior and not by sexual orientation or gender identity. It is important to ask about specific sexual and health-related practices, such as how often they see their healthcare providers, level of trust in the medical system, and willingness to follow-up with recommended screenings or treatments, to accurately assess medical and mental health risks in our clients.

Cancer

Though definitive studies are lacking, preliminary data suggests that sexual and gender minorities have a heightened risk for certain cancers. More research is needed to understand the natural history of disease in these populations. MSM have higher rates of non-Hodgkin lymphoma and

Kaposi's sarcoma associated with HIV/AIDS infection. Evidence increasingly suggests that MSM are at increased risk for anal cancer due to increased rates of human papillomavirus (HPV) and, as of yet, lack of standardized screening in this population. HIV-positive MSM should have yearly anal PAP tests, and those who are HIV negative should be screened every 2–3 years. The HPV vaccine is under study for the MSM population. Because the risk for HPV and anal cancer travels with sexual behavior and not sexual orientation, it is important to also inquire about current and historical sexual practices while working with all of your patients and not just those who are self-identified homosexuals.

Though no definitive studies have been completed, lesbians may be at higher risk of breast cancer than heterosexual women due to higher rates of risk factors, such as obesity, alcohol consumption, nulliparity, and lower rates of breast cancer screening. Lesbians also tend to receive less frequent gynecologic care than heterosexual women and might also be at higher risk for greater morbidity and mortality from gynecologic cancers, such as uterine and ovarian cancer. Women who have had sex with women (WSW) should be screened with PAP and for HPV as per the established recommendations for all women and vaccinated against HPV when appropriate [3, 41].

HIV/AIDS

The human immunodeficiency virus (HIV) is the infectious agent that can lead to acquired immune deficiency syndrome, or AIDS. HIV is spread through direct contact with an infected person's blood, semen, vaginal secretions, and breast milk. The HIV/AIDS epidemic has had enormous impact on global health, and patterns of transmission vary greatly between countries. In 2011, an estimated 34.2 million people worldwide were living with HIV, and there were 2.4 million new cases of HIV infections in 2011 alone [42]. Worldwide, unprotected sexual contact between people of the opposite sex accounts for more cases than those for same-sex contacts. However in the United States, MSM have been the largest subpopulation affected. Although the popular image of a person with HIV/AIDS is of a White gay man, African Americans account for 46% of those living with HIV with Latinos accounting for 18% and Whites accounting for 35%. New HIV infection rates remain disproportionally high among younger African American and Latino MSM [43].

Since AIDS was first recognized in 1981, we have made great strides in the prevention of HIV transmission and in HIV/AIDS care. The Center for Disease Control (CDC) estimates that 1.1 million people in the United States are living with HIV infection and that approximately 1 in 5 (21%) of those people are unaware of their infection [42]. With the advent of highly active antiretroviral treatments (HAART), what was once a nearly certain fatal disease has become a chronic disease for those who have access to treatment [3]. The availability of HAART not only increases the lifespan of those with HIV infection but also lowers some people's perception of risk and thus their behavior around unprotected sex and needle sharing. The long-term sequela of HAART, such as high cholesterol, diabetes, and the redistribution of body fat, need to be monitored closely by primary care, medical specialist, and mental health professionals.

The health implications of HIV are far-reaching and range from life-threatening opportunistic infections and malignancies to mental health challenges. Although significant medical advancements have improved the treatment of HIV in the United States, access to preventative care continues to be complicated and challenging for members of the LGBT community. Oral pre-exposure prohylaxis (PrEP) is a once-daily pill that can significantly reduce an HIV-negative person's risk of getting HIV through common high-risk exposures, such as sexual activity or injection drug use. Despite its efficacy and approval by the Centers for Disease Control (CDC), US Food and Drug Administration (FDA), and US Public Health Service, few healthcare providers are appropriately trained in screening for PrEP eligibility. Improving access

to services across the HIV care and prevention continumm requires training medical and mental health professionals to screen and counsel all patients on safer sexual practices and appropriate adherence to preventitive medications [44, 45]. Those reporting higher-risk behavior, such as multiple partners, unprotected sex, needle sharing, or sex with partners who are sharing needles, should be screened more frequently, approximately every 3–6 months [3]. Professionals may erroneously assume that lesbians have had no history of sexual contact with men. In one study, 77% of self-identified lesbians had one or more male sexual partners in their lifetime. WSW appear to have higher rates of unprotected sex when having sex with men, more sexual contact with MSM, and more sexual contact with IV drug users when compared with exclusively heterosexual women [43]. These statistics demonstrate the importance of screening WSW for HIV along with women who are not sexual minorities.

Other Sexually Transmitted Diseases and Hepatitis

Because STDs and the behaviors associated with acquiring them increase the likelihood of acquiring and transmitting HIV, it is important that all patients be screened and counseled on safer sex practices and other preventative measures. Some surveillance data suggests that rates for syphilis and gonorrhea may be increasing among MSM. The current recommendation is that MSM should be screened yearly for gonorrhea, syphilis, chlamydia, herpes, HPV-associated genital and anal warts, and HIV. MSM are also at increased risk for proctitis, pharyngitis, and prostatitis, which are infection and inflammation of the rectum, throat, and prostate, respectively [41]. In terms of risk for lesbians and WSW, there have been confirmed cases of transmission of herpes, HPV-associated anal and genital warts, bacterial vaginosis, and trichomoniasis. Despite these risks, lesbians and WSW are screened and counseled on safer sex practices less frequently than exclusively heterosexual women by their healthcare providers [41].

The most common types of viral hepatitis, or inflammation of the liver, are hepatitis A, B, and C. All three of these unrelated viruses can produce an acute illness characterized by nausea, malaise, abdominal pain, and jaundice. Many persons infected with hepatitis B or C, which are transmitted through contact with an infected person's blood or body fluid, are unaware they are infected. Both hepatitis B and C viruses can produce chronic infections that often remain clinically silent for decades while increasing risk for liver disease and liver cancer [46]. Vaccines are available for hepatitis A and B. Due to an elevated risk for hepatitis A and B in MSM, all MSM should be adequately vaccinated though many are not.

Mental Health and Substance Abuse

Gender and sexual minorities have higher prevalence of depression, anxiety, substance use disorders, suicidal ideation, and posttraumatic stress disorder. Some researchers hypothesize that the cause of the higher prevalence of these disorders is partially attributable to societal stigma, prejudice, and discrimination against gender and sexual minorities, which in turn leads to stress and mental health problems. This hypothesis, the *minority stress theory*, will be discussed in further detail in the next section. In the few larger-scale, national epidemiologic studies, suicidal ideation and attempt rates approach or exceed 50% and 20%, respectively. Recent studies of sexual minority youth populations continue to report alarmingly high rates of suicidal ideation and attempts at 3–7 times higher prevalence as compared with heterosexual youth [42]. However, some research demonstrates that gender diverse youth whose identities are supported experience comparable rates of psychopathology to their cisgender peers, and parental rejection may be an essential predictor of psychological functioning in adulthood [47]. With regard to substance use, gender and sexual minorities have higher rates of tobacco use, which is associated with increased risk for heart disease, lung cancer and emphysema,

and a variety of other health problems. Studies indicate that gender and sexual minorities have higher rates of alcohol and illicit drug use. All patients should be routinely screened for alcohol and substance use disorders, especially since use is associated with other high-risk behaviors and negatively affects other chronic diseases. Clinicians should be familiar with some illicit drugs used more frequently among gay men, such as inhalants, hallucinogens, and the "club drugs," such as ketamine, MDMA (ecstasy, Molly), methamphetamine (crystal meth), and GHB. A few studies have included lesbians and have found higher rates of tobacco, marijuana, cocaine, and alcohol use as compared to heterosexual women [3, 42].

Minority Stress Theory: Prejudice, Social Stress, and Health

Ilan H. Meyer and others have written extensively on the topic of *minority stress* as a possible explanation for why gender and sexual minorities have higher prevalences of mental health problems, substance use, and perhaps medical morbidity and mortality as well. In psychology, stressors are defined as events and conditions, such as the death of a loved one, job loss, or new illness diagnosis, that cause change and require that an individual adapt to a new life circumstance or situation. These situations include social conditions, which strongly impact the lives of those belonging to stigmatized social groups. According to Meyer and other stress researchers:

Prejudice and discrimination related to low socioeconomic status, racism, sexism, or homophobia—much like the changes precipitated by personal life events that are common to all people—can induce changes that require adaptation and can therefore be conceptualized as stressful [48].

The minority stress framework describes four underlying stress processes: (1) experience of prejudice events (discrimination), (2) expectations of rejection (stigma), (3) hiding and concealing, (4) internalized homophobia, and ameliorative coping processes. These stress processes can be described along a continuum from distal stressors, which are usually objective events and conditions, to proximal personal processes defined as subjective because they rely on individual perceptions and appraisals [48].

Starting with distal effects, studies have shown that gender and sexual minorities are disproportionally exposed to prejudice events, including discrimination and violence. For example, LGB adults are twice as likely as heterosexual people to have experienced a life event related to prejudice, such as being fired from a job. Furthermore, 20–25% of lesbians and gays have experienced victimization, including physical and sexual assault, robbery, and property crime. School-based studies suggest that gender and sexual minority youth are much more likely to be victimized by antigay prejudice events than heterosexual peers and that the psychological impact of these events can lead to severe negative developmental outcomes.

Stigma, or a mark of shame or disgrace, placed upon gender and sexual minorities by society leads to expectations of rejection and discrimination within the minority group [48]. These minority groups learn to become "constantly on guard" or vigilant that others that they come across in daily life might be prejudiced against them. Moving more proximally to the self, those living on the continuum often have to conceal their stigmatized identity to avoid negative reactions from others. However, there is a psychological cost to concealment as one's energies and cognitive processes become disproportionately consumed and siphoned to this end. There have been many studies describing the adverse psychological, health, and job-related outcomes due to workplace fear of discrimination and concealment around sexual minorities. Although experiences of discrimination and societal stigma negatively impact the psychological well-being of all minority groups, a growing body of research suggests that social support and perceived acceptance may be protective against the aforementioned risks. Furthermore, sexual and gender minorities who are supported in the expression of their identities experience developmentally normative distress and psychopathology, and the literature shows that expressing emotions and

sharing important aspects of one's self with others—through confessions and disclosures in meaningful relationships—are important factors in maintaining physical and mental health [49].

Internalized homophobia, or the internalization of societal antigay attitudes, within lesbians, bisexuals, and gay men, represents what Meyer describes as a form of stress that is "internal and insidious." Research has shown that internalized homophobia correlates with depression and anxiety symptoms, substance use disorders, and suicidal ideation. Studies also suggest an association with self-harm, eating disorders, HIV risk-taking behaviors, and difficulties with intimate relationships and sexual functioning [48].

Those living on the gender and sexual continuum also have access to powerful coping and resilience resources, such as opportunities for group solidarity and cohesiveness. Gender and sexual minorities have created stigma-free, empowering environments that foster growth and integration of one's gender and sexual identity with other important aspects of one's life. These environments and relationships allow for a reappraisal of the stressful condition, yielding it less power to negatively impact upon psychological well-being [48].

Multiple Minorities

Within each of us, we hold multiple identities. Gender and sexual identity are just two among many possible realms of self-definition and affiliation, including those based upon socioeconomic status, geographic region, race and ethnicity, religious and spiritual affiliation, and others. Furthermore, within each of these groups, there is significant heterogeneity. Those who hold multiple minority status may face unique struggles and simultaneously have access to alternative social support networks and resources. For example, LGB people of color can face alienation and discrimination by the LGB community and from their racial and ethnic community of origin, which sometimes leads individuals to feel forced to choose one identity over the other [3]. Individuals with multiple minority status (i.e., a lesbian, Latina female or an Asian-American, transgendered man) can also connect with others from similarly diverse backgrounds to create opportunities for social support and further integration of their complex identities. Religious and spiritual affiliations and institutions can also play a powerful role in one's acceptance or rejection of same-sex attraction, behavior, and identity. Men and women have very different experiences of living on the gender and sexual continuum based upon the unique developmental trajectories and socialization patterns and expectations for boys/men and girls/women within our society [3]. Other important realms to consider in your work are the effects of socioeconomic status, disability, and geography on the identity of those living on the gender and sexual continuum.

Case BA: Assessment

After seeing BA for the initial evaluation, treatment focused on anxiety and panic attacks, and BA was able to successfully attend high school. After a month of school, they reported continued anxiety that was a function of feeling intensely uncomfortable within their body. Through open-ended questioning by the clinician, BA disclosed that they identify as agender and not as a female. During subsequent sessions, an assessment of gender and sexual development was undertaken. BA reported that they never felt female, and when in elementary school and middle school, they did not see this as an issue. BA identified that going through puberty and growing larger breasts made them feel "less like themselves." They reported that they did not ever experience any sexual attraction toward others, though reported enjoying masturbation. They reported romantic feelings toward individuals who present as feminine but denied any sexual attraction to any gender.

Case SL: Assessment

Seeing SL for the initial evaluation, a full assessment of gender and sexual development was undertaken in addition to psychiatric functioning. SL reported that, for as long as he can remember,

he felt uncomfortable conforming to "typical girly things." Throughout elementary school, SL described feeling drawn to male peers and became passionate about games and activities that made him feel "strong like the boys," including karate, violent video games, and sports. SL experienced significant rejection by male peers throughout childhood, which he speculates was a result of his insistence on wearing dresses and pink clothing to "compensate" for the discomfort he felt socially in gendered social contexts. SL began experiencing significant symptoms of social anxiety around age 11 and started isolating himself to avoid discomfort with female peers and rejection by male peers. SL described first learning about transgender identities and gender nonconformity through the Internet at age 12 and recalls writing in his diary, "I don't think I'm totally a girl." SL began exploring his gender identity in secret, referring to himself using typically male names in the mirror, taking photos with his hair tucked into a hat, and participating in message boards with trans-individuals online. SL's willingness to begin sharing the more masculine aspects of his identity changed after experiencing his first period at age 13, which led to overwhelming distress associated with his anatomy. Since age 13, SL described feeling "nauseated" by the round shape of his face, large breasts, vagina, high-pitch voice, lack of body/facial hair, and noted feelings of disgust associated with his capacity to bear children. Around age 14, SL described beginning to engage in NSSIBs to alleviate feelings of hopelessness and negative thoughts about his body that impaired his sleep and ability to focus during classes. SL did not disclose his anatomical dysphoria or gender identity questioning until he entered his first romantic relationship at age 16. SL began dating a transgender female peer who shared her experience transitioning socially and initiating hormone therapy. SL explained that exploring his sexuality and gender expression with a supportive partner helped normalize his preference for gender and sexual fluidity, leading him to come out to his parents and a few close friends at school. SL noted continuing to explore his gender and sexual identity and described himself as "mostly a boy and mostly attracted to feminine people."

Treatment

Treatment Overview

There is not a treatment for heterosexuality. Nor is there a treatment for homosexuality or bisexuality or gender variance. The scientific literature suggests that while one can, to some degree, alter one's behavioral patterns around sexual orientation and gender identity, it is not possible to change an enduring pattern or homosexual or gender-variant development [50–52]. Attempts to change one's sexual orientation through therapy (at times known as "conversion therapy" or "reparative therapy") have been practiced nearly as long as therapy has existed; however, there is little evidence to support its efficacy. Anecdotal reports that speak to its efficacy are counterbalanced by anecdotal reports that speak to its lasting psychological harm. One of the more controversial papers on the subject, "Can Some Gay Men and Lesbians Change Their Sexual Orientation? 200 Participants Reporting a Change from Homosexual to Heterosexual Orientation" [53], argued that reparative therapy may be effective for a small group of individuals wishing to change their sexual orientation. However, in 2011, Spitzer retracted his claim, reporting "in retrospect, I have to admit I think the critiques are largely correct… The findings can be considered evidence for what those who have undergone ex-gay therapy say about it, but nothing more" (http://prospect.org/article/my-so-called-ex-gay-life). The potential risks of this type of "therapy" include depression, anxiety, self-destructive behavior, and the reinforcement of the belief that sexual attraction toward the member of the same sex or a gender identity that doesn't match one's biological sex is pathological. The American Psychiatric Association, the American Psychological Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the National Association of Social Workers all refer to the practice of reparative therapy as substandard and/or unethical care. So if changing one's sexual orientation or gender identity is not a valid goal for treatment, what are appropriate

goals and special considerations for treatment of LGBTQ patients?

Recognition of Similarities

First of all, it is important to note that there can be more commonalities in treatment planning for a bipolar gay man versus a bipolar straight woman than there are between a gay man with social phobia and a gay man with schizophrenia. A thorough assessment and diagnostic evaluation should first and foremost guide the treatment planning. Standard, evidenced-based interventions should be put into place for any primary psychiatric disorders. However, in working with the LGBTQ population, context is important. It is important to know the cultural norms, as well as the individual norms for the patient you are treating. For example, sexual expression and the frequency of sexual encounters can change based on the norms of the culture the patient identifies with. How does a treatment provider recognize the manic symptom of hypersexuality in the case of an asexual patient versus in a patient who routinely has multiple sex partners each week?

Identification and Management of Psychiatric and Medical Comorbidities

As described earlier in the chapter, LGBTQ individuals have an increased risk for a number of psychiatric and medical comorbidities. The culturally sensitive provider will learn how to assess for these comorbidities and apply evidence-based practices to address them. A mental health professional need not identify as LGBTQ in order to provide a treatment environment free of bias; however, some LGBTQ patients will specifically request having a provider with more personal understanding of what it means to be LGBTQ. It is the responsibility of the provider to help connect their patients to other culturally sensitive providers in order to reduce the risk of further healthcare discrimination. It is important to be aware of professional and community resources that can provide safe, supportive environments for LGBTQ individuals.

Identification and Management of High-Risk Behaviors

As described earlier in the chapter, LGBTQ individuals are more likely to be the victims of bullying or systematic discrimination and more likely to contemplate as well as attempt suicide. Data in this realm can be quite terrifying. Up to 40% of transgendered adults have attempted suicide at least once in their lives [32]. Researchers have begun to investigate risk factors and demographics of those more likely to attempt suicide in addition to investigating resiliency factors that are protective. Treatment in many ways is guided by this research. A stable sense of identity and a connection to a family/community that is supportive are two resiliency factors that have been identified as protective for suicide risk in youth populations [54, 55]. As such, the treatment provider has an opportunity to provide a safe space for a patient to explore their own identity free from judgment or free from agenda. In this way, the therapist can "protect the individual's full capacity for integrated identity formation and adaptive functioning" [56]. For children and adolescents, the presence of an interested adult is protective against suicide for lesbian, gay, and bisexual youth, and the therapist can both fill that role and help their patients connect to community supports. Family interventions, particularly when working with children and adolescents are vital to help build family connectedness and mutual understanding of the patient's exploration of their gender and sexuality.

Understand and Intervene on Stigma and Bias

It is the job of the healthcare professional to understand the societal and cultural context by which their patient may be exposed to stigma and bias and to help address and/or manage the psychological impact. In some schools and work-

place environments, people are openly targeted for appearing gay, lesbian, or gender variant. Although Title VII of the Civil Rights Act of 1964 protects employees from being fired based on their race, religion, national origin, or sex, LGBT identities are not explicitly protected by Title VII in the eyes of the federal government. Numerous unsuccessful attempts have been made to update the terms of Title VII, but for the majority of LGBT employees in the United States, protection from discrimination in the workplace varies by state, county, or even city.

It is not explicitly stated that LGBT employees can be protected from termination based on their identities. As such, LGBTQ individuals often have to hide their identities at work or at school in order to protect themselves. As providers we have the opportunity to educate potential allies in these stigmatizing environments and help to build a safer environment for our LGBTQ patients. In addition, Medicaid policy dictates that no coverage be provided for treatment related to gender identity-related concerns, nor do many other insurers. As such, a two-tier system is created for gender-variant individuals—those that can afford the life-saving treatment and those who cannot.

Special Considerations for Gender Variance

The World Professional Association for Transgender Health is an international, multidisciplinary professional association with a "goal to promote evidenced-based care, education, research, advocacy, public policy and respect in transgender health" (http://www.wpath.org/about_mission.cfm). As a part of their mandate, they publish the Standards of Care for the Health of Transsexual, Transgendered, and Gender Non-Conforming People. The overall goal of the Standards of Care (SOC) "is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment." The SOC provides guidelines for mental health and medical professionals providing care for gender-variant individuals and seeks to establish evidenced-based practices. They recommend that mental health clinicians working with gender-variant individuals should have basic competence in mental health assessments and treatments in addition to a knowledge of the range of gender-nonconforming identities and expressions and of the assessment and treatment of gender dysphoria. Ongoing education and supervision in the field is vital to maintaining sensitivity and efficacy.

As for any person, a good treatment begins with a thorough assessment. Assessment of gender-variant individuals "includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers…" [57]. As described earlier, gender-variant behaviors are more common in childhood than in adulthood, and most children meeting criteria for gender identity disorder in childhood will no longer meet qualifications for that diagnosis as adults [58]. As such, it is important for the clinician to be "aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents…" [56] as well as in adults.

The health professional should provide education to their patients regarding options for gender identity expression and medical interventions and be able to assess for eligibility, preparation, and referral for hormone therapy and surgery. At present, the SOC recommends that if a patient is to begin puberty suppression or hormone treatment (i.e., estrogen for a biological male with a female gender identity or testosterone for a biological female with male gender identity), a qualified mental health professional must first assess the patient and provide a letter that identifies the patient's personal and treatment history, progress, and eligibility. An understanding of the risks, benefits, and alternatives must be demonstrated and the treatment options reviewed. It is a similar pro-

cess for either breast reduction/removal or augmentation surgeries. For genital assignment surgeries, two separate qualified mental health professionals must provide support. Hormone treatment and surgery can be lifesaving, and the literature suggests that relief from gender dysphoria cannot be achieved without a closer congruence between one's gender identity and their primary/secondary sex characteristics [59–61].

Psychotherapy is not an absolute requirement for these referrals, nor is there one specific type of therapy that is recommended. The goals of therapy for gender-variant individuals are not manifestly different from anyone else—to maximize well-being, self-fulfillment, and quality of life. However, supporting a patient (as well as their family and community) through a gender transition is a unique task, and providers working with transgender clients should have experience with this process. For example, the mental health professionals must educate themselves about the processes for changing one's identity documents, advocacy options, and peer supports within the gender-variant community.

While there are unique aspects to treatment of the LGBTQ population, the process of treatment is no different. Every person develops a sense of their gender and their sexuality, and every person is profoundly influenced by these processes. To bring gender and sexuality into the treatment is to better understand and enrich the therapeutic relationship and encourage an open dialogue about identity that will have reaching impact beyond the realm of gender and sexuality.

Case BA: Treatment Follow-Up

BA engaged in weekly psychotherapy to address symptoms of panic disorder without agoraphobia, generalized anxiety disorder, and gender dysphoria in adolescence. The first stage of treatment focused on anxiety symptoms as BA did not report gender dysphoria until a few months into treatment. After helping BA manage anxiety better at home and at school, treatment focused on education regarding gender identity development. Given BA's strong and persistent agender identification, it was recommended that BA socially transition. The clinician worked with BA on finding a safe chest binder and in facilitating conversations between BA and their parents around their gender identity. The clinician and BA also collaboratively worked with BA's school alerting teachers to BA's preferred name and pronouns. This social transition improved BA's ability to engage effectively in school. They reported improvements in mood and anxiety in the classroom and felt affirmed in their gender identity with teachers and peers. BA continues to struggle with dysphoria related to their breasts and is considering a breast reduction or chest masculinization when they graduate from high school. They are not interested in hormone therapies and report that they feel affirmed in their gender through the use of gender-neutral pronouns from their family, friends, providers, and school personnel.

Case SL: Treatment Follow-Up

SL began weekly therapy with a new mental health provider to address the impact of gender dysphoria on the mental health challenges and risks impacting his ability to access hormone therapy. SL's treatment initially focused on improving coping skills to reduce the severity of life-threatening NSSIBs and rehearsing social skills to address symptoms of social anxiety impairing his capacity to appropriately elicit social support. SL began to report improved social functioning at school and increased perceived support following participation in an LGBTQ+ support group in his community. After a few months of reduced symptoms of anxiety and depression, treatment began to focus on clarifying goals for social and medical transition. The mental health provider collaborated with SL and his parents to advocate for use of his preferred name and pronouns at school and participated in family sessions to prepare for sharing his gender identity with extended family members. As a result of social transition across settings, SL began to report reduced feelings of shame and hopelessness and the family participated in an

initial consultation at a local clinic to receive information about the risks, benefits, and realistic expectations for initiating hormone therapy. As SL's parents assented to hormone treatment and his mental health provider determined that his mental health was stable and reasonably well-managed, SL began receiving weekly injections of testosterone. After several months of hormone therapy, SL continues to experience significant anatomical dysphoria related to his breasts and genitalia and noted an increase in social anxiety in response to people commenting on noticeable changes to his body/facial hair and voice tone. Although SL still struggles with accepting his gender identity and presentation without surgical intervention, he continues to cope effectively with urges to engage in self-harm and is working with his mental health provider to develop an appropriate treatment team when he begins college.

Summary

Gender and sexuality exist in continuums with infinite possibilities. The gender and sexuality continuums are separate yet interrelated realms. The gender continuum can be further expanded into separate but not mutually exclusive masculine and feminine continuums. Consolidated gender and sexual identity develops across the lifecycle as a result of the continual integration of gender- and sexuality-specific realms of attraction/orientation, behavior/expression, and identity. Each individual is unique and composed of multiple identities that exist within and interact with other sociocultural realms, such as socioeconomic status, geographic region, race and ethnicity, religious and spiritual affiliation, and gender and sexuality, among others.

In order to provide the most effective, comprehensive, and appropriate care for our patients, we must be able to respectfully inquire about *all* of these realms for *all* of our patients. Research to date has shown that by building our level of skill, knowledge, and comfort in asking about these aspects of our patients' lives, we can improve overall health outcomes and strengthen our therapeutic alliances. Future directions for clinical work, research, and education are vast and include but are not limited to ensuring equal access to and improved quality of care for those living on the gender and sexual continuums as well as addressing the roots of stigma, discrimination, and prejudice both within healthcare and society at large.

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