Special Issue: Mental Health and Sexual and Gender Minority Youth

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Welcome to JAACAP Connect!

What is JAACAP Connect?
All are invited! JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), the leading journal focused exclusively on psychiatric research and treatment of children and adolescents. A core mission of JAACAP Connect is to engage trainees and practitioners in the process of lifelong learning via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.

Why do we need JAACAP Connect?
The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. JAACAP Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences.

Who reads JAACAP Connect?
All students, trainees, and clinicians who are interested in child and adolescent mental health will benefit from reading JAACAP Connect, available online at www.jaacap.com/content/connect. AACAP members will receive emails announcing new quarterly issues.

Who writes JAACAP Connect?
You do! We seek highly motivated students, trainees, early career, and seasoned clinicians and researchers from all disciplines with compelling observations about child and adolescent psychiatry. We pair authors with mentors when necessary, and work as a team to create the final manuscripts.

What are the content requirements for JAACAP Connect articles?
JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our first edition, the topic and format can vary widely, from neuroscience to teen music choices.

How can JAACAP Connect help with my educational requirements?
Motivated by the ACGME/ABPN Psychiatry Milestone Project©, JAACAP Connect aims to promote the development of the skillset necessary for translating scientific research into clinical practice. The process of science-based publication creates a vital set of skills that is rarely acquired elsewhere, and models the real-life thought process of translating scientific findings into clinical care. To bring this experience to more trainees and providers, JAACAP Connect aims to enhance mastery of translating scientific findings into clinical reality by encouraging publishing as education.

JAACAP Connect combines education and skill acquisition with mentorship and guidance to offer new experiences in science-based publication. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles. Opportunities for increasing knowledge and skills through publishing as education will be available through continued contributions and direct involvement with the JAACAP Connect editorial team, using an apprenticeship model.

Start Thinking About Authorship With JAACAP Connect
What trends have you observed that deserve a closer look? Can you envision re-framing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome, and you are invited.
Passing of the Torch

This Special Issue is my final issue as Editor of JAACAP Connect given the completion of my term in December 2018. Originally slated for publication in Fall 2018, this issue was delayed due to the illness and passing of a member of my family.

I take pride both in this Special Issue’s focus on mental health among sexual and gender minority youth and in the fostered connections—through mentorship, co-authorship, and collaboration—that are reflected in this Connect issue. Our Editorial Board and I very much enjoyed working with Nix S. Zelin, MD, a talented and knowledgeable resident, and with Scott Liebowitz, MD, Co-Chair of the AACAP Sexual Orientation and Gender Identity Issues Committee—both of whom helped curate and bring to fruition this issue. We also enjoyed the opportunity to connect our authors early in their process with experts in our field who are active in our national and international professional organizations. In so doing, this issue exemplifies the mission with which Michelle S. Horner, DO, founded Connect: “to engage trainees and practitioners in the process of learning throughout the lifespan via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.”

As Connect moves forward, I also would like to acknowledge and congratulate Justin Schreiber, DO, MPH, who assumed the role of Editor in January 2019. He is a remarkable individual whose passion for advocacy and citizenship as a physician are impressive, and I very much look forward to the directions in which he will lead Connect.

Finally, I would like to thank all of the authors and mentors who have contributed to Connect over my tenure as Editor, and, in addition to Michelle and Justin, also would like to thank Andrés Martin, MD, MPH, Douglas K. Novins, MD, Mary K. Billingsley, ELS, Mariel Gambino, and the entirety of the Connect Editorial Team for their tremendous commitment to ensuring that connections of all kinds are made.

What immediately follows is an introduction that I invited Nix to prepare, given her significant contributions to this Special Issue.

Oliver M. Stroeh, MD
Former Editor
As a third-year medical student, I once made a pediatric patient scream.

A young teen with poorly controlled chronic health issues and a difficult home situation, “Alex” had received no visitors over the preceding 5 days of her hospitalization and made it clear that the medical staff were a poor substitute. As I worked with Alex, she gradually opened up and became curious—about medicine, about what it means to be a medical doctor versus a medical student, and about me—where I was from, what television shows I liked, and if I knew about her favorite YouTube stars.

“Do you have a boyfriend?” she asked.

I replied, “No, I’m actually married. I have a wife.”

Alex shrieked.

My heart stopped.

“Are you GAY?”

My chest suddenly tight with unease, I said, “Yes.”

“Me too! I’ve never met an adult who’s gay!”

Alex visibly brightened, cracking a wide smile as she told me that she was a lesbian and that I was the first adult and the second person with whom she had ever shared her identity (the first being a friend who had recently come out). Alex’s mother had told her “being anything but straight is a sin and you’ll go to hell.” Alex planned on “coming out” to her mother once she was old enough to support herself. Alex said she knew that her mother would kick her out upon coming out, so she wanted to be able to take care of herself. Her only access to community, role modeling, and support was through watching YouTube videos of a lesbian couple and talking with a single peer. Thirsty for connection and affirmation, she peppered me with questions.

Honored and humbled to be entrusted with Alex’s disclosure, I returned to my clinical team to discuss how to best incorporate this information into her care. I was surprised when the supervising resident expressed concern and discomfort, explaining that she was inexperienced about “these types of complex situations” and recommended I speak to Alex’s social worker. I was again surprised when the attending, concerned about the potential negative impact of discontinuity of care, asked if Alex would be better served “having this conversation with someone else that she will have more long-term contact with.”

I was shocked when the social worker flatly refused to speak to Alex: “Oh, I know her. She has lots of problems. And this isn’t even related to her medical problems. She can deal with private matters in her private life.”

The data are convincing: extensive mental and physical health disparities exist between sexual and gender minority (SGM) youth and adults, and their counterparts in the general population. The etiology of these disparities is multifactorial, with societal stigma playing a key role in their creation and perpetuation. Research also shows that health care providers have played an undeniable role in this process. A substantial portion of SGM individuals avoids or delays seeking care due to past experiences of bias and discrimination in healthcare. In turn, a significant fraction of providers and providers in training reports discomfort and even a lack of competence in addressing SGM-specific health concerns and incorporating culturally-responsive practices in providing care to SGM patients.

As a mental health provider in training, budding educator, SGM health researcher, and a queer cisgender woman...
with non-normative gender expression, I am delighted to introduce this special lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) issue of JAACAP Connect dedicated to exploring the following: stigma and mental health among SGM populations (Structural Stigma, Chavez et al.), mental health concerns of sexual minority youth (Mental Health Among Sexual Minority Youth, Marin-Rodriguez et al.), and SGM-specific mental health interventions (A Review of Mental Health Interventions for Lesbian, Gay, Bisexual, and Transgender Youth and Adults, Murota et al.). It is my sincere hope that this Special Issue will prove a useful resource for students, trainees, and practitioners who seek to better understand or to review what is known about mental health among SGM youth, and to disseminate best practices and promising innovations.

This Special Issue began as a simple inquiry about a potential writing experience for one of my pre-medical mentees passionate about SGM health. That simple inquiry blossomed with the vision and support of Dr. Oliver Stroeh, Editor of JAACAP Connect and Dr. Justin Schreiber, Editor-in-Chief of JAACAP Connect, who asked me to dream bigger and expand the proposed article into a comprehensive special issue. Over the course of this project, I have had the pleasure of working with an impressive and inspiring group of trainees and pre-medical applicants, some of whom I knew before and others of whom I have had the pleasure of meeting through this project. My sincerest thanks and appreciation to Dr. Alexis M. Chavez, Dr. Brenda Marin-Rodriguez, and Dinora M. Murota for their passion, curiosity, dedication, and patience. I am also incredibly grateful to Dr. Scott Liebowitz, Co-Chair of the AACAP Sexual Orientation and Gender Identity Issues Committee, and his colleagues on the committee, Dr. Aron Janssen, Dr. Cynthia Telingator, and Dr. Peter T. Daniolos, who volunteered to serve as mentors and content experts for this project.

Alex left the hospital a few days later. In that time, we as a team had several opportunities to discuss in depth how Alex’s identity was intimately tied to her risk for and experience of chronic disease, as well as to her unique life experience, challenges, and strengths. We also had the opportunity to provide high quality and compassionate care, which by necessity included addressing Alex’s disclosure and connecting her with community resource without violating her confidentiality or our legal and ethical obligations as healthcare providers caring for a minor.

May this LGBTQ+ Special Issue inspire, inform, and support such important discussions, wherever they may be—in the clinic, in the classroom, in the community, in research or elsewhere!

About the Author

Nix S. Zelin, MD, currently conducts human sexuality research at For Goodness Sake, LLC. She is passionate about LGBTQI+ mental health, mentorship and medical education.

Disclosure: Dr. Zelin has reported no biomedical financial interests or potential conflicts of interest.

*Variations of this acronym will appear based on authors’ usage throughout manuscripts.
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Gender Fluidity: New Freedoms or New Pressures?

David C. Rettew, MD

Despite some significant changes over the past decades, society continues to assert its power on gender identity and expression in both subtle and not so subtle ways. From the way a parent decorates their expected baby's nursery, to the gender of astronauts and nurses in book and television characters, to the type of toy one receives when ordering a McDonald's happy meal, signals continue to be sent regarding what it means in this world to be a boy or a girl. The impact of these various influences is undeniable but, as we also know, far from omnipotent. We learn this from many of our transgender patients, friends, and colleagues, many of whom describe an inner sense of certainty that, despite all the cultural pressure, their assigned gender at birth just never fit an inner sense of who they are. We also know this from many cisgender children whose progressively-minded parents, for example, build beautiful dollhouses for their young boys only to have them used as car jumping ramps and destinations for dinosaur monster invasions. Yet for many transgender individuals, a lot of pain can develop when the world of external expectations and the world of authentic expression of one's affirmed gender collide. And sadly, this inner distress too often is accompanied by emotional and physical pain in the form outright abuse and bullying.

For these reasons, there has been a noticeable shift over the years in the recommended approach to children who express various degrees of gender incongruence or fluidity. During my training in the early 2000s (which admittedly can't be construed as the norm that all residents and fellows experienced at the time), we were taught what might be called the “big tent” approach, in which we were encouraged to supportively challenge the notion that just liking “boy” or “girl” things did not need to mean that someone actually was the “other” gender. By expanding a child's view of what it means, or more specifically what it does not mean, to be a boy or a girl, we could then help them feel more comfortable about their particular tastes and behaviors without the need for them to take measures that then were considered more extreme and, frankly, problematic.

Such an approach was clearly a step forward compared to some traditional methods of actively confronting and even punishing children for what was considered to be gender-atypical behavior, but it likely still left many kids feeling invalidated and criticized for who they were. Fast forward about 15 years or so, and things have continued to evolve. Today, one might summarize the current recommendations for children with gender incongruence as being much less focused on getting the kid to fit the society and much more focused on getting society to fit the kid. This means motivating people in the child's environment such as parents, teachers, and peers to not just tolerate but really embrace a child's gender incongruent feelings and behaviors at whatever level they are. Such a change in approach has been guided by some research which suggests that the well-documented high levels of psychopathology among transgender and gender incongruent individuals are at least primarily driven by the rejection and outright hostility that the person experiences from others. In a study by Olson et al., children whose transgender identity was supported and had socially transitioned were not found later to have elevated rates of clinical depressive or anxiety symptoms.

But, as with most things, the devil is always in the details. The children in the study above weren’t simply natal boys who like to paint their fingernails or natal girls who played with trucks; these were kids who “persistently,
insistently, and consistently (pg 2)” identified as the “opposite” gender. Consequently, it remains an open and debated question about what the best approach is to take with kids who express less persistent, insistently, and consistent gender incongruence or dysphoria. The current consensus among most mental health professionals (always a dangerous thing to infer) seems to be to accept and support the child where they are, and then follow their lead, while advocating on their behalf to the world around them. Fair enough, but could there be any hazards with that approach, especially if a parent starts to get out in front of where the child actually is? Furthermore, a related and interesting question that has been raised (remembering the stuff about the power of culture in the opening sentences) is whether a gender-neutral environment not only releases a child from the pressure of society’s artificial set point with regard to the gender spectrum but actually moves the needle somewhere else. Such a concern has been brought up widely in the media. Even the Pope, who is often viewed as more LGBTQ friendly than most or all of his predecessors, has called the endorsement of a more non-binary worldview of gender a form of “ideological colonization.”

Research on this question has been slowly arriving. For example, a recent Swedish study of 3- to 6-year-old children compared kids who were in typical preschool programs versus those in gender-neutral programs, where teachers did their best basically to eliminate the role of gender in the classroom with regards to everything from toy preferences to pronouns. Perhaps not surprisingly, they found differences in some things and not others. The gender-neutral classroom did seem to reduce some gender-based stereotypes, for example, but did not influence the preference of same-sex peers as preferred playmates and did not appear to have an effect on children’s gender identity.

For many, a perfectly legitimate response to all this might be a resounding “What does it matter?” In other words, who cares if a non-binary gender identity for some kids is actually a product of a culture’s less rigid views while for others the path is more highly influenced by genetics or prenatal factors? Since we’ve already learned that basically everything with regard to mental functions comes from mutually interacting genetic and environmental factors, the fact that gender identity is too suggests that any value judgements about which hypothesized pathway is more valid on an individual basis is both morally and scientifically perilous. This perspective makes a lot of sense, in my view. At the same time, however, I believe it is also important to remember that, after seeing all the stories on the news about the suffering of gender incongruent youth, you don’t have to be a fascist or a hateful parent to fear the potential implications of gender incongruence for your child and express some hesitation about fully getting “on board” when your child first expresses non-binary feelings about their gender.

In the end, after all the nuance, political controversy, and scientific complexity, maybe we are left with the endorsement of some simple goals as mental health professionals in trying to navigate this new and fascinating territory with our patients and families: active listening, compassion, curiosity, and an attempt to guide without over-steering.

References
About the Author
David C. Rettew, MD, is an associate professor of psychiatry and pediatrics at the University of Vermont Larner College of Medicine and the Medical Director for the Child Division of the Vermont Department of Mental Health. He is author of the book Child Psychiatry: New Thinking About the Boundary Between Traits and Illness and the “ABCs of Child Psychiatry” blog on the Psychology Today website. You can follow him on Twitter at @PediPsych.

Disclosure: Dr. Rettew has received royalties for his blog for Psychology Today and from Guilford Press.

To Participate in the Lab to Smartphone Column
To suggest a topic for this column or to inquire about co-writing a Lab to Smartphone column with Dr. Rettew or another child psychiatry mentor, please send an email to david.rettew@med.uvm.edu.

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What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

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Structural Stigma

Alexis M. Chavez, MD, and Aron Janssen, MD

There are well-documented health disparities in the LGBTQ population. LGBTQ youth are at higher risk for depression, anxiety, and addiction. In a Center for Disease Control and Prevention survey, 60% of LGB students reported having been so sad or hopeless that they stopped doing some of their usual activities. Studies in LGBT adults have found higher risks for tobacco, alcohol, other drug use, obesity, cancer, and HIV. When examining health disparities in minority populations such as LGBTQ populations, it is important to consider the role that stress and stigma play in order to fully appreciate how these disparities are created, increased, and perpetuated.

Discrimination exists in many forms and at many different levels, ranging from the individual to the institution. Structural stigma refers to systems of rules and patterns of behavior within a society that restrict rights and opportunities of minority groups. It can also be called structural discrimination, systemic discrimination, or institutionalized discrimination, although these various concepts have been separated at times by their focus on legal aspects or intentionality of the discrimination. At the core, they all have focused on the disadvantages suffered by oppressed groups for the advantages of the majority group in power. Historically, structural discrimination was primarily applied to legal (de jure) discrimination; however, the very concept of a social structure includes expected behaviors of its members. Structural discrimination also exists in these cultural norms and attitudes (de facto discrimination) and may be intentionally hidden at times.

Chronic stigmatization leads to negative health outcomes. One model through which to understand this is the minority stress model. In this model described by Meyer et al., external forces such as discrimination lead to expectation of the recurrence of discrimination. The greater the stigma, the greater the vigilance for these events. This hypervigilance can lead to internalization of this discrimination and negative valuation of the self. As a result, LGBTQ people are at higher risk of numerous medical and mental health problems.

Sexual and/or gender minority youth are at higher risk for many adverse events: being physically forced to have sex, experiencing sexual dating violence, experiencing physical dating violence, being bullied at school or online, and missing school due to safety concerns. They experience particularly high rates of bullying and 40% of homeless youth are estimated to be LGBT.

The minority stress model can be applied to understand how structural stigma affects the health of LGBTQ people. With higher levels of structural stigma (an external force), there is a direct increase in health problems in this population. Even the perception of social rejection is as important to health outcomes as actual experiences. Conversely, there is a decrease in health problems when structural stigma is decreased.

There have been some significant gains in LGBTQ rights during recent history. Such gains include same-sex marriage legalization by the Supreme Court in 2015, or The Equal Employment Opportunity Commission (EEOC) ruling during the Obama administration that Title VII of the Civil Rights Act of 1964 (“Title VII”) does not allow discrimination based on gender identity or sexual orientation because they are forms of sex discrimination. However, progress is not always linear. In the current political environment, there have been several setbacks for LGBTQ people as well. In 2016, North Carolina (NC) passed the Public Facilities Privacy & Security Act, commonly known as HB2. This bill prevented the creation of any laws in NC that would protect LGBT people. It also dictated that people use restrooms and changing facilities that correspond to the sex identified on their birth certificates. In early 2017, NC HB2 was replaced with a narrower law that, through the year 2020, restricts cities and counties from
protecting against employment discrimination based on sexual orientation and gender identity. In 2016, Mississippi passed the Religious Liberty Accommodations Act, HB 1523, which allowed for discrimination against same-sex marriage or transgender individuals based on “sincerely held religious beliefs or moral convictions.” In more than half of the states in the US, there are no anti-discrimination laws for gender identity or sexual orientation.

Discriminatory laws (de jure discrimination) have not been applied equally to sexual minority and gender identity. During the current administration, the Attorney General at the time, Jeff Sessions, wrote a memo to clarify that Title VII will not be interpreted to protect gender identity under the category of sex-based discrimination. The reasoning behind the ban was that the military would incur “tremendous medical costs.” Transgender individuals were barred from enlisting in the military from August 2017 until the ban was struck down in district court in January 2018.

Additionally, discrimination continues to occur independently of codified law or the interpretation thereof (de facto discrimination). In 2017, a study conducted by Suffolk University Law School’s Housing Discrimination Testing Program showed that when looking for apartments in Greater Boston (where there are laws protecting against discrimination of gender identity), transgender and gender non-conforming people received discriminatory differential treatment 61% of the time. In addition, they were less likely to be shown additional areas of the apartment complex, [or] offered a financial incentive to rent, [and] more likely to be told negative comments about the apartment and the neighborhood, and … to be quoted a higher rental price.

The current political climate and its contributions to the structural stigma experienced by LGBT communities has resulted in a rise of concern among LGBTQ youth. Over the 24-hour period following the presidential election in 2016, the nonprofit organization The Trevor Project, the nation’s largest LGBTQ youth crisis intervention and suicide prevention organization, received from transgender youth more than double their usual number of LGBTQ suicide hotline calls. The Trevor Project again experienced an influx in calls after the Texas legislature introduced an anti-trans bill in 2017. Another crisis hotline, Trans Lifeline, saw similar significant increases in call volume; as reported in 2017, “in many ways, the story our call volume tells is our community being in more or less constant crisis since November (2016).”

It is difficult to approximate the full extent of the health impact of the current stigma due to limited availability of large data sets of LGBTQ populations. Indeed, the lack of this is a form of structural stigma and perpetuates disparities. In April 2016, despite the fact that “more than 75 members of Congress wrote to the Census Bureau to request the addition of sexual orientation and gender identity as a subject for the American Community Survey (ACS)… [the Census Bureau] concluded [in 2017] there was no federal data need to change the planned census and ACS subjects.”

Furthermore, the high levels of discrimination that are currently seen may have a more significant impact years from now. A 2011 Institute of Medicine (IOM) report found that “the disparities in both mental and physical health that are seen between LGBT and heterosexual and non-gender-variant youth are influenced largely by their experiences of stigma and discrimination during the development of their sexual orientation and gender identity and throughout the life course.” Those youth that are currently experiencing stigma due to their sexual orientation or gender identity may have lasting adverse health effects.

The health disparities we see in LGBTQ youth have been documented even during periods of greater political support. Given the known association between structural stigma and health outcomes, it stands that with the recent political climate and its increasing level of
discrimination, there are greater adverse health effects than have previously been measured. To counter this, LGBTQ youth would benefit from increased levels of support wherever possible. It is important for providers to be knowledgeable about the stress their patients may face—particularly as a result of structural stigma—in order to best serve this population.

**Take Home Summary**

Structural stigma has a direct, negative effect on the mental health of LGBTQ youth. The level of structural stigma against LGBTQ youth has been increasing in the current political climate, and may have lasting negative effects on their mental health.

**References**


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About the Authors

Alexis M. Chavez, MD, is the medical director of The Trevor Project. She is a founder of multiple award-winning clinics with focuses on LGBTQ mental health and interdisciplinary trans health, and has trained providers across the country to improve competency working with LGBTQ patients. She has held various offices and positions from the local to national level including as a member of the Council of Research of the APA; Treasurer of AGLP, the national organization of LGBTQ Psychiatrists; member of the Sexual Orientation and Gender Identity Issues Committee of AACAP; and a member of the Board of Directors for the GLBT Center of Colorado. She is an APA-SAMHSA Fellow, a 2018 Power Gala Award Winner, and an aunt to three adorable children.

Aron Janssen, MD, is a Clinical Associate Professor of Child Psychiatry at NYU Langone, New York, NY. He is the founder and director of the Gender and Sexuality Service at the NYU Child Study Center.

Disclosure: Drs. Chavez and Janssen have reported no biomedical financial interests or potential conflicts of interest.
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Mental Health Among Sexual Minority Youth

Brenda Marin Rodriguez, PhD, and Cynthia Telingator, MD

The term sexual minority youth (SMY) encompasses youth who are not exclusively heterosexual. These are youth whose sexual orientations, identities, and/or behaviors are not exclusively heterosexual. Sexual identity is one’s personal identity as a sexual being, a label used in regard to oneself, such as “gay,” “lesbian,” “queer,” “pansexual,” or “asexual.” Sexual identity may not be indicative of sexual behaviors and, thus, understanding both identity and behavior are essential to providing excellent care—particularly as SMY youth often face health disparities. SMY youth, like their heterosexual peers, have strengths and vulnerabilities. Although the majority of sexual minority children and adolescents do well, they are likely to experience mental health issues such as anxiety, depression, substance abuse, and suicidality at higher rates than their heteronormative peers. This phenomenon may be due to stigma, microaggressions, victimization, and/or discrimination regarding their sexual identities, which in turn effects overall health. In a 2013 survey performed by the Gay, Lesbian & Straight Education Network, 55% of sexual and gender minority youth surveyed stated that they felt unsafe at school due to perceived/experienced harassment from peers. This harassment can lead to an increase in suicidal ideation and attempts due to internalized shame and stigma, social isolation, and conflict about their identities. Microaggressions, stigma, and shame may also be experienced at home and in the community. Healthcare providers are in a unique position to support minority youth across multiple domains if they are aware and informed of social supports and experiences of conflict.

In an attempt to improve the medical and mental healthcare practices provided to SMY, healthcare providers should be comfortable discussing these issues. Openness to listening to youth and supporting their identity development is essential to maintaining an alliance. Patients’ trust in their providers is often impacted by their experience of feeling heard and seen. In the long-term, developing alliances includes gaining understanding of the patients’ past and present relationships with their providers. Being aware of their positive and negative experiences can help providers understand the patients’ willingness to seek medical and mental health support when needed.

Definitions

The following definitions reflect some current terminology that patients may use in describing their sexual identities.

Sexual Orientation: an individual’s inclination to feel sexual attraction or arousal to a particular body type or identity. The term has also been used as an umbrella term, which encompasses three dimensions: identity, behavior, and attraction. An individual’s sexual orientation identity is dependent on the gender identity of the person(s) an individual is romantically and/or sexually attracted to. Sexual behavior refers to the sexual acts in which an individual engages. A person’s sexual identity may be incongruent with that individual’s behavior.

Sexual Minority: a group comprised of individuals whose sexual orientation identities and/or behaviors differ from the societal norm. This umbrella term includes youth who identify as gay, lesbian, bisexual, pansexual, and asexual, as well as youth whose sexual partners do not identify with the opposite gender in a binary (male/female) model of gender.

Asexual: a term to describe a sexual orientation primarily characterized by low or absent sexual attraction. Asexuality is not the same as lacking romantic attraction or being celibate; some asexual individuals have romantic relationships and/or sexual relationships.
Bisexual: a term to describe a sexual orientation characterized by romantic attraction to both female-identifying and male-identifying individuals.7

Demisexual: a term to describe a sexual orientation characterized by feeling sexual attraction only to people with whom an individual has an emotional bond.10

Gay: a term to describe a sexual orientation characterized by romantic and sexual attraction to persons of the same gender in a binary model of gender. Some people, especially in the African American community, alternately identify as ‘Same Gender Loving’.10

Heterosexual/Straight: a term to describe a sexual orientation characterized by romantic and sexual attraction to the opposite gender in a binary model of gender.

Lesbian: a term to describe a sexual orientation of a female-identified person whose romantic and sexual attraction is primarily to other female-identified people.

Pansexual/Omnisexual: a term to describe a sexual orientation characterized by romantic attraction to others regardless of their gender identity or biological sex.9

Queer: historically, this term was derogatory slang used to describe individuals perceived as being part of a sexual or gender minority group. More recently, this term has been reclaimed, particularly by younger members of the sexual and gender minority community. In this more recent iteration, queer can (1) refer to an individual’s sexual identity, (2) refer to sexual identity, sexual orientation, sexual behavior, gender identity or gender expression that does not conform to societal norms based on cisgenderism and heterosexuality, and (3) refer, as an umbrella term, to the LGBTQ community.

Questioning: a term for an individual exploring their sexual orientation, gender identity and/or gender expression.10

Sexual Development
An early awareness of one’s sexuality begins during childhood. However, the substantial physical, psychological, and socio-cultural changes that occur during adolescence often increase an individual’s desire to explore and understand the various aspects of sexuality, including attractions, behaviors and identity.3 The development of one’s sexual identity can be affected by many factors, including the religion and the socio-cultural landscape in which one is raised. Therefore, SMY may “cover,” or hide their true identity in order not to alienate family, friends, religious supports, and their communities.12 Factors such as caregiver views on sexuality, peer relationships, sexual education, media exposure, family support, and cultural gender hierarchies can impact an individual’s comfort with their sexual identity, sexual exploration, and sexual expression. Sexual identity may be fluid across development and experience.

Role of a Mental Health Provider to SMY
Individuals may develop rigid or fluid sexual identities. As a mental health provider, it is important that the provider supports the patients’ understandings of their sexual identities. Moreover, it is important to help patients develop self-efficacy and a strong support system for all aspects of their identities. Self-efficacy can be promoted by providing an education on sexual health practices that promote healthy sexual relationships.

Although there is no uniformly recommended evidence-based treatment strategy to assist youth with negotiating adolescence as a SMY, there are various approaches, including family, psychodynamic, and cognitive-behavioral psychotherapeutic approaches, which have resulted in positive outcomes.1 The initial responsiveness and openness of the clinician will set the tone for the therapeutic encounter. Closed-ended questions will often foreclose on the possibility of developing trust and openness on the part of the SMY. The patient is less likely to speak about same-sex attractions if the clinician assumes heterosexuality. Alternatively, identifying an adolescent with same-sex desires as gay or lesbian, or any assumptions made based on a single moment in time without the adolescent labeling themselves as such, may prohibit exploration of other sexual identities, attractions, or behaviors. By creating a safe and nonjudgmental space the therapist can explore feelings that the adolescent is experiencing.
Caregiver Acceptance Versus Rejection

Building a strong support system can greatly empower young patients. Assessing the patient’s emotional support from family or other caregivers is an important part of assessing safety and well-being. It is also important to assess school and community safety and support.

Some parents/caregivers may be resistant to embracing SMY. Parent/caregiver rejection of sexual minority young adults is correlated with higher levels of attempted suicide, depression, unprotected sexual activity, and substance abuse. However, caregiver acceptance seems to be a protective factor to SMY health. Parent/caregiver support of sexual orientation in LGBT youth is correlated with decreased levels of substance abuse, suicidality and depression, as well as greater self-esteem and better general health status. If the clinician has an alliance with the parents and the permission of the child/adolescent, the clinician can address the parents’ concerns and questions with the goal of supporting the family. Outside agencies such as Parents, Families and Friends of Lesbians and Gays (PFLAG) also offer outside support and community for parents of SMY.

SMY who experience stigma and microaggressions within health care systems may be dissuaded from accessing healthcare. Trainees working in these environments should identify mentors who are willing to support them in advocating for infrastructural and policy changes to support minority youth.

Establishing Trust

Establishing trust with a patient is essential to the development of a positive professional relationship. Offering patients a place in which they feel comfortable disclosing all aspects of their lives and their identities can help them to address medical and mental health concerns across the lifespan. Attending to the following guidelines can be helpful in creating a positive therapeutic alliance:

- **Use preferred pronouns.** Rather than assume an understanding of a patient’s identity, ask the patient about their preferred name and pronouns at the beginning of an interaction. Making this standard practice communicates openness and respect towards all patients.

- **Inquire about how a patient self-identifies with regards to sexual identity.** This may or may not be reflective of sexual practices, so it is important to inquire about sexual behavior and attraction, as well. Regardless of sexual practices, it is important to know how an individual identifies in a multidimensional way, and that it may change over time.

- **Provide privacy.** When talking about potentially difficult topics such as sexual orientation or gender identity, make sure not to address these topics for the first time in front of caregivers. Give patients privacy to express themselves and ask whether these are topics that can, or should, be addressed in front of their caregivers. Let the patient decide if and when they will discuss gender or sexual identity with their caregivers.

- **Address power dynamics.** Patients and their caregivers might be resistant to opening up to health care providers because of perceived power dynamics. Patients may feel that a provider has the power to act against their personal self-interest. Explain to patients and caregivers your role. Ask them openly about any anxieties they may have about mental health care and address compassionately any fears or misconceptions they may have.

- **Embrace narrative medicine.** In narrative medicine, the health provider asks the patient to describe which aspects of their lives are going well, and what parts are not going well. Therefore, instead of relying on particular identity labels and making assumptions about their struggles, let the patient define/explain who they are, what their life is like, and what they would like your help with.

Creating a space where SMY feel safe in disclosing their sexual attractions, behavior, and identity to a mental health provider will facilitate a relationship based on
trust, mutual respect, and acceptance. Identity is not limited to one’s sexual identity or sexual practices, but sexual identity is an aspect of development, which may shift and change over time. Support and acceptance allow for the integration of this important aspect of identity across the intersectionality of identity exploration and integration. The lack of support for this aspect of self can have negative consequences for the health and well-being of sexual minority patients. Clinicians are in a unique position to support these youth and develop an alliance that has positive long-term ramifications.

**Take Home Summary**

Sexual minority youth (SMY) encompasses youth whose sexual orientation, identities and/or behaviors are not exclusively heterosexual. SMY often face health disparities due to stigma. Healthcare providers can support SMY if they are informed of issues which these youth may confront. It is also essential to be aware of the importance of evaluating familial and community supports, and places where they may encounter emotional and physical harm.

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A Review of Mental Health Interventions for Lesbian, Gay, Bisexual, and Transgender Youth and Adults

Dinora M. Murota, BA, and Peter T. Daniolos, MD

**Objective:** Lesbian, gay, bisexual, and transgender (LGBT) people, particularly LGBT youth, are at higher risk for developing a mental illness compared to their straight and cis-gender peers. As such, the purpose of this review is to identify evaluated mental health interventions tailored for LGBT youth and adults.

**Method:** A systematic review of peer reviewed articles related to mental health interventions in LGBT youth and adults was conducted for articles published before March 2018 via Ovid MEDLINE. In addition, a keyword search of PubMed was conducted. In this review, four studies are examined, and two ongoing studies are noted. Articles were selected if they described an evaluated mental health intervention tailored for LGBT youth or adults.

**Results:** Four interventions were identified that met inclusion criteria: one study on a cognitive behavioral therapy (CBT) intervention for gender and sexual-minority youth, one attachment-based family therapy study adapted for suicidal lesbian, gay, and bisexual (LGB) youth and their parents, one CBT intervention for young gay and bisexual men, and one expressive writing intervention for gay, male college students. In addition, two ongoing studies on interventions for LGB young adults were identified.

**Conclusion:** There is a clear and concerning dearth of clinically evaluated mental health interventions for LGBT youth and adults, particularly of studies including transgender people, which should be viewed by researchers and clinicians as a call to action to address the mental health needs of LGBT youth and adults.

Compared to the general population, lesbian, gay, bisexual, and transgender (LGBT) youth, as well as the LGBT population as a whole, are at higher risk of developing mental illnesses (such as depression, anxiety, eating disorders, and substance abuse disorders) and suicidal ideation. Indeed, LGBT individuals in their teens and early twenties are at higher risk for depression than even older LGB adults. Many researchers attribute these mental health disparities to minority stress, which includes stress due to internalized stigma and shame, as well as the discrimination that LGBT people face, not only from strangers, but from healthcare workers and their own families. Moreover, LGBT youth may experience especially high levels of stress, as early adolescence is the period during which a majority of LGBT youth “come out” and disclose their LGBT identity. Consequently, it is essential that LGBT youth receive appropriate mental health care that takes into account their particular hardships and distinct needs. Although some guidelines on affirmative mental health practice for LGBT youth exist for clinicians, there are very few studies on the efficacy of mental health interventions targeted towards LGBT youth or even the LGBT population as a whole. This review explores the literature on mental health interventions tailored to LGBT youth and/or adults, identifies and describes effective interventions, and determines areas for further study.

**Method**
A systematic review of peer-reviewed articles related to mental health interventions in LGBT youth and adults was conducted for articles published before March 2018. Articles were selected if they described an evaluated mental health intervention tailored for LGBT youth or adults. Articles were identified via Ovid MEDLINE using the search terms “LGBTQ AND interventions AND all ages AND English AND evaluation.” The search provided 256 results, of which 3 were selected for the final sample. Using PubMed’s Automatic Term Matching feature to search sequentially for matching subjects,
journals (if no matching subjects are identified), and authors (if neither matching subjects or journals are identified), PubMed was also searched with three sets of key words: “LGBT AND mental health AND intervention” (128 results, 0 selected for the final sample after removing duplicates); “LGB AND mental health AND intervention” (53 results, 2 selected for the final sample after removing duplicates); and “transgender AND mental health AND intervention” (278 results, 0 selected for the final sample after removing duplicates). In addition, an ancestral approach was utilized to discover further relevant literature (1 selected for the final sample). The authors reviewed the article titles for relevance and, if relevant, read the abstract. Based on the abstract, articles underwent full-text screening by DM. Case studies were not included, nor were studies focusing exclusively on HIV-positive LGBT adults or youth.

Results

Of the four articles that met inclusion criteria, two studies reviewed interventions for youth: one, a pilot study examining the effectiveness of a cognitive behavioral therapy (CBT) intervention tailored for gender and sexual-minority youth, and the other, a preliminary study determining the effectiveness of an attachment-based family therapy adapted for use with suicidal LGB youth and their parents. The other two identified studies focused on interventions for adults: a randomized controlled trial looking at the efficacy of CBT for young gay and bisexual men, and a study analyzing the efficacy of an expressive writing intervention for gay male college students. Lastly, two articles described ongoing intervention studies, but did not provide outcomes evaluating the interventions.

Tailored LGBT Mental Health Interventions With Evaluations

Craig and Austin reported the outcomes of AFFIRM, a feasibility study which examined the effectiveness of an affirmative, eight-module cognitive-behavioral therapy (CBT) intervention intended to improve coping and reduce depression in LGBT youth. The thirty 15- to 18-year-old participants identified as non-heterosexual and two were transgender. Modules were delivered to groups of 10 over a two-day retreat at a sexual and gender minority community center by trained facilitators who themselves identified as members of the sexual and gender minority population (including LGBT, queer, intersex, and gender-nonconforming).

Depression, reflective coping, and stress appraisal were assessed over a four-week period prior to the intervention. Stress appraisal was composed of three subscales: challenge appraisal (which ascribes “potential personal growth to stressful experiences” and assesses whether stress challenges wellbeing); threat appraisal (“the belief that an occurrence may contribute to future or present harm”); and resource appraisal (which assesses whether personal resources can be used to cope with stressors). These outcomes and the acceptability of the program were evaluated immediately after the intervention and again three months later. All 30 participants completed the pre-intervention and immediate post-intervention assessments. Only 17 participants completed the three-month post-intervention assessment. No demographic differences (such as sexual orientation, gender identity, or levels of psychological distress) existed between those that did and did not complete the final assessment.

The researchers found a decrease in depression between baseline and the end of treatment ($p < .001$), as well as between baseline and three-month follow up ($p < .05$); an increase in reflective coping between baseline and three-month follow up ($p = .05$); a decrease in threat appraisal between baseline and end of treatment ($p < .05$) and between baseline and three-month follow up ($p = .05$); and increases in challenge appraisal and resource appraisal between baseline and end of treatment ($p < .001$ and $p = .04$, respectively). 97% of participants reported that they had learned to cope with stress, that they could use what they had learned to help deal with problems in their lives, and that they would recommend the intervention to other sexual and gender minority youth.

These results suggest that tailored CBT modules could be beneficial for LGBT youth. However, the absence
of a control group renders it unclear whether AFFIRM was more effective than a non-LGBT oriented treatment may have been. In addition, the sample size was small, and many participants did not complete the 3-month assessment. Finally, it is unclear whether this intervention had differing levels of efficacy for different gender and sexual minority subpopulations.

Diamond et al. developed and evaluated attachment-based family therapy (ABFT) tailored for suicidal LGB adolescents and their parents. The intervention consisted of eight to sixteen hour-long sessions held weekly—including sessions with the child alone, the parent(s) alone, and the child and parents together—and delivered over twelve weeks. The adapted ABFT identified five tasks for the adolescent and/or parent(s): (1) the “Relational Reframe Task” focuses on the quality of the parent-child relationship to strengthen it and determine why the adolescent does not ask the parent(s) for help when considering suicide; (2) the “Adolescent Alliance Task” conducted with the adolescent to identify and prepare the adolescent to discuss central family conflicts associated with the adolescent’s suicidal ideation; (3) the “Parent Alliance Task” to increase parental empathy and love and improve parenting methods; (4) the “Reattachment Task” to enable child and parent(s) to re-discuss family conflicts and relational themes using acquired skills; and (5) the “Competency Promoting Task” to develop the child’s sense of autonomy and competency while maintaining strong family ties. Relative to standard ABFT, this tailored intervention increased the number of sessions with the parents of LGB teens in order to help them process negative emotions regarding their child’s sexual orientation, discuss the notion of acceptance, and increase their ability to recognize and avoid committing microaggressions.

All 10 adolescents (ages 14-18 years; mean age 15.1 years) included in this study had been admitted to psychiatric hospitals for suicidal ideation or attempts. Eight were cisgender girls, 2 were cisgender boys. Eight participants exhibited moderate-severe depressive symptoms, 9 reported a past suicide attempt, and 7 reported multiple suicide attempts. ABFT was conducted with both parents for 4 adolescents, and with solely the mother for 6 adolescents. Of the 10 adolescent participants, 8 completed the intervention (attending 8-16 sessions). The adolescents’ suicidal ideation, depressive symptoms, and attachment patterns to their mothers (including attachment-related anxiety and avoidance) were assessed at baseline, six weeks into the intervention, and at the end of the intervention at twelve weeks. Attachment was only evaluated for seven participants.

Suicidal ideation and depressive symptoms decreased over the course of treatment for all participants (N = 10, \( p = .001 \) and \( p = .03 \), respectively), as well as for the eight participants who completed treatment (\( p = .001 \) and \( p = .05 \), respectively). Attachment-related anxiety and avoidance decreased among the five participants who completed the study and for whom attachment was evaluated (\( p = .05 \) and \( p = .05 \) respectively). This study was limited by small sample size and the lack of a control group receiving non-tailored ABFT.

Pachankis et al. analyzed the efficacy of CBT adapted for young gay and bisexual men (ages 18-35 years; mean age 25.94 years). The ESTEEM (Effective Skills to Empower Effective Men) intervention consists of a series of ten CBT sessions to reduce minority-stress for men with mental health disorders, such as depression and anxiety, as well as co-occurring risky behaviors, such as alcohol use and condomless sex. One-on-one therapy sessions were provided over a three-month period, and participants were given homework between sessions. Subjects were randomly assigned to one of two groups; one group received immediate treatment and another group received treatment after three months on a waitlist.

Twenty-four subjects completed all ten ESTEEM sessions, 35 completed at least half of the sessions, and 15 completed only one session. The authors used an intent-to-treat approach, and thus included all eligible randomized cases (N = 63) in their analyses.
At the three-month mark, the treatment group exhibited significantly reduced depressive symptoms ($p < .001$), alcohol use problems ($p < .001$), sexual compulsivity ($p < .001$), and past-90-day condomless sex with casual partners ($p < .001$), and significantly improved condom use self-efficacy ($p < .001$) compared to the waitlist group. Treatment effects, other than sexual compulsivity, were maintained at the 6-month mark. No significant improvement in minority stress processes and universal mental health risk factors were found. However, pooled comparisons demonstrated significant improvement across all of the minority stress and universal health risk factors, except for concealment and emotion dysregulation. A follow up study, published less than a year after the original study, identified that this therapy was most effective in gay and bisexual men who had increased levels of internalized homonegativity; participants higher in implicit internalized homonegativity (i.e., negative associations with homosexuality) had greater reductions in depression ($p = .031$), anxiety ($p = .014$), and past 90-day condomless anal sex with casual partners ($p = .028$), and those with higher explicit internalized homonegativity (i.e., self-reported negative ideas regarding homosexuality) had greater reductions in past 90-day heavy drinking ($p = .003$).

These initial and follow-up studies were limited by small sample size and the absence of a control group receiving CBT not tailored to sexual minority men. In addition, all recruited participants lived in a large, metropolitan, east-coast city, and were recruited via avenues associated with greater likelihood of being out and involved in the gay community. This study did not include lesbian women, bisexual women and/or transgender women and men. However, the results suggest that similar interventions may be beneficial for these populations, especially for individuals struggling with high levels of homonegativity and transnegativity.

Pachankis and Goldfried analyzed the effectiveness of an online expressive writing intervention for cis-gender gay male college students. Participants (mean age 20.19 years) were randomly assigned to one of 3 groups and instructed to write on a secure web interface for twenty minutes before bed on the same topic over three consecutive days. The first group wrote about the most stressful or traumatic gay-related event in their lives. The second group did the same after reading what they had written the previous night. The third group wrote about a neutral topic each night. Overall psychological distress, depression, physical health symptoms, positive and negative affect, gay-related rejection sensitivity, gay-related self-esteem, and openness and comfort with sexual orientation were assessed one day prior to the intervention, one day after the intervention, and three months after the first post-test. Seventy-seven participants from U.S. universities completed the study.

No significant differences were found between the two experimental groups at one day or three months post-intervention, so the researchers chose to analyze the combination of the two experimental groups. Participants in the experimental groups were significantly more open about their sexual orientation than those in the control group at the time of the three-month follow up ($p = .03$), and those who benefited the most were those who wrote about more distressing topics (levels of distress were given by the participants), and those who had decreased levels of social support. No other significant differences were found between the experimental and control groups at follow-up.

As there was no comparison to a group of participants that wrote about a traumatic event unrelated to sexual orientation, it is unclear whether writing about a gay-related trauma event is more beneficial than writing about other forms of trauma. In addition, study participants were all young, college-educated, cisgender, gay men, so the efficacy of this intervention for other populations is untested.

**Ongoing Tailored LGBT Mental Health Interventions Without Evaluations**

Two ongoing interventions were identified, for which evaluation results are not yet available. However, given the paucity of research on tailored LGBT mental health interventions, we include brief descriptions of these
Pepping et al., describe a randomized controlled trial of tailored compassion-focused therapy (CFT) versus non-tailored CBT for LGB young adults (18-25) targeting depressive symptoms.24 Both the CFT and CBT consist of eight online modules with associated reading and activities. The CFT intervention includes eight weekly hour-long Skype sessions with a therapist, while the CBT intervention includes one hour-long session with a therapist at week four. The primary outcome measure is depressive symptoms, and secondary outcome measures are suicidal ideation, anxiety, internalized homophobia, shame, guilt-proneness, and self-compassion.

Abbott et al. intend to evaluate the effectiveness of online CBT developed to reduce anxiety and depression and to improve wellbeing in LGB young adults (18-25 years old).25 The program consists of seven CBT-based mental health and wellbeing modules and off-line assignments, as well as an eighth module on help and prevention for suicidal ideation. The program is tailored to each individual and provides modules that cover up to three of the following mental health problems, based on an initial assessment of the user: generalized anxiety, social anxiety, post-traumatic stress, obsessions and/or compulsions, panic, specific fear, and depressive symptoms. Participants are randomly assigned in an immediate treatment group versus a waitlist group that begins treatment after twenty weeks. The primary outcomes include anxiety and depression symptom measures, and secondary outcomes include symptoms related to the three mental health problems for which an individual received modules based on the initial assessment, as well as life satisfaction, wellbeing, internalized homophobia, help-seeking attitudes, and locus of control.

**Discussion**

It is startling that we identified only four studies evaluating the efficacy of LGB-affirmative mental health interventions and only two other ongoing studies of tailored interventions. There is clearly a large gap in LGB research, a gap which should be viewed as a call to action towards addressing the specific mental health needs of LGBT individuals and LGBT youth in particular. While the four evaluated interventions reviewed above appear promising, they are limited in similar ways: all had small sample sizes and none had a control group that received a non-tailored therapy. The study by Pepping et al. addresses some of the limitations of the studies described above, as it tests the efficacy of a tailored vs. non-tailored therapy. The ongoing studies by Pepping et al. and Abbott et al. will add to the very limited body of knowledge regarding effective LGB tailored mental health interventions, the relationship between internalized homophobia and program effectiveness, and the utility of online interventions for LGB youth. However, it should be noted that neither of these studies include transgender individuals.

Furthermore, no studies were found that focused exclusively on transgender individuals or trans youth. The transgender youth population has equal if not higher rates of depression and suicidal ideation than other LGB youth; consequently, it is imperative to develop and assess mental health interventions that are sensitive to this community’s specific needs and the challenges young trans people face.26

Only one intervention which incorporated the parents of LGB youth was identified. How caregivers react to a youth’s sexual orientation and/or gender identity has a significant impact on that youth’s health: increased family acceptance correlates to better physical and psychological health in youth, whereas increased familial rejection correlates to an increased likelihood of depression, suicidal attempts, illegal drug use, and unprotected sex.27,28,29,30 Clearly, interventions that focus not only on LGBT youth, but on the youth’s caregivers and the caregiver-child relationship have the potential to significantly improve mental health in sexual and gender minority youth, and thus represent an important direction for future research.

Finally, no interventions were identified that deeply explored the impact that medical care providers can have on the mental health of their LGBT patients. In a 2009
survey of LGBT people, almost 56% of LGB people and 70% of transgender people had experienced discrimination from healthcare providers.\(^{31}\) Clearly, it is essential to promote acceptance of and education on serving LGBT clients amongst clinicians, including physicians, nurses, pharmacists, psychologists, and therapists. Yet more than 50% of medical and public health school curricula do not contain instruction on LGBT health concerns outside of HIV/AIDS related content.\(^{32}\) There have been several studies on the efficacy of LGBT-affirmative training- including mental health training- for physicians, residents, nurse practitioners, interns, and medical school students, and many have reported that providers have felt more knowledgeable about issues faced by LGBT patients, felt increased willingness to treat LGBT patients, felt better equipped to care for them, and have had decreased homo-negative and trans-negative feelings after the training.\(^{33,34,35,36,37,38}\) However, none of these studies have had long-term follow up to determine whether these were lasting effects and none have measured whether patient care or patient satisfaction were improved after these trainings. This illustrates the need to determine what types of interventions for providers will be most effective to help them confidently, competently, and compassionately treat their LGBT patients.

**Conclusion**

Given that LGBT youth are at higher risk for mental illness and face different challenges than their straight and cis-gender peers, it is alarming that there are so few mental health interventions tailored towards LGBT youth. The need for these interventions is widely recognized, yet few that are targeted towards LGB youth, and even fewer targeted towards transgender youth, exist. While there is a clear dearth of research on LGBT-oriented mental health interventions, the studies identified in this review provide a foundation for further, more inclusive, clinical research. It is essential that future studies focus not only on lesbian, gay, bisexual, and, in particular, transgender youth, but also on the role parents and care providers play in supporting LGBT children and adolescents. Moreover, so that they may thrive, LGBT youth and adults need to be supported, and their complex experiences acknowledged and responded to by their families, care providers, and researchers.

**Take Home Summary**

Lesbian, gay, bisexual, and transgender (LGBT) people, particularly LGBT youth, are at higher risk for developing a mental illness compared to their straight and cis-gender peers. However, there is a clear and concerning dearth of clinically-evaluated mental health interventions for LGBT youth and adults, particularly of studies including transgender people, which should be viewed by researchers and clinicians as a call to action to address the mental health needs of LGBT youth and adults.

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