NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE

Mental Health Care for LGBTQIA+ People

AETC AIDS Education & Training Center Program New England

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LGBTQIA+ Education and Training

The National LGBTQIA+ Health Education Center offers educational programs, resources, and consultation to health care organizations with the goal of providing affirmative, high quality, cost-effective health care for lesbian, gay, bisexual, transgender, queer, intersex and asexual, and all sexual and gender minority (LGBTQIA+) people.

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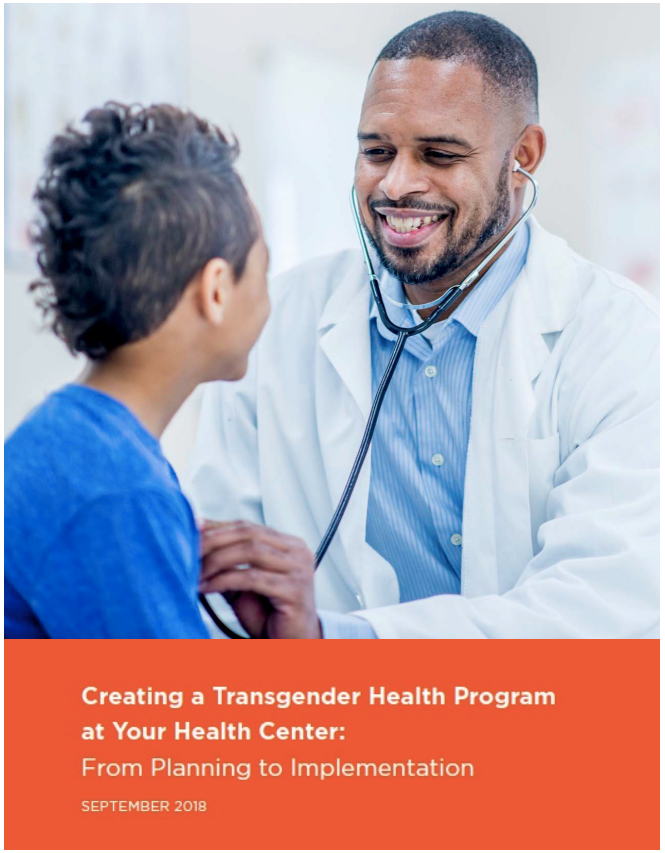

NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER
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Continuing Medical Education Disclosure

- Program Faculty: Alex S. Keuroghlian, MD, MPH;
- Current Position: Director of the Division of Education and Training at the Fenway Institute; Associate Professor of Psychiatry, Harvard Medical School/Massachusetts General Hospital
- Disclosure: Editor of forthcoming McGraw-Hill Education textbook, will receive future royalties.

Learning Objectives

- At the end of this session, participants will be able to:

  1. Explain the context for mental health inequities across diagnostic categories within a sexual and gender minority stress and resilience framework

  2. Describe culturally responsive tailoring of evidence-based clinical practices for sexual and gender minority people

  3. Apply strategies for building inclusive, affirming, and trauma-informed health care environments to optimize mental health outcomes for sexual and gender people

Gender Identity and Sexual Orientation: The Basics

Sexual Orientation and Gender Identity are Not the Same

- All people have a sexual orientation and gender identity
  - How people identify can change
  - Terminology varies
- Gender Identity ≠ Sexual Orientation

Sex Assigned at Birth

Female Intersex Male

Gender Identity and Gender Expression

- Gender identity
  - A person's inner sense of being a girl/woman, boy/man, something else, or having no gender
  - All people have a gender identity
- Gender expression
  - How one expresses themselves according to social or cultural cues, including things like behavior, mannerisms, speech patterns, dress, names, pronouns, etc.
  - May be on a continuum

A complete glossary of terms is available at https://www.lgbtqiahealtheducation.org/publication/lgbtqia-glossary-of-terms-for-health-care-teams/

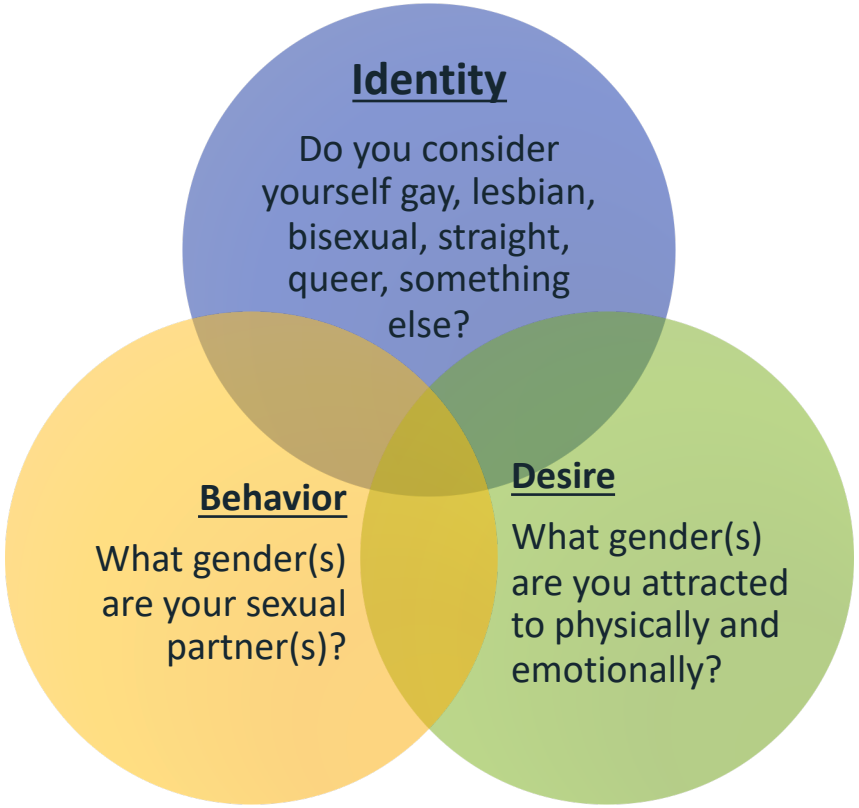
Gender Identity Terminology

- Transgender: gender identity not congruent with societal expectations based on the sex assigned at birth
- Binary terminology
  - Transgender girl/woman, trans girl/woman
  - Transgender boy/man, trans boy/man
- Non-binary terminology
  - Genderqueer person, gender fluid person
- Trans masculine, Trans feminine
  - Inclusive of binary and non-binary identities

Sexual Orientation

- Sexual orientation: how a person experiences their physical, emotional and romantic attachments to others
- Desire
- Behavior
  - Risk of sexually transmitted infections is related to behavior, not identity
- Identity
  - e.g., straight, gay, lesbian, bisexual, queer, asexual, pansexual

Dimensions of Sexual Orientation:



Minority Stress Framework

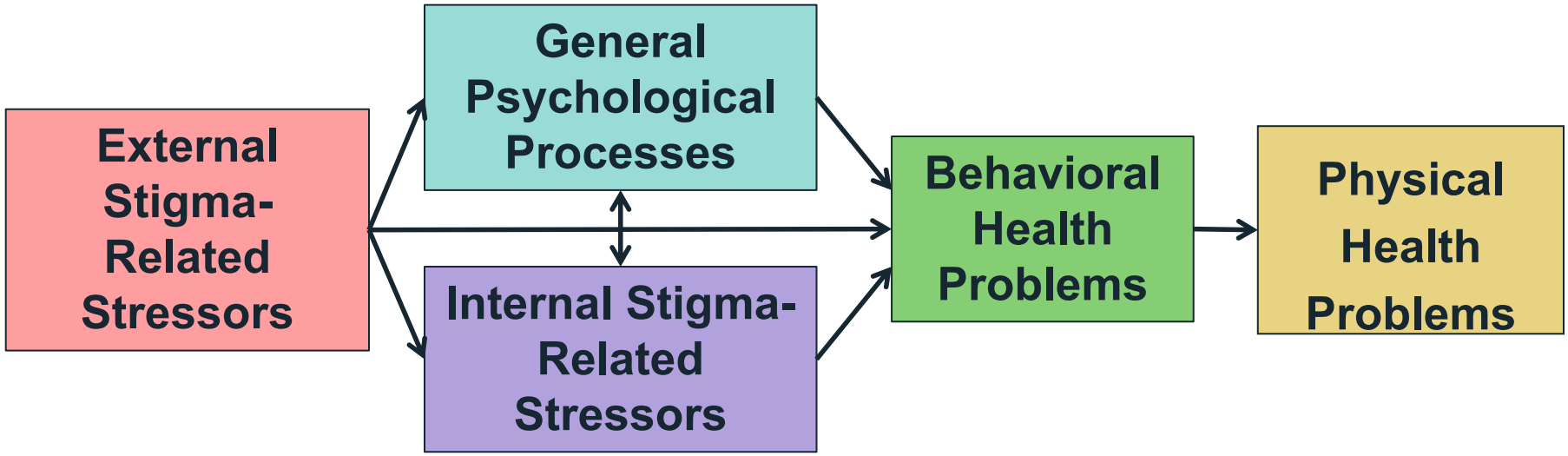


Fig. 1: Adapted from Hatzenbuehler, 2009

Interpersonal Stigma

Structural Stigma

- Structural, or institutional discrimination includes the policies of private and governmental institutions that intentionally restrict the opportunities of certain people, as well as policies that unintentionally restrict these opportunities.

Intrapersonal Stigma:

"…And to the degree that the individual maintains a show before others that they themselves does not believe, they can come to experience a special kind of alienation from self and a special kind of wariness of others."[3]

Disparities among LGBTQIA+ Youth

- Youth
  - 2 to 3 times more likely to attempt suicide
  - More likely to be homeless (20-40% are sexual and gender minorities)
  - Risk of HIV and other STIs
- Despite an overall decrease in HIV incidence from 2008-2014 reported for the first time in 2017, incidence remains high and stable among Black MSM, and is now increasing among gay and bisexual Latinx men (20%) and those aged 25-34 (35%).[10]

Disparities among Older LGBTQIA+ Adults

- Additional barriers to health because of isolation, fewer family supports, and a lack of social and support services.

Disparities among Sexual Minority Men

- Compared with straight men, gay and bisexual men are more likely to meet criteria for:[2]
  - major depressive disorder (x 3)
  - panic disorder (x 5)
  - at least 2 co-occurring disorders (x 4)

Disparities among Sexual Minority Women

- Compared with straight women, lesbian and bisexual women are more likely to meet criteria for:
  - generalized anxiety disorder (x 3)
  - at least 2 co-occurring disorders (x 3)

Sexual Minority Mental Health Service Utilization

- Compared with general population, sexual minority people are more likely to:
  - See mental health provider (x 2-3)
  - See PCP for mental health problem (x 1.5-3)
  - Attend support or therapy group (x 3-4)

- Compared with general population, gay and bisexual men more likely to take psychiatric medication (x 4)

Depression and Anxiety among Transgender Adults

- Prevalence of clinically significant depressive symptoms:[3]
  - 51% of transgender women
  - 48% of transgender men
- Prevalence of clinically significant anxiety symptoms:
  - 40% of transgender women
  - 48% of transgender men

Suicidality among SGM Youth

- Compared with peers, SGM youth are more likely to:[8,9]
  - report suicidal ideation (x 3)
  - attempt suicide (x 4, with 30-40% prevalence)
- Questioning youth more likely to experience depression or suicidality than LGBTQIA+ peers

Suicidality: Gender and Sexual Minority Adults

- Lifetime prevalence of suicide attempts in the United States:
  - General adult population: 4%
  - Sexual minority adults: 11-20%
  - Gender minority adults: 41%

Kann *et al.* (2011); Perou and Bitsko (2013)

Suicidality (2015 U.S. Transgender Survey)

In the preceding 12 months:

- 48% had seriously thought about suicide
- 24% made a plan to kill themselves
- 7% had attempted suicide

- 40% had attempted suicide at one point in their lives
- 34% had first attempt by age 13
- 92% had first attempt by age 25

Research

JAMA Psychiatry | Original Investigation

Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults

Jack L. Turban, MD, MHS; Noor Beckwith, MD; Sari L. Reisner, ScD, MA; Alex S. Keuroghlian, MD, MPH

Adverse Impact of Exposure to Conversion Efforts

- 27,715 transgender adult respondents to 2015 U.S. Transgender Survey
- 14% reported gender identity conversion efforts
- Lifetime exposure associated with:
  - lifetime suicidal attempt (aOR 2.27; 95% CI 1.09 to 2.24; *P*<.001)
- Exposure before age 10 associated with:
  - lifetime suicide attempt (aOR 4.15; 95% CI, 2.44-7.69; *P*<0.001)
- No difference in outcomes between conversion efforts by religious advisors versus secular-type professionals

Turban *et al*. (2019)

Journal of Adolescent Health xxx (2021) 1–8

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH

www.jahonline.org

Original article

Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes

Jack L. Turban, M.D., M.H.S. [a,*], Dana King, A.L.M. [b], Jason J. Li, B.A. [c], and Alex S. Keuroghlian, M.D., M.P.H. [b,d]

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Article history: Received February 11, 2021; Accepted June 1, 2021

Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation

Jack L. Turban, MD, MHS,[a] Dana King, ALM,[b] Jeremi M. Carswell, MD,[c] Alex S. Keuroghlian, MD, MPH[a,b]

abstract

BACKGROUND AND OBJECTIVES: Gonadotropin-releasing hormone analogues are commonly prescribed to suppress endogenous puberty for transgender adolescents. There are limited data regarding the mental health benefits of this treatment. Our objective for this study was to examine associations between access to pubertal suppression during adolescence and adult mental health outcomes.

METHODS: Using a cross-sectional survey of 20 619 transgender adults aged 18 to 36 years, we examined self-reported history of pubertal suppression during adolescence. Using multivariable logistic regression, we examined associations between access to pubertal suppression and adult mental health outcomes, including multiple measures of suicidality.

RESULTS: Of the sample, 16.9% reported that they ever wanted pubertal suppression as part of their gender-related care. Their mean age was 23.4 years, and 45.2% were assigned male sex at birth. Of them, 2.5% received pubertal suppression. After adjustment for demographic variables and level of family support for gender identity, those who received treatment with pubertal suppression, when compared with those who wanted pubertal suppression but did not receive it, had lower odds of lifetime suicidal ideation (adjusted odds ratio = 0.3; 95% confidence interval = 0.2–0.6).

CONCLUSIONS: This is the first study in which associations between access to pubertal suppression and suicidality are examined. There is a significant inverse association between treatment with pubertal suppression during adolescence and lifetime suicidal ideation among transgender adults who ever wanted this treatment. These results align with past literature, suggesting that pubertal suppression for transgender adolescents who want this treatment is associated with favorable mental health outcomes.

Turban *et al*. (2020)

Pubertal Suppression and Risk for Suicidal Ideation

- 2.5% of respondents who desired pubertal suppression had ever received it

- Recipients of pubertal suppression, compared to those who desired it but did not receive it, had lower odds of lifetime suicidal ideation
  - aOR = 0.3; 95% CI = 0.2-0.6; *P* = 0.001

Turban *et al*. (2020)

Gender-affirming Hormones in Adolescence Associated with Better Adult Mental Health

PLOS ONE

RESEARCH ARTICLE

Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults

Jack L. Turban[1]*, Dana King[2], Julia Kobe[2], Sari L. Reisner[2,3,4,5], Alex S. Keuroghlian[2,6,7]

JAMA Surgery | Original Investigation

Association Between Gender-Affirming Surgeries and Mental Health Outcomes

Anthony N. Almazan, BA; Alex S. Keuroghlian, MD, MPH

Invited Commentary

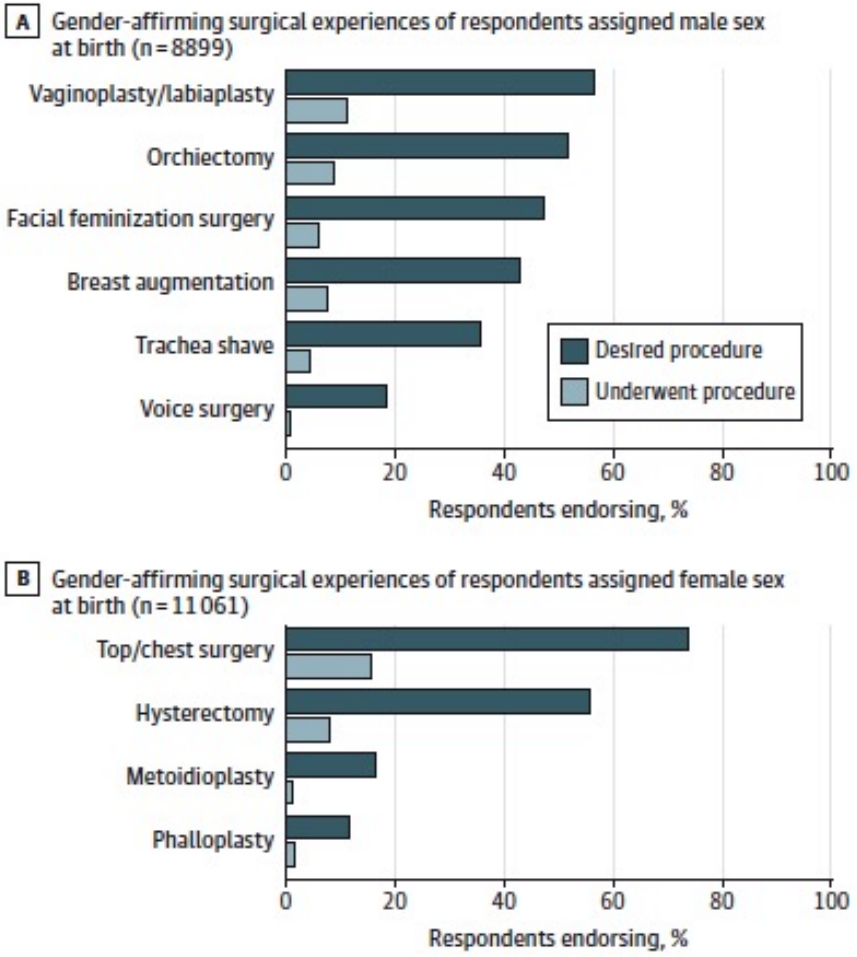
IMPORTANCE Requests for gender-affirming surgeries are rapidly increasing among transgender and gender diverse (TGD) people. However, there is limited evidence regarding the mental health benefits of these surgeries.

OBJECTIVE To evaluate associations between gender-affirming surgeries and mental health outcomes, including psychological distress, substance use, and suicide risk.

DESIGN, SETTING, AND PARTICIPANTS In this study, we performed a secondary analysis of data from the 2015 US Transgender Survey, the largest existing data set containing comprehensive information on the surgical and mental health experiences of TGD people. The survey was conducted across 50 states, Washington, DC, US territories, and US military bases abroad. A total of 27 715 TGD adults took the US Transgender Survey, which was disseminated by community-based outreach from August 19, 2015, to September 21, 2015. Data were analyzed between November 1, 2020, and January 3, 2021.

EXPOSURES The exposure group included respondents who endorsed undergoing 1 or more types of gender-affirming surgery at least 2 years prior to submitting survey responses. The comparison group included respondents who endorsed a desire for 1 or more types of gender-affirming surgery but denied undergoing any gender-affirming surgeries.

Figure 1. Desire for and History of Gender-Affirming Surgical Procedures in Study Sample



Includes 2015 US Transgender Survey respondents who indicated they desired and either had or had not undergone at least 1 type of gender-affirming surgery. Respondents were presented with 1 of 2 lists of gender-affirming surgeries based on their self-reported sex assigned at birth.

Almazan and Keuroghlian (2021)

Figure 2. Comparison of Mental Health Outcomes Among Respondents Who Did and Did Not Undergo Gender-Affirming Surgery

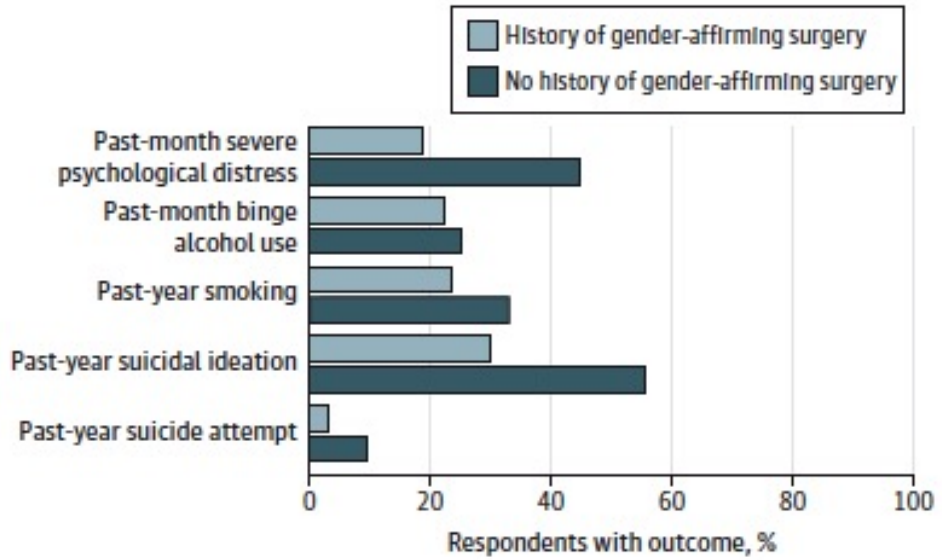


Table 2. Association Between History of Gender-Affirming Surgery and Mental Health Outcomes[a]

Variable	aOR (95% CI)[b]	*P* value
Severe psychological distress (past month)[c]	0.58 (0.50-0.67)	<.001
Substance use		
Binge alcohol use (past month)[d]	0.83 (0.72-0.96)	.01
Smoking (past year)	0.65 (0.57-0.75)	<.001
Suicidality (past year)		
Ideation	0.56 (0.50-0.64)	<.001
Attempt	0.65 (0.47-0.90)	.009

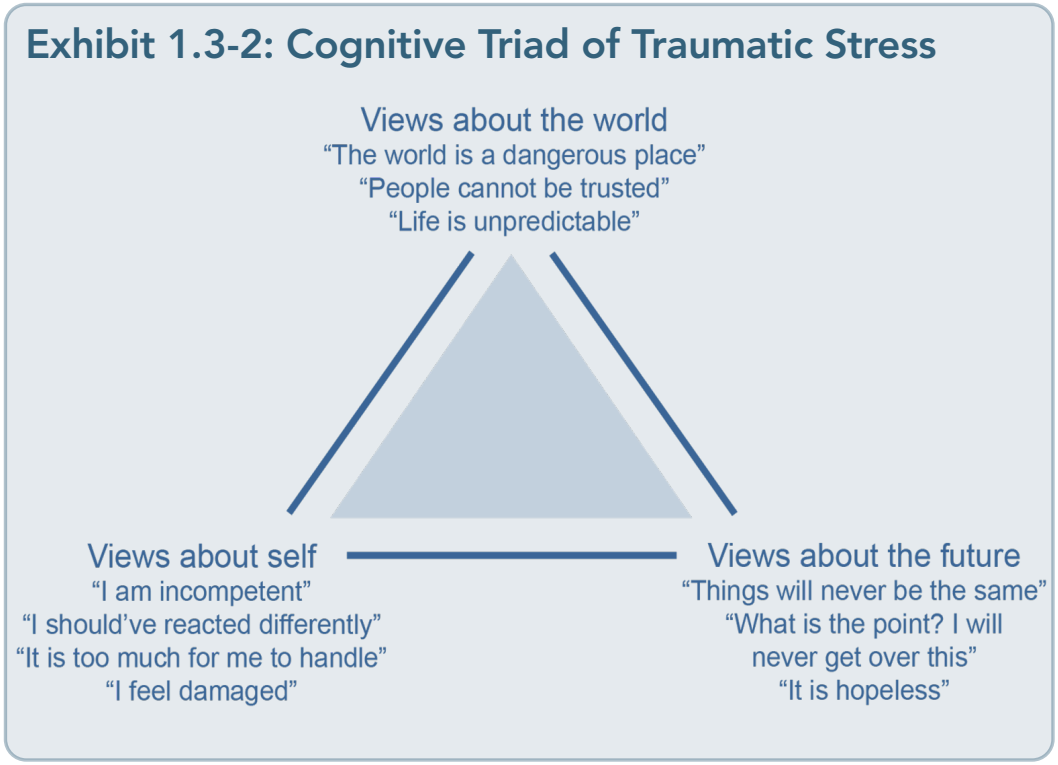
Almazan and Keuroghlian (2021)

Table 3. Association Between Degree of Surgical Gender Affirmation and Mental Health Outcomes[a]

	Received some desired surgeries (n = 3311)[b]		Received all desired surgeries (n = 2448)[b]	
Variable	aOR (95% CI)	*P* value	aOR (95% CI)	*P* value
Severe psychological distress (past month)[c]	0.70 (0.60-0.81)	<.001	0.47 (0.39-0.56)	<.001
Substance use				
Binge alcohol use (past month)[d]	0.97 (0.84-1.11)	.63	0.75 (0.64-0.87)	<.001
Smoking (past year)	0.75 (0.66-0.86)	<.001	0.58 (0.49-0.68)	<.001
Suicidality (past year)				
Ideation	0.72 (0.63-0.81)	<.001	0.44 (0.38-0.51)	<.001
Attempt	0.70 (0.53-0.93)	.01	0.44 (0.28-0.70)	<.001

Almazan and Keuroghlian (2021)

Cognitive Triad of Traumatic Stress



SAMHSA (2014)

Minority Stress Impact on Antiretroviral Adherence

- Transgender women and men who have sex with men are the two subpopulations with the greatest HIV incidence and prevalence in the U.S.[39-41]
- Antiretroviral medications for HIV treatment and pre-exposure prophylaxis require adequate adherence for effectiveness.[42-44]

References available upon request

Minority Stress Impact on Antiretroviral Adherence

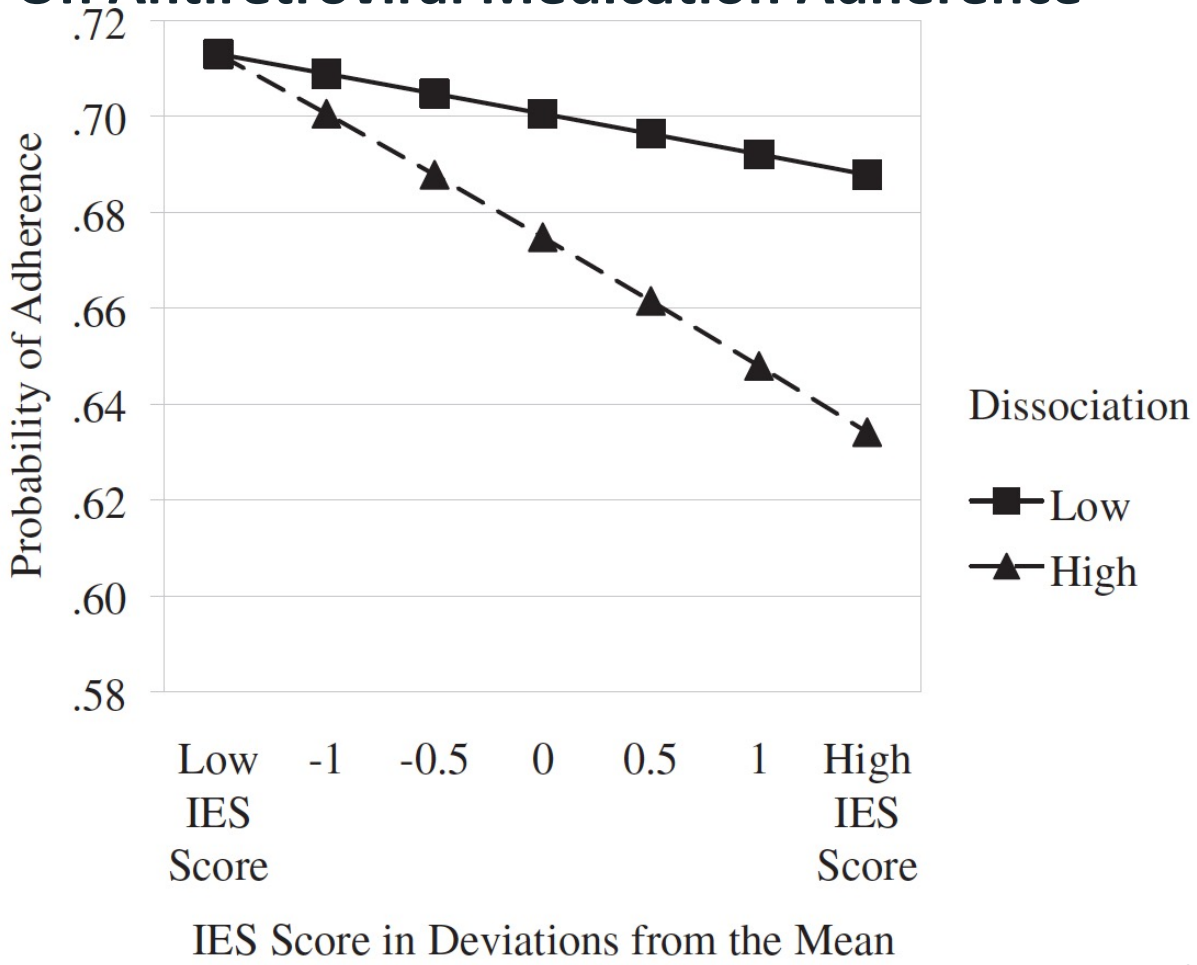
- Studies of antiretroviral adherence emphasize population-specific contextual barriers.
- Sexual and gender minority stress (e.g. discrimination, victimization) both adversely impact HIV self-care.[45-49]

References available upon request

PTSD and Antiretroviral Adherence

Interaction Effect of PTSD and Dissociation On Antiretroviral Medication Adherence

Fig. 2: Graph from "Trauma, dissociation and antiretroviral adherence among persons living with HIV/AIDS."[50]



Keuroghlian et al., 2011

PTSD and Antiretroviral Adherence

- Importance of psychosocial interventions that target posttraumatic stress symptoms to maximize antiretroviral adherence in community populations.[51,52]
- Integration of trauma-focused treatment services into antiretroviral medication management may effectively improve adherence.

Bio-behavioral HIV Care

- Tailored behavioral interventions exist for antiretroviral adherence (e.g. Life-Steps).[53]
- Combined biomedical and behavioral HIV treatment and prevention strategies are optimal.
- Behavioral health treatments that restructure minority stress cognitions can improve self-care and physical health outcomes.[54]

Minority Stress and Substance Use Disorders

- SGM people have disproportionate substance use disorder (SUD) prevalence as a downstream effect of minority stress.[10-12]
- Substance use mediates the relationship between life stress and sexual risk.[13]

Minority Stress and Substance Use Disorders

- SUDs are associated with condom-less intercourse and HIV infection.[14,15]
- SUDs are barriers to HIV pre-exposure prophylaxis (PrEP) adherence in populations at high risk for HIV.[16]

Substance Use among Sexual Minority People

- Sexual minority-identified youth initiate alcohol and illicit drug use earlier than sexual majority identified youth.[17]
- Sexual minority women are at greater risk for alcohol and drug use disorders.[18]
- Sexual minority men are at greater risk of drug use disorders.
- Bisexual people are at higher risk for substance use disorders.

Addictions among TGD People

- Substance use disorders (SUDs) among TGD people have historically been understudied
- Reporting of gender identity data in SUD-related research is limited
- In several studies, TGD people have elevated prevalence of alcohol and drug use disorders compared with the general population

Flentje *et al*. (2015)*;* Benotsch *et al*. (2013); Santos *et al*. (2014)

Gender Minority Stress and Substance Use among TGD People

- 35% of transgender people who experienced school-related verbal harassment, physical assault, sexual assault, or expulsion reported **using substances** to cope with mistreatment related to gender identity or expression
- Psychological stress of health care access disparities faced by transgender people is believed to contribute to worse mental health, including **disproportionate substance use as a coping strategy**

Grant *et al*. (2015); Poteat *et al*. (2013); Wilson *et al*. (2015)

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Full length article

Substance use and treatment of substance use disorders in a community sample of transgender adults

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Substance Use Disorders among TGD Adults

- Among 452 TGD adults, increased odds of SUD treatment history plus recent substance use were associated with:
  - intimate partner violence
  - PTSD
  - public accommodations discrimination
  - unstable housing
  - sex work
- Higher SUD prevalence increasingly viewed as downstream effects of chronic gender minority stress

Keuroghlian *et al*. (2015)

SUBSTANCE ABUSE
https://doi.org/10.1080/08897077.2018.1544963

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COMMENTARY

Understanding and treating opioid use disorders in lesbian, gay, bisexual, transgender, and queer populations

Michael P. Girouard, BA[a], Hilary Goldhammer, SM[b], and Alex S. Keuroghlian, MD, MPH[a,b,c]

[a]Department of Psychiatry, Harvard Medical School, Massachusetts, USA; [b]National LGBT Health Education Center, The Fenway Institute, Fenway Health, Boston, Massachusetts, USA; [c]Department of Psychiatry, Massachusetts General Hospital, Boston, Massachusetts, USA

ABSTRACT

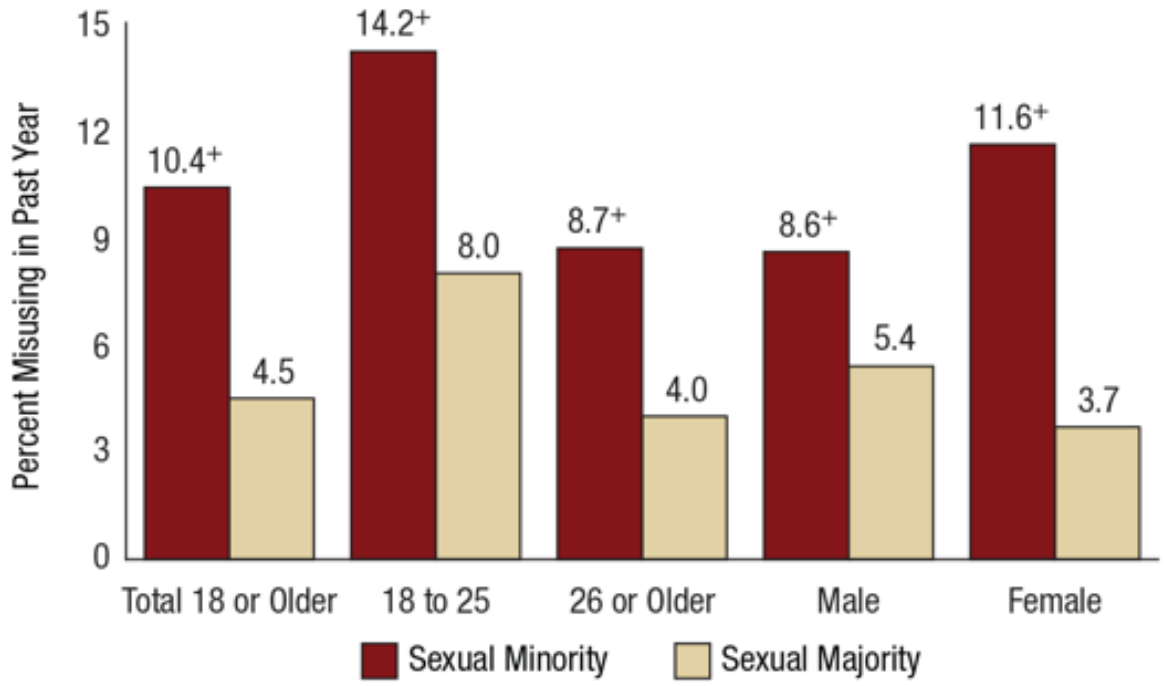
Although little is known about the specific burden of the opioid epidemic on lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations, there is evidence to suggest that opioid use disorders are disproportionately prevalent in the LGBTQ community. In this commentary, we present an overview of the current state of evidence on opioid use and misuse among LGBTQ-identified people in the United States and suggest ways to adapt behavioral health interventions to the specific needs of this population. Programs that integrate behavioral health with primary care, address minority stress, and use a trauma-informed approach have the most potential to produce effective, long-term benefits for LGBTQ-identified people with opioid use disorders.

KEYWORDS

Cognitive-behavioral therapy; gay; opioid-related disorders; opioids; prescription drug misuse; sexual and gender minorities; substance use disorders

2015 National Survey on Drug Use and Mental Health

Figure 5. Past Year Misuse of Prescription Pain Relievers among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

SAMHSA, 2015

Opioid Use Disorders among Sexual Minority Groups

- Sexual minority youth aged 16 to 25 are more likely to initiate prescription opioid misuse early in life compared with their sexual majority counterparts (Kecojevic et al., 2012).

- Among young men who have sex with men (MSM) aged 18 to 29, higher perceived stress is associated with higher opioid misuse (Kecojevic et al., 2015).

Opioid Use Disorders among Sexual Minority Groups

- Higher life stress among young Black MSM in Chicago was associated with greater odds of prescription opioid use (Voisin et al., 2017).

- Nonmedical opioid use among MSM is associated with increased risk of condomless sexual intercourse and sharing syringes (Zule et al., 2016).

Opioid Use Disorders among TGD People

- Transgender middle school and high school students more than twice as likely to report recent prescription pain medication use compared to other students
- Transgender adults on Medicare have increased prevalence of chronic pain compared to cisgender (non-transgender) adults.
- Transgender patients may be at increased risk post-operatively of developing an opioid use disorder.

De Pedro *et al.* (2017); Dragon *et al.* (2017)

Opioid Agonists and Gender-affirming hormone therapy

- Co-prescription of opioid agonists (e.g., methadone and buprenorphine) and gender-affirming hormone therapy
  - safe and feasible with appropriate monitoring and follow-up.

Kerridge *et al.* (2017); Dragon *et al.* (2017)

Drug and Alcohol Dependence 186 (2018) 138–146

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Review

Alcohol research with transgender populations: A systematic review and recommendations to strengthen future studies

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Alcohol Research with TGD Populations

- Recommendations:
  - Being explicit as to whether and how sex assigned at birth, current sex-based physiology, and/or social gender are operationalized and relevant for research questions
  - Expanding repertoire of alcohol measures to include those not contingent on sex or gender
  - Testing psychometric performance of established screening instruments (e.g., AUDIT) with TGD populations
  - Shifting beyond cross-sectional study designs
  - Shared decision-making in counseling regard healthy alcohol use

Gilbert *et al*. (2018)

Screening, Counseling, and Shared Decision Making for Alcohol Use with Transgender and Gender-Diverse Populations

Jacob Arellano-Anderson, BS[1] and Alex S. Keuroghlian, MD, MPH[1–3]

Abstract

At-risk alcohol use occurs among transgender and gender-diverse (TGD) populations, yet current alcohol use screening tools and guidelines do not distinguish between sex- and gender-related characteristics, having been developed without accounting for natal sex-based physiology, effects of gender-affirming medical care, and gendered drinking behavior among TGD people. More research on how sex- and gender-related factors independently influence alcohol use can help validate gender-inclusive screening protocols and develop evidence-based guidelines meaningful for people of all genders. In the interim, clinicians must be mindful of gender diversity and engage in transparent, collaborative discussions when screening for and counseling about alcohol use.

Keywords: alcohol, counseling, gender identity, nonbinary, screening, transgender

Gendered Guidelines for Unhealthy Alcohol Use

Term	Society	Definition	Limitations for TGD Populations
Gendered			
Moderate drinking	CDC	1 drink per day for women and up to 2 drinks per day for men.	Assumption of cisgender and binary gender identities is exclusionary toward TGD people. Unclear if based on factors related to natal sex-based physiology, or current sex-based physiology, which may vary for TGD people who have accessed gender-affirming medical or surgical care.
Heavy drinking	CDC	Alcohol consumption that exceeds an established threshold of 15 weekly drinks for men and 7 weekly drinks for women OR 5 drinks per episode for men and 4 drinks per episode for women.	
Binge drinking	NIAAA/CDC	A pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 g/dL, specified as typically occurring after 4 drinks for women and 5 drinks for men—in about 2 hours.	

Columns 1 through 3 are adapted from Connor EA *et al.*[24]

Arellano-Anderson and Keuroghlian (*2020*)

PERSPECTIVES

Distinguishing and Addressing Gender Minority Stress and Borderline Personality Symptoms

Hilary Goldhammer, SM, Cary Crall, MD, and Alex S. Keuroghlian, MD, MPH

Abstract: As transgender and gender-diverse people are gaining increased visibility in clinical settings, clinicians are requesting better guidance on providing affirming care to improve the mental health and well-being of these patients. In particular, more direction is needed on whether, when, and how to diagnose and treat borderline personality disorder among gender minorities, partially in response to beliefs among some mental health clinicians that a gender minority identity may be a manifestation of identity diffusion. In this Perspectives article, we argue that gender minority identity, even when fluid, is rarely a sign of identity diffusion. By taking a careful history of a patient's gender identity development, the clinician can clarify and gain more conviction regarding the presence of a patient's gender minority identity. Moreover, multiple stigma-related stressors experienced by gender minorities may produce symptoms and behaviors that can mimic or be consistent with certain diagnostic criteria for borderline personality disorder. We therefore conclude with recommendations for adopting a gender-affirming framework to treat borderline personality symptoms when present among gender minority patients, with implications for future research and practice.

Keywords: borderline personality disorder, gender dysphoria, gender identity, gender minority, transgender

Affirming Gender Identity of Patients With Serious Mental Illness

William B. Smith, M.D., Hilary Goldhammer, S.M., Alex S. Keuroghlian, M.D., M.P.H.

Transgender people who experience serious mental illness represent a uniquely vulnerable population. Because of limited research, however, recommendations for treating this population are scarce. In this article, the authors describe the challenge of recognizing gender dysphoria in people with serious mental illness. They then discuss why existing evidence and clinical experience support provision of gender-affirming medical and surgical treatments for transgender people who have serious mental illness and also demonstrate capacity to make informed medical decisions. More research is needed to develop evidence-based treatments and programs for transgender people with serious mental illness.

Psychiatric Services 2018; 0:1–3; doi: 10.1176/appi.ps.201800232

Gender Identity and Psychiatric Disorders

- Often impede gender identity exploration and alleviation of distress
- Need to stabilize psychiatric symptoms for facilitation of gender identity discovery and affirmation
- World Professional Association for Transgender Health guidelines for reasonable control of physical and mental health problems

Smith *et al.* (2018)

Suggested Practices for Serving LGBTQIA+ Communities

Minority Stress Treatment Principles for Clinicians

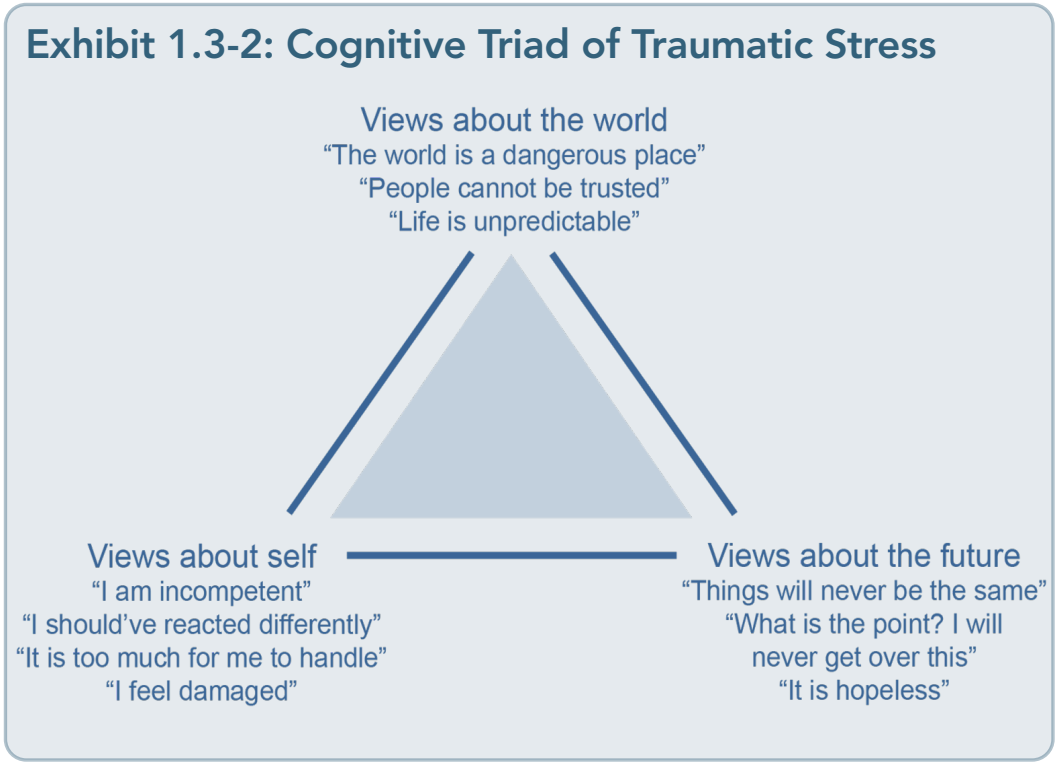
- Normalize adverse impact of minority stress
- Facilitate emotional awareness, regulation, and acceptance
- Empower assertive communication
- Restructure minority stress cognitions
- Validate unique strengths of LGBTQIA+ people
- Foster supportive relationships and community
- Affirm healthy, rewarding expressions of gender

Adapted from Pachankis (2015)

Cognitive Processing Therapy for PTSD

- Adapting selected components of cognitive processing therapy for PTSD by Resick
- Focus:
  - Education about posttraumatic stress;
  - Writing an Impact Statement to help understand how trauma influences beliefs;
  - Identifying maladaptive thoughts about trauma linked to emotional distress;
  - Decreasing avoidance and increasing resilient coping.

Cognitive Triad of Traumatic Stress



SAMHSA (2014)

Cognitive Processing Therapy for Minority Stress

- Possible tailoring for LGBTQIA+ people:
  - Focus on how identity-specific stigma causes posttraumatic stress (e.g., avoidance, mistrust, hypervigilence, low self-esteem);
  - Attributing challenges to minority stress rather than personal failings;
  - Impact Statement on how discrimination and victimization affect beliefs (e.g., expecting rejection, concealment needs, internalized homophobia/transphobia);
  - Decreasing avoidance (e.g., isolation from LGBTQIA+ communities or medical care);
  - Impact of minority stress on health behaviors and goals.

Girouard et al. (2019)

Cognitive-behavioral Therapy for Substance Use Disorders

- Adapting selected topics and practice exercises from the manual by Carroll
- Focus:
  - Coping With Craving (triggers, managing cues, craving control)
  - Shoring Up Motivation and Commitment (clarifying and prioritizing goals, addressing ambivalence)
  - Refusal Skills and Assertiveness (substance refusal skills, passive/aggressive/assertive responding)
  - All-Purpose Coping Plan (anticipating high-risk situations, personal coping plan)
  - HIV Risk Reduction

Cognitive-behavioral Therapy for Substance Use Disorders

- Possible tailoring for LGBTQIA+ people:
  - Minority stress-specific triggers for cravings (e.g., identity-related discrimination and victimization, expectations of rejection, identity concealment, and internalized homophobia/transphobia)
  - SUDs as barriers to personalized health goals
  - Assertive substance refusal with sex partners; HIV risk from hormone and silicone self-injections; SUDs as barriers to personalized health goals

Girouard *et al.* (2019)

Anticipating and Managing Expectations

- LGBTQIA+ people have a history of experiencing stigma and discrimination in diverse settings
- Don’t be surprised if a mistake results in a patient becoming upset
- Don’t personalize the reaction
- Apologizing when patients become upset, even if what was said was well-intentioned, can help defuse a difficult situation and re-establish a constructive dialogue

Pronouns

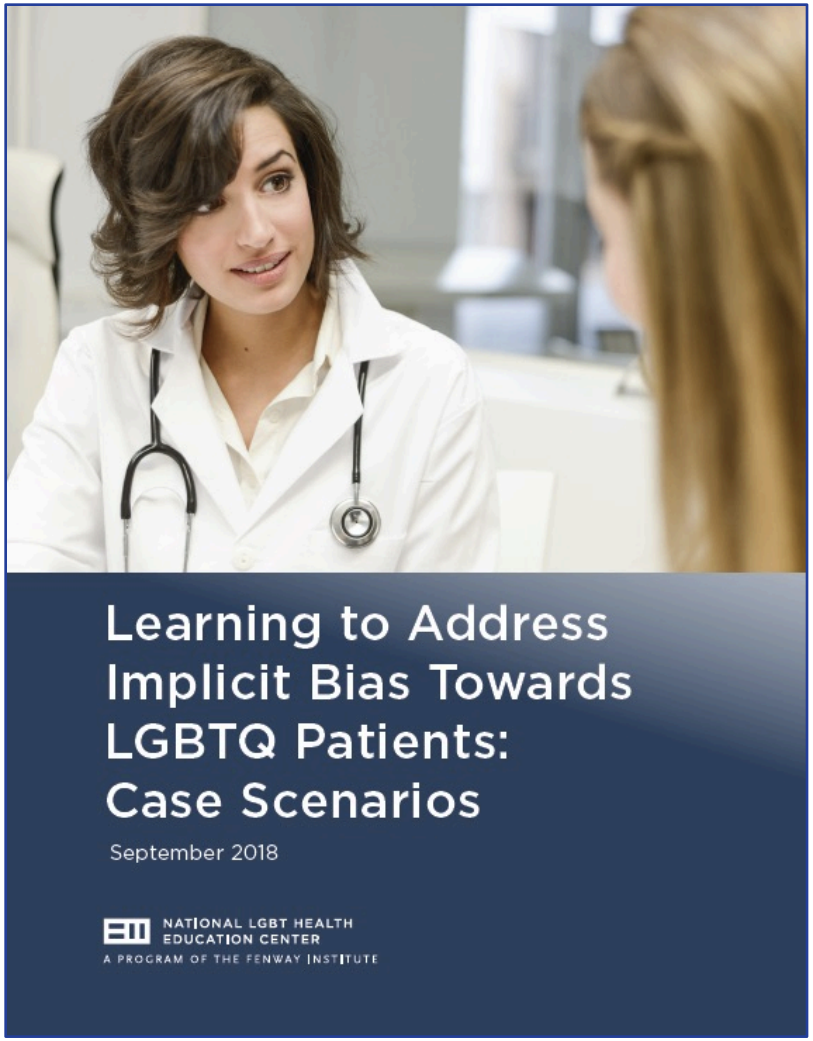
People may have a range of pronouns, including she/her/hers and he/him/his, as well as less-common pronouns such as they/them/theirs and ze/hir/hirs (pronounced zee/hear/hears).

Subjective	Objective	Possessive	Examples
He	Him	His	He is in the waiting room. The doctor is ready to see him. That chart is his.
She	Her	Hers	She is in the waiting room. The doctor is ready to see her. That chart is hers.
They	Them	Theirs	They are in the waiting room. The doctor is ready to see them. That chart is theirs.
Ze	Hir	Hirs	Ze is in the waiting room. The doctor is ready to see hir. That chart is hirs.

Avoiding Assumptions

- You cannot assume someone's gender identity or sexual orientation based on how they look or sound.
- To avoid assuming gender identity or sexual orientation with new patients:
  - *Instead of*: "How may I help you, Ma'am/Sir?"
  - *Say*: "How may I help you?"
  - *Instead of*: "He/She is here for his/her appointment."
  - *Say*: "The patient is here in the waiting room."
  - *Instead of*: "Do you have a husband/wife?"
  - *Say*: "Are you in a relationship?"
  - *Instead of*: "What are your mother's and father's names?"
  - *Say*: "What is your guardian's/caregiver's name?"

Training All Staff To Mitigate Implicit Bias Against LGBTQIA+ People



Psychosomatics 2020:■:■–■

Perspective

Strategies to Mitigate Clinician Implicit Bias Against Sexual and Gender Minority Patients

Michal J. McDowell, M.D., M.P.H., Hilary Goldhammer, S.M., Jennifer E. Potter, M.D., Alex S. Keuroghlian, M.D., M.P.H.

Background: *Implicit bias is an ingrained, unconscious cultural stereotype that can negatively affect a person's interactions with members of stigmatized groups, including sexual and gender minorities. Clinician implicit biases may negatively impact the quality of patient care.*
Methods: *This article uses 4 case scenarios to illustrate how implicit bias among psychiatrists and other clinicians can affect patient-clinician communication and diminish the quality of health care provided to sexual and gender minority people. We offer strategies for clinicians to recognize, challenge, and address implicit bias.*
Discussion: *Through continuing education, self-reflection, and practice, psychiatrists and other clinicians can improve communication and foster more affirming care experiences for their sexual and gender minority patients, with the goal of addressing and ultimately eliminating sexual and gender minority health disparities.*
(Psychosomatics 2020; ■:■–■)

Key words: sexual minority, gender minority, implicit bias, unconscious bias, LGBT, communication.

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Editorial

Envisioning a future for transgender and gender-diverse people beyond the DSM

Jacob E. Perlson, Oakland C. Walters and Alex S. Keuroghlian

Envisioning a Future for TGD People Beyond the DSM

- Uncoupling gender diversity from the stigma of diagnostic classification in clinical practice
- Non-diagnosis codes (Z-codes in ICD-10 or Q-codes in ICD-11) that specify “factors influencing health status” may allow reimbursement by third-party payers
- Seeking reimbursement for services without a diagnosis (e.g., “psychiatric evaluation preceding gender-affirming surgical intervention”) and without assumption of distress or psychopathology

Perlson *et al*. (*2020*)

Resilience in the LGBTQIA+ Community

Despite the many challenges that LGBTQIA+ people often face, both internal and community-derived resilience can protect the health and well-being of LGBTQIA+ people.

Questions?

Thank you!

NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER

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The National LGBTQIA+ Health Education Center provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people.

The Education Center is part of The Fenway Institute, the research, training, and health policy division of Fenway Health, a Federally Qualified Health Center, and one of the world's largest LGBTQIA+ focused health centers.

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