# Mental Health Care for LGBT Youths

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Lesbian, gay, bisexual, and transgender (LGBT) youths comprise a diverse population with unique developmental experiences and needs. Many experience some form of anti-LGBT stigma. Although most LGBT youths cope well and are free from mental illness, they are at increased risk for a number of psychiatric and other health problems compared with the general population. These problems include depression, anxiety, suicidality, tobacco and substance use, and disordered eating. These disorders are significant sources of morbidity and mortality and are risk factors for other health problems, including HIV and other sexually transmitted infections. Preliminary evidence suggests the same is true for gender dysphoric youths. The minority stress hypothesis holds that exposure to LGBT-specific stigma causes these disparities among LGBT youth. During the past decade, increasing attention has been devoted to developing evidence-based practice guidelines to address the mental health needs of LGBT youths, with an emphasis on core clinical competencies for practitioners working with this population. This review addresses key principles for mental health promotion and care of LGBT youths. Key resources for clinicians and two clinical vignettes are included.

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LGBT youths have unique mental health needs of which the general clinician should be aware. Although most are generally healthy, they frequently have distinctive developmental experiences and stressors that place them at elevated risk. A growing evidence base, including detailed reports and practice parameters published by organizations such as the Institute of Medicine and the American Academy of Child and Adolescent Psychiatry, is available to guide clinicians in providing competent clinical care.

Historically, the stigma associated with being gay, lesbian, or bisexual was exacerbated by the psychiatric diagnosis of homosexuality. That diagnosis was removed from the *DSM-II* in 1973 (1, 2) and from the *ICD-10* in 1992 (3). The diagnostic status of transgender and gender diverse individuals is a matter of ongoing discussion and revision (4).

A number of medical organizations have comprehensively reviewed the health status and needs of LGBT youths. These reviews, summarized below, include information about physical and mental health disparities among LGBT youths and discuss the etiology, treatment, prevention, and research needs for many of these issues. Transgender youths have been particularly understudied. Key findings are summarized for lesbian, gay, and bisexual or for transgender youths accordingly.

## FINDINGS OF MAJOR MEDICAL ORGANIZATIONS ON HEALTH DISPARITIES AMONG LGBT YOUTHS

### Institute of Medicine (IOM)

In 2011, the IOM released a groundbreaking report on the health status of LGBT populations, documenting key findings and recommendations. The IOM noted a relative paucity of research among children and adolescents compared with adults. Key findings included that LGBT children and adolescents are at higher risk of depression, suicidal ideation, and suicide attempts and have increased rates of smoking, alcohol, and substance use relative to their heterosexual peers. The IOM found that some small studies with clinical and convenience samples have found higher rates of depression and suicidality among transgender youths as well. Risk factors for suicidality include sexual minority status, rejection by family, and homophobic victimization. LGBT youths face higher rates of harassment, victimization, and violence than heterosexual and non-gender-minority youths. In addition, LGBT youths are disproportionately represented among the homeless population (5). Family acceptance and school safety are protective factors and potential targets for clinical interventions. Family acceptance has been shown to protect against depression, suicidal ideation and attempts, and substance use among LGBT youths (6).

### American Academy of Child and Adolescent Psychiatry (AACAP)

In 2012, the AACAP released its Practice Parameter on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents (7). This document identifies specific developmental, psychological, and social stressors that influence the mental health care needs of LGBT youths and guides clinicians in decision making when caring for these patients. The guide describes clinically relevant terminology, biological factors,

**BOX 1. Nine principles from the American Academy of Child and Adolescent Psychiatry's Practice Parameter on Gay, Lesbian, or Bisexual Orientation; Gender Nonconformity; and Gender Discordance in Children and Adolescents**[a]

1. A comprehensive diagnostic evaluation should include an age-appropriate assessment of psychosexual development for all youths.
2. The need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youths.
3. Family dynamics pertinent to sexual orientation, gender nonconformity, and gender identity should be explored in the context of cultural values of the youth, family, and community.
4. Clinicians should inquire about circumstances commonly encountered by youths with sexual and gender minority status that confer increased psychiatric risk (bullying, suicide, high-risk behaviors, substance abuse, HIV/AIDS, and other sexually transmitted illnesses).
5. Clinicians should aim to foster healthy psychosexual development of sexual and gender minority youths and to protect each individual's full capacity for integrated identity formation and adaptive functioning.
6. Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy and that attempts to do so may be harmful.
7. Clinicians should be aware of the current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.
8. Clinicians should be prepared to consult and act as a liaison with schools, community agencies, and other health care providers, advocating for the unique needs of sexual and gender minority youths and their families.
9. Mental health professionals should be aware of community and professional resources relevant to sexual and gender minority youths.

[a]Adapted from Adelson et al. (7).

and developmental and psychosocial concepts, such as the relationships between gender nonconformity, identity development, and sexual orientation, which are important for practicing psychiatrists to know. Nine main practice principles are identified and outlined (Box 1) (7). Their application in clinical practice is discussed below in the section on treatment.

### American Psychiatric Association (APA)

During the revision of *DSM-5*, from 2008 to 2013, there were calls to remove the diagnosis of gender identity disorder from the manual to avoid pathologizing gender diversity. A diagnosis was retained to provide a conceptual framework for valid transgender-specific health care needs, including gender-affirming physical and mental health care and access to such care via insurance or other coverage (8, 9). To address these concerns about the *DSM-IV-TR* diagnosis of gender identity disorder, in 2013 the APA replaced the diagnosis with the *DSM-5* diagnosis of gender dysphoria. Gender dysphoria refers to the distress an individual may experience resulting from an incongruence between gender identity and birth-assigned gender (9). This distress, rather than identity per se, is the focus of the diagnosis. This distress is different from that resulting from stigma, although these may co-occur. Within this overarching diagnosis are two developmentally appropriate criteria sets—one for children and one for adolescents and adults (Box 2).

### World Health Organization (WHO)

In 2019, the WHO Assembly voted to approve revisions to the *ICD-11*. In doing so, the *ICD-10* diagnosis of gender identity disorder in children was replaced by gender incongruence in children. Further, the diagnoses of gender incongruence in children and gender incongruence in adolescents and adults were moved from the *ICD-10*'s mental disorders section and placed in a new chapter on conditions related to sexual health (10). The implications of this change for practice are yet to be determined, because the United States only began to use the *ICD-10* in 2015, and it remains unclear when it will adopt the *ICD-11*.

## MENTAL HEALTH NEEDS OF LGBT YOUTHS

### Unique Developmental Experiences of LGBT Youths

LGBT youths have the same developmental needs as the general population. In addition, clinicians providing care to LGBT youths should consider this population's unique needs in four important developmental domains influencing health and mental health: sexual orientation, sexual identity or sexual orientation identity, gender expression, and gender identity.

*Sexual orientation* refers to the gender(s) of those to whom an individual is sexually or romantically attracted: homosexual (same sex), heterosexual (other sex), and bisexual (both male and female). An individual's *sexual identity or sexual orientation identity* is referred to with the terms lesbian, gay, and bisexual. *Gender expression* refers to the degree of gender typicality of a child or youth's play preferences (including toys and inclination for rough-and-tumble play), use of styles, mannerisms, and other gender-typed behavior. *Gender identity* refers to the gender with which the individual identifies, and may or may not be congruent with gender expression. For example, an adolescent may have a private female gender identity and a public male gender expression. Some terms that can be used to describe gender identity include girl, boy, nonbinary, agender, and genderqueer, although there are many others. Clinicians working with LGB and gender dysphoric youths can learn to distinguish the four developmental domains. Stressors related to development in one or more domains can result in adverse experiences for the patient.

**BOX 2. *DSM-5* diagnostic criteria for gender dysphoria[a]**

**Gender Dysphoria in Children (F64.2)**

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
   3. A strong preference for cross-gender roles in make-believe play or fantasy play.
   4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
   5. A strong preference for playmates of the other gender.
   6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
   7. A strong dislike of one's sexual anatomy.
   8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:
With a disorder of sex development (e.g., a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome).
Coding note: Code the disorder of sex development as well as gender dysphoria.

**Gender Dysphoria in Adolescents and Adults (F64.0)**

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
With a disorder of sex development (e.g., a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome).
Coding note: Code the disorder of sex development as well as gender dysphoria.
Specify if:
Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

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Gender dysphoria, a persistent and severe emotional distress related to one's gender identity and a desire to be an alternative gender different from one's assigned gender, differs from gender nonconformity. Gender nonconformity refers to the behavioral expression of gender-typed traits in a given sociocultural context; it is distinct from the identity component of gender dysphoria, which refers to a psychological experience of one's gender rather than to gender-related behavior. These can be congruent but are not necessarily so.

Individuals exposed to negative reactions about their gender or sexual identity from peers, family, or society are at increased risk for psychological distress. The rates at which LGBT youths experience depression, anxiety, and substance abuse are increased compared with the general population and include a two-to-fourfold increased risk for suicidality (ideation and behavior) (11). Exposure to interpersonal stigma, such as family rejection and harassment from peers, has been associated with greater risk for suicidality. Fear of rejection or risk of physical or emotional harm because of divergence in sexual or gender development can often lead pediatric patients to hide their feelings, such as experiencing same-sex romantic attraction, variation in gender expression, and gender dysphoria. Hiding one's identity, and the dilemma over whether to come out (reveal one's identity) to peers and family, are experiences unique to the emotional development of LGBT youths. In addition, transgender youths sometimes have unique medical and

**BOX 3. Professional organizations and community resources pertaining to lesbian, gay, bisexual, and transgender youths**

American Academy of Child and Adolescent Psychiatry (AACAP): aacap.org
Association of Gay and Lesbian Psychiatrists (AGLP): aglp.org
Gay and Lesbian Medical Association (GLMA): glma.org
Pride CAPA (formerly the Lesbian and Gay Child and Adolescent Psychiatric Association): www.pridecapa.org
World Professional Association for Transgender Health (WPATH): wpath.org
National LGBT Health Education Center at The Fenway Institute: lgbthealtheducation.org
Gay, Lesbian, and Straight Education Network (GLSEN): glsen.org
Trans Student Educational Resources (TSER): transstudent.org
PFLAG: A national organization with local chapters providing support for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people, their parents and families, and allies: pflag.org
The Family Acceptance Project: familyproject.sfsu.edu
The Trevor Project: Provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer, and questioning youth: thetrevorproject.org

mental health needs related to the distress they may experience because of discordance between their gender identity and their assigned birth gender. Mental health clinicians and pediatricians familiar with these concepts are best able to appropriately discuss sexual orientation, gender expression, and gender identity with their patients (6).

### Minority Stress and Stigma

The minority stress hypothesis (12) provides a conceptual framework for understanding the increased rates of physical and mental health disparities among the LGBT population. This hypothesis posits that exposure to anti-LGBT stigma causes the disparities found among LGBT youths. Examples of stigma include family nonacceptance; peer bullying; employment or housing discrimination; criminalization of same-sex or transgender behavior; reality-based identity concealment and rejection anticipation; and exposure to discriminatory laws, policies and societal norms.

The bulk of sexual and gender minority stress research, however, has been conducted with LGBT adults. Goldbach and Gibbs used qualitative methods to address the applicability of minority stress theory to LGBT adolescents, finding that although the model applies, further attention in adolescents should be devoted to group- and individual-level coping resources, social and family context, and sexual identity development (13). They further note that, whereas the original model emphasizes negative expectations as an internal factor, assessing expectations of actual acceptance is of unique developmental importance among LGBT adolescents. Although it may be challenging to reduce sources of social stress, the presence of coping resources may be another clinically modifiable factor. The proposed emphasis on social and family context for gender and sexual minority adolescents is concordant with data demonstrating the importance of family acceptance and school safety as protective factors (14). Finally, identity formation is a central developmental task of adolescence, such that the development and integration of sexual and gender identity pose an additional developmental challenge that may be influenced by exposure to stigma.

The multiple levels at which minority stress operates—individual, interpersonal, and structural (i.e., laws, policies, and norms)—underscore the role of mental health professionals at each of these levels (15, 16). Individual-level interventions include using various psychotherapeutic modalities aimed at helping LGBT youths cope with stress. One randomized controlled trial assessed the efficacy of a modified cognitive-behavioral therapy intervention for gay and bisexual young men, showing positive outcomes on depression, alcohol use, and HIV risk behavior (16). Interpersonal-level interventions include family-focused interventions aimed at increasing family acceptance and support; identification of key social and family contexts through which LGBT youths experience minority stress; school-based interventions geared toward increasing school acceptance and safety; and collaborative and consultative work with other mental and physical health practitioners to promote access to LGBT-affirmative health care. Structural-level approaches include advocacy and policy development at state, local, and institutional levels. All three levels are critical targets for improving health outcomes for LGBT youths.

## TREATMENT OF MENTAL HEALTH ISSUES

The AACAP's practice parameter on the assessment and treatment of children and adolescents with depressive disorders (17) is one of several publications available to guide mental health clinicians in providing treatment to all youths. This document advises routine screening for depression in all psychiatric assessments of children and adolescents. Early identification and effective treatment of unipolar and bipolar depression, substance- or medication-induced depression, depressive disorders caused by medical conditions, dysthymia, and adjustment disorders leads to reduction in illness severity and lower rates of suicide, substance abuse, and persistence of depression into adulthood. These principles, carried out with appropriate clinical and cultural competence, are applicable to LGBT youths and are further described in the AACAP practice parameter.

Mental health professionals can help LGBT youths improve social support, coping methods, and problem-solving skills. Anti-LGBT stigma that has contributed to a depressive episode may persist after the depressive episode has been

resolved, and continued psychotherapy may be needed to maintain remission by supporting ongoing coping with this stigma or with related psychosocial, familial, and interpersonal stressors and conflicts. Continued parent-child conflict has been associated with prolonged episodes of depression and increased rates of relapse. Irritability and conflictual relationships—common features of depression among youths—may strain interpersonal relationships. As a result, potentially supportive peers and family may withdraw from the adolescent, leading to increased feelings of isolation for the adolescent. It is important to assess the youth's social network at the beginning of treatment. The strength of this social network may be especially strained, and complicated by lack of acceptance from peers and family, for adolescents who are transgender, gender diverse, or members of a sexual minority. Therefore, clinicians may need to consider specific stressors related to sexual orientation, gender expression, and/or gender identity, in addition to other psychosocial and contextual issues, for youths who do not respond to standard treatments for depression.

Standard, developmentally appropriate treatment for mild-to-moderate depressive illness may include supportive psychotherapy or structured treatments, such as interpersonal psychotherapy, cognitive-behavioral therapy, or psychodynamic psychotherapy. In addition, school and family or caregiver interventions may be key components of treatment for children and adolescents (17).

Clinicians should be mindful regarding issues of confidentiality and disclosure when engaging the LGBT's patient's support system. Principle 2 of the AACAP's practice parameter (7) says, "the need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youth." Clinicians must consider the patient's safety; acceptance or rejection by family, community, and school; and support available or absent when working with a patient regarding disclosure of a transgender, gender diverse, and/or LGBT identity (i.e., when and to whom a patient is considering coming out).

Clinicians should be prepared to address the complexity of a patient's decision to come out. Doing so may be relatively simple if the child has a supportive family and school system. However, the issue is more complicated when disclosure of gender or sexual minority status may cause harm to the child or adolescent. The coming out process varies from patient to patient. Clinicians should consider how unique clinical factors, including the psychosocial context, influence whether, how, and when coming out is appropriate for a given youth. In planning treatment, practitioners should consider opportunities to strengthen the relationship between the child and family or caregiver, guide caregivers in providing support, help to manage family crises, and decrease interpersonal and familial conflicts (7).

LGBT youths also face unique challenges when seeking substance use treatment, especially when there is family involvement or a recommendation for residential treatment. Clinicians should consider gender and sexual identity development when formulating the treatment plan, keeping in mind that the treatment setting works best when it is welcoming, nonjudgmental, and open to affirming the youth's gender and sexual identity (18).

**Support for Families of Transgender Youths**

In addition to stigma, transgender and gender diverse youths and their families may face additional stress related to decision-making regarding transgender-specific social and medical interventions to affirm gender identity. A *social transition,* which involves no medical or surgical intervention, can be accomplished in many ways and to multiple degrees. This transition involves, for example, choosing a hairstyle and clothing that reflect one's gender identity or using a name and pronouns congruent with one's gender identity. Social transition can occur across all environments, or may be limited to specific settings, such as in the home, at specific supportive events, or on vacation. Although there is little empirical evidence on the risks and benefits of early social transitioning among gender dysphoric youths, preliminary information from Dutch cohort studies in specialty clinics has identified some factors associated with a higher likelihood that prepubertal gender dysphoria will continue into adolescence. These factors include a greater intensity of dysphoria and meeting criteria for a formal diagnosis; a cognitive or affective cross-gender identification (that is, saying "I am" or "I feel like" rather than "I wish I were the other sex"); having a younger age of presentation; having a male birth gender assignment; and having gone through an early social role transition, especially for those assigned male at birth (19, 20).

Several clinical cohorts have found that the developmental trajectory of gender dysphoria among children is more variable than that among adults, with a majority not reporting gender dysphoria persisting into adolescence or young adulthood (19–23). In a number of clinical cohorts, gender dysphoria manifesting in adolescence and adulthood has tended to be stable over time. In contrast, in a number of specialty clinic cohorts, a majority of gender dysphoric prepubertal children have no longer reported gender dysphoria in adolescence or young adulthood. Instead, a majority have reported a nonheterosexual orientation. This finding has been questioned because of a number of possible confounders, including selection bias for patients more likely to disavow transgender identity over time, identity concealment because of stigma in adolescence or adulthood, and/or overly broad initial inclusion criteria (24). Further research including population-based samples and long-term follow-up is needed to rule out such confounders or other sources of misclassification.

Mental health professionals can consider helping children and families evaluate their options, weigh risks and benefits, and tolerate uncertainty. *Gender transition* is a highly complex process, and clinicians who have experience with assisting patients in transition should be consulted. They can provide guidance on how to support families in

making and executing decisions about the timing and nature of steps toward social transition and can help families affirm and support a gender dysphoric child, even if social gender transition is not undertaken. Mental health professionals can help families navigate and advocate for their child in the school and community (e.g., access to bathrooms at school), and, as puberty approaches, help pave the way for decision making about hormonal interventions. This decision making may include considering reversible suppression of puberty with gonadotropin-releasing hormone analogs, and possibly at a later stage, use of irreversible cross-gender hormones, including estrogens and testosterone (25).

Clinicians can discuss the risks and benefits of social and medical transition with patients in a developmentally appropriate manner, especially when social transition is being considered by prepubertal children. The clinician can consider the risk of later distress due to posttransition regret, if cross-gender identity fades postpubertally, and can weigh this risk against the potential benefit of a prepubertal gender transition that might improve the psychosocial functioning of children whose transgender identity is affirmed by others. Clinicians can consider helping children to explore their gender, supporting the family when there is uncertainty in whether the gender dysphoria will remain stable over time, and encouraging caregivers to provide children with support and acceptance as their gender identity becomes clear. The Fenway Guide also addresses limitations on current clinical knowledge and the need for more research in this population in order to develop and update clinical practice guidelines (26).

### Collaboration With Pediatricians

Collaboration between mental health clinicians and pediatricians is key to providing competent psychiatric care to LGBT youths, particularly because the majority of LGBT youths are seen by pediatricians and not by the limited supply of mental health professionals. This care may range from medical treatment of gender dysphoria to ensuring a patient has access to a medical home where patient-centered, team-based comprehensive and continuous medical care is provided by clinicians and basic primary care needs are met. Social stressors, such as stigma, parental and community rejection, and social isolation place LGBT youths at risk of experiencing health inequities compared with their non-LGBT peers. As a result of both increased rates of psychiatric illness influencing health risk behaviors and epidemic patterns, LGBT youths may be at increased risk of engaging in behaviors that expose them to sexually transmitted infections, including HIV; sexual assault or abuse; and teen pregnancy (27). For example, men who have sex with men account for approximately 4% of the male U.S. population, yet they make up 78% of new HIV infections among men and 68% of total new HIV infections (27). Reported sexual attraction does not always align with sexual behavior among youths, and a majority of young women who have sex with women report previous male partners. Discussions about sexual and reproductive health and future family planning intentions may help clinicians to understand how LGBT youths see themselves in the future and how they conceptualize family. It is important to avoid making assumptions about pregnancy risk or fertility intentions of LGBT youths (27).

An additional issue that brings psychiatric clinicians to work closely with pediatricians is the treatment of eating disordered behavior. Up to 25% of high-school-age girls and 11% of high-school-age boys report engaging in eating disordered behavior, including daily vomiting to control weight (28). In general, eating disordered behaviors peak in adolescence, which is also a key period in sexual identity development. LGBT youths with eating disorders may be affected in unique ways. Issues related to LGBT identity and family acceptance may arise in treatment of eating disorders, because most treatments are family based. In addition, gay and bisexual boys have been found to have increased body image and weight concerns, viewing themselves as overweight when they are in a healthy weight rage, and lesbians have been found to view themselves as in the normal range when they are in fact in the obese or overweight range (14). Body image concerns, distortions in body image, or general body dissatisfaction are prevalent, albeit not ubiquitous, concerns of gender dysphoric youths (28). The intersection between transgender identity and eating disorders remains understudied. Appropriate care for gender dysphoric youths with concomitant eating disorders should include affirmation of and appropriate medical support for the youths' gender identity (28).

## CLINICAL VIGNETTES

The following vignettes are hypothetical examples based on clinical experience and literature.

### Separation Anxiety in a Gender-Nonconforming Prepubertal Child

*Part 1.*

> A nine-year-old boy in the fourth grade of a public school was evaluated by his pediatrician for frequent stomach aches causing school absences. No medical cause was found other than distress caused by bullying at school. The pediatrician referred the child and family to a psychiatrist. The parents reported a 1-year history of mood and behavioral change, including onset of separation anxiety, reluctance to engage in peer group activities, and introversion in a formerly outgoing, popular child. This change occurred in the context of lack of proficiency in, and an aversion to, gender-typical interest in team sports, leading to loss of social standing with peers. He prefers to participate in school drama and dance activities instead of athletics. On one occasion, peers teased him for wearing a purple spangled costume they considered effeminate in a dance performance. Since then, they have been calling him names, including *faggot* and *trans*.
>
> The school has been applying its nonbullying policy inconsistently. Parents are warm, loving, and appropriately

> concerned, but confused about how to best support their child. They met with the school administrator, who explained "some of our families don't agree with the gay and trans agenda, and our non-bullying policy doesn't include disagreeing with their family values." The parents are unsure how to respond.

This clinical scenario illustrates how minority stress can lead to adverse mental health outcomes caused by exposure to stigma—in this case, both interpersonal (peer bullying) and structural (lack of an equitable school antibullying policy). Protective factors for this child include parental acceptance, good premorbid functioning, and absence of developmental pathology. These factors are not yet fully actualized; however, they point to possible points of clinical intervention.

Clinical questions at this stage of evaluation include the following: What is the developmental significance of nonconforming gender expression? Is this child developing along a cisgender nonheterosexual trajectory? A transgender one? Both? Neither? What is the best clinical plan to address separation anxiety and peer and/or school avoidance? Is a systems intervention possible for the bullying?

After assessing the patient's safety for continued outpatient care, the psychiatrist decided to continue the evaluation phase to clarify these issues.

*Part 2.*

> In follow-up, the father expressed feeling like a failure. He himself had suffered from social anxiety as a child. He identifies with his son, and he blames himself for failing to protect him as he would have liked to have been protected by his own father at the same age.
>
> In a separate individual interview, including interactive play and art techniques, the child's drawing of a family was noteworthy for the depicted child being distant from the adults, and the male adult figure being drawn less colorfully and appearing to frown. The child expresses no gender dysphoria, either in drawings or in play.

*Key clinical points.* This scenario illustrates the possible role of family factors influencing the child's symptoms, including paternal anxiety and/or depression. These factors may be inhibiting the child's capacity to adaptively use regression within the parental relationship to refuel with family support, learn adaptive social skills, and become willing to accept return to school.

Clinical questions at this stage include the following: Does the father need to be evaluated for depression and/or anxiety? If treated successfully, will he function better as a parent to convey hopefulness to and foster adaptive coping by the patient? Is the child's gender nonconformity indicative of cisgender identity in a developing nonheterosexual child, concealment of transgender identity, both, or neither?

Although the answers to some of these questions may not be known for some time—especially those involving long-term development of gender and sexuality outcomes—the clinician can address significant current problems. Whatever this child's ultimate developmental outcome, he should not be bullied, and intervention is necessary. Clinicians should be aware of antibullying policies, laws, resources, and educational options for protecting students from a stigmatizing school climate. Parent guidance for school advocacy and/or clinician school consultation may help the school understand that equitable protection from bullying for this child does not contradict other families' values. A multimodal treatment plan may include individual psychotherapy, pharmacotherapy, parent guidance, paternal mental health referral, and environmental intervention and/or school consultation.

### Major Depressive Disorder in an Adolescent Girl Coming Out as a Lesbian

*Part 1.*

> The parents of a 14-year-old girl are requesting a psychiatric evaluation for their daughter. They live in the suburbs 2 hours outside of a large city and have been referred by the high school counselor, who told them their daughter was found in the school bathroom cutting her forearm with a box cutter. The cuts are superficial and do not require medical attention, and when initially evaluated, the teenager reports this behavior has been ongoing for most of her freshman year of high school. She says that all of the close friends she had since elementary school have stopped talking to her, "because they all found out I like girls." She spends most of her time after school at home in her room, talking with friends online, all of whom live in other parts of the country. She says they are the only ones who understand her, and that she has no one else to talk with about her sexual orientation: "If I talked about how I feel in real life, my parents would freak out, I can't tell them anything." She discloses feeling increasingly depressed and suicidal since coming out to a peer at school and thinks if her parents discover she is a lesbian then they will "disown" her. She says, "they don't know any gay people, and I've heard them say homophobic things."

This vignette illustrates family and peer rejection compounding the symptoms of depression in an adolescent. The clinician should distinguish normal changes in adolescent behavior from signs and symptoms of depression in adolescence. One can expect a (sometimes drastic) change in social interests and a shift away from a desire to please parents and toward identification and reliance on peers for emotional and social support. This vignette, however, highlights the social withdrawal, emotional distress, and daily negative affect that can occur among adolescents with depression. In this case, the patient has socially withdrawn from her peers who are not accepting of her sexual identity, and she has begun coping with her painful emotions via self-injury and suicidal ideation. In addition, a genuine possibility of parental nonacceptance is distressing to the patient and complicates the opportunity for encouraging parental support.

Clinical questions at this stage of evaluation include the following: How might one address self-injury, suicidal ideation, and safety in the context of distress about sexual orientation and family and/or peer rejection? How should this

teenager's sexual orientation and developing identity be understood in the context of her self-injurious behavior—as a component of an identity disturbance or as a stable orientation that is stigmatized? What is developmentally appropriate adolescent behavior in this situation? What can the clinician do to create a safe, accepting, and nonjudgmental setting for this adolescent to openly discuss her sexual orientation, identity, and behavior?

*Part 2.*

> Upon further inquiry about her online life, the patient reveals she has developed a close relationship with a teenage girl in another state. They often interact together online through a role-playing game that allows the patient to portray herself as a lesbian character. She reveals that she thinks she has romantic feelings for her friend and feels very isolated and worries about how her parents will react. Careful assessment of her history reveals that the youth's pattern of attractions is an enduring component of stable interpersonal relationships, albeit a conflicted one. She then asks her psychiatrist, "Are you going to tell them?"

Clinical questions at this stage include the following: How might one discuss confidentiality about sexual orientation with this patient? How can the clinician provide emotional support to this adolescent and help her to develop social support if her peers are not accepting of her sexual orientation? How might a clinician address the coming out process, given that this patient is very worried about potential family rejection?

*Key clinical points.* Assuring confidentiality will help create a strong therapeutic alliance between the patient and clinician. AACAP's practice principles include guidance on the initial evaluation, including the need for appropriate confidentiality; for understanding the domains of sexual orientation, gender expression and identity; for signaling a nonstigmatizing environment to foster the clinical alliance; and for eliciting pronoun preferences when clinically appropriate. The coming out process is complex and unique to each individual. An adolescent may first disclose having romantic feelings about same-sex peers to close friends but not come out to parents because of fear of rejection, risk of losing financial support, or concern for physical safety. Clinicians may assess whether it is safe for adolescents to disclose their sexual orientation to family and peers and may help mitigate the psychological distress patients may endure by keeping their LGBT identity hidden from others. Psychotherapy can help adolescents identify supportive family and friends and weigh the risks and benefits of deciding whether to come out and to whom. Clinicians may consider using collateral family therapy and guidance to support this process. In addition to individual psychotherapy and the consideration of pharmacologic treatment of depressive symptoms, clinical interventions may include family therapy to improve communication between parents and the adolescent, parent psychoeducation about sexuality and family acceptance, and school advocacy to address bullying and to identify additional sources of social support.

## CONCLUSIONS

LGBT youths face unique developmental and psychosocial challenges that mental health clinicians should understand and consider addressing when formulating treatment plans. Ideally, mental health clinicians should be prepared for and comfortable with discussing sexual development and gender identity when consulted by families or pediatricians seeking treatment for a child or adolescent patient. Therapeutic work focusing on identity consolidation and addressing self-stigma (patients' distress related to their own identity) can help foster healthy psychosexual development for LGBT youths. Clinicians who are uncomfortable working with this population should seek supervision and become familiar with clinical alternatives, which may include telepsychiatry and/or consultants, so they can refer patients to a therapist who can provide appropriate care. Furthermore, multiple evidence-based, peer-reviewed resources and publications by professional and community organizations (Box 3) are available to provide guidance about treatment options and challenges whenever questions arise in the care of LGBT youths with psychiatric disorders.

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