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Mental Health Disparities by Identity Among Gender and Sexual Minorities

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Introduction

One of the major obstacles faced by the queer and trans community is the poorer mental health outcomes this group tends to have. There is a disparity in mental health between people who are part of gender and sexual minority groups, and those who are not. Due to the connection between mental health, marginalization, and stigma in society (Meyer, 2003), this disparity may weigh more heavily on people whose identities are especially marginalized, such as bisexuals, asexuals, trans people in general, and non-binary trans people even more so. It is difficult to determine how exactly mental health disparities impact people with these identities because of the lack of psychological literature about these groups. Further, gender and sexual identities are complex and fluid, and therefore can be hard to define, and although people with some identities tend to experience more stigma than others, whether this correlation can be attributed to the identity itself or to other factors is undetermined. The lack of representation of gender and sexual minorities in literature demonstrates that these marginalized groups are historically ignored in research as well as in broader society.

Aim of the Present Review

This literary review and analysis will point out mental health disparities experienced by gender and sexual minorities and the causes of and protective factors against these disparities. Then, the review will explore how the factors that contribute to and protect against mental health disparities impact the most marginalized sexual and gender minorities differently from how they affect lesbian and gay individuals. Although some literature has explored the health disparity between lesbian/gay and straight individuals, less research has examined the health disparities experienced by trans, bisexual, and asexual individuals. No single study to date has compared the health disparities between all the different sexual and gender identities in the LGBTQIA2S+

community. I would contend that bisexual, asexual, and trans individuals experience even greater disparities due to the greater marginalization that these groups face. Because these individuals experience the greatest amount of minority stressors, the most discrimination from within the mental health field itself, and the least access to protective factors, it is especially important that there is more research conducted about the mental health of individuals in asexual, bisexual, and trans communities, and that this research is used to help mental health practitioners do better in serving these communities.

Studies over the years have provided evidence that at least some members of the LGBTQIA2s+ (lesbian, queer, bisexual, transgender, intersex, asexual, two-spirit) community struggle with mental health more often than the general public, although most studies focus on lesbian, gay and bisexual individuals (Cochran, Ackerman, Mays, & Ross, 2004; Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; McCabe, Bostwick, Hughes, West, & Boyd, 2010). A more inclusive review of multiple studies found that overall, lesbian, gay, bisexual, trans, and queer people use mental health services more frequently (Sing & Shelton, 2011) and are more likely to display mental health symptoms than comparison groups (D'Augelli, 2002). There are two primary reasons that these disparities are important. First, mental health problems can affect quality of life, employment, relationships, and other aspects of life, and there is even research showing that this is specifically true in sexual minorities (King & McKeown, 2003). Second, this disparity may point to problems in society in general, and within the mental health field itself, that contribute to these outcomes for LGBTQIA2S+ individuals. These problems include discrimination and stigmatizing attitudes perpetuated by mental health practitioners that result in inadequate mental health care for LGBTQIA2S+ people. Once the causes of mental health disparities are identified, mental health problems in gender and sexual minorities can be

prevented and treated more effectively. Therefore, significant research should be dedicated to determining what causes these mental health disparities. Currently, issues related to LGBTQIA2S+ individuals are underrepresented in the body of psychological research, which may be sending the message to this community that psychologists do not see them as important (Sing & Shelton 2011).

Extent and Nature of Existing Literature

Many of the articles that focus on the LGBTQIA2S+ community contain commentary on the overall lack of research about the mental health outcomes of this community (Sing & Shelton 2011), demonstrating that while some researchers are aware of the underrepresentation of gender and sexual minorities, this awareness has not yet been sufficient to end the underrepresentation. When it comes to identities within the community that are more marginalized and less recognized or understood by broader society, such as asexuality or trans/nonbinary identity, the representation is even less. Over the course of this literature search, it appears that the largest amount of research on mental health disparities had been conducted on lesbian, gay, and bi individuals as a single group, sometimes labeled "sexual minorities." This excludes trans individuals, those whose sexual identity does not fit neatly into one of the three labels, and treating all these identities as a single homogenous group makes it impossible to tell if one identity is affected more than the others. The next most researched topic seemed to be bisexual health disparities, followed by trans/gender minority health disparities. The articles about trans people/ gender minorities mostly focused on this group as a whole, with most of the focus on transwomen/ transfeminine people and less on trans men/ transmasculine individuals. There were no articles that exclusively focused on those with a nonbinary gender identity, genderqueer, genderfluid, or any variation thereof, but many of the articles about gender minorities did

acknowledge the existence of nonbinary gender identities. Finally, there were several articles about asexuality, a relatively recent addition to the field from around the past decade. Other specific identities such as pansexuality or demisexuality receive no specific attention in the literature. To put this in perspective, the identities receiving some of the most attention, bisexuality and trans identities, are still considered "underrepresented" in the literature by recent researchers (Sing & Shelton, 2011).

The varying degrees of recognition and validation of identities in society overall is similar to how often they are represented in the scientific literature, making psychological research another facet of society in which gender and sexual minority identities are further marginalized. Lesbian and gay identities are at least accepted as valid identities by most of western society, and lesbian and gay individuals experience a degree of cultural acceptance, at least for lesbian and gay people who fit into other social norms. However, they are still underrepresented in media and associated with a host of stereotypes, and still experience discrimination at an institutional level (Pizer, Sears, Mallory, & Hunter, 2012). Bisexual people also experience institutional discrimination and underrepresentation, as well as many stereotypes that tend to be more invalidating of their identities than lesbian and gay stereotypes, such as the notion that bisexual people just want attention and in reality are either straight or gay (Klesse, 2011). Trans people, while they have begun to gain more cultural visibility in very recent years, are still hugely misunderstood by much of society, and endure discrimination and stigma in nearly every facet of society, from legal documents to bathrooms to hate crimes (Pizer, Sears, Mallory, & Hunter, 2012; Meyer, 2010). Most representation of trans people in media is focused on transwomen exclusively, and typically portrays them as tragic characters, rarely living until the end (GLAAD, 2016). Asexuality is virtually never represented in media, and is either

unknown or misunderstood by the majority of society (MacInnis & Hodson, 2012). Asexual people in their personal lives also experience significant dismissal and rejection of their identities (MacInnis & Hodson, 2012). So if psychological research continues to perpetuate this marginalization, it will be another way in which people of asexual, bisexual, and trans identities experience adversity and underrepresentation in society.

The lack of representation of asexual, bisexual, and trans identities in psychological research and broader society may also mean that the individuals with these identities also experience the most severe mental health disparities. However, due to the limited research, this is difficult to determine. Another factor complicating this issue is the fact that the distinctions between different identities may not be clear cut, due to the complexity of sexual and gender identities, different reasons behind using various labels (for example, using the label bisexual rather than pansexual may be dependent on factors such as whether someone has heard of the term bisexual, or whether they believe bisexuality reinforces the gender binary (*Diva Magazine,* 2015)), and the variability of operational definitions of identities in the research. The fluidity and inconsistency of sexual and gender identity makes it difficult to draw firm conclusions based on differences between specific identities held by individuals.

Important Definitions

One major problem in the current literature is the lack of standard operational definitions for various gender and sexual identities (Matthews, Blosnich, Farmer, & Adams 2014). For example, whether bisexuality is defined based on sexual behavior with people of more than one gender, or attraction to people of more than one gender, or self-identification as “bisexual” makes a difference in which participants would be considered part of that group. However, some basic definitions, for the purpose of this review, can be found in the table below.:

Asexuality	Lack of sexual attraction
Demisexuality	Subsection of asexuality in which someone only experiences sexual attraction to people with whom they have a strong emotional connection.
Bi+	Umbrella term for anyone attracted to more than one gender
Bisexuality	Attraction to the same gender and one other gender
Pansexuality	Attraction to all genders (may express attraction "regardless of" or "unrelated to" gender)
Polysexuality	Attraction to more than two, but not all, genders
Monosexuality	Attraction to only one gender (whether same or other)
Homosexuality	Attraction to the same gender (formerly a clinical term, generally not used by individuals who it describes, gay or lesbian is used more often)
Gay	Attraction to the same gender, most commonly applied to men who are attracted to men, but can be applied to people of any gender
Lesbian	A woman who is attracted to women
Heterosexuality	Attraction to the other gender (often referred to as straight)
Trans	Umbrella term for anyone whose gender identity is not compatible with sex assigned at birth
Nonbinary	General term for someone who does not identify as either a man or a woman, but some people without a binary gender identity may prefer another term such as genderqueer, or agender meaning no gender, or genderfluid meaning changing between gender categories
Two-spirit	An identity specific to Native American cultures used by some to broadly refer to certain gender minority individuals in their communities
Transgender	Essentially the same as above, but may imply female-to-male or male-to-female, so less inclusive of nonbinary identities
Male-to-Female (MtF)/transwoman	Someone who was assigned the sex of male at birth but identifies as a woman
Female-to-Male (FtM)/transman	Someone who was assigned the sex of female at birth but identifies as a man

Transfeminine	A term describing people assigned male at birth who may not identify completely within the binary category of women but do identify as feminine and trans
Transmasculine	A term describing people assigned female at birth who may not identify completely within the binary category of men but do identify as masculine and trans
Cisgender	Gender identity that is compatible with sex assigned at birth (e.g. not trans)
Gender minority	Anyone who is not cisgender (essentially a synonym for trans)
Sexual minority	Anyone who is not heterosexual
Queer	"An umbrella term sometimes used by LGBTQA people to refer to the entire LGBT community… It is important to note that the word queer is an in-group term, and a word that can be considered offensive to some people, depending on their generation, geographic location, and relationship with the word." (University of Michigan International Spectrum, 2016)

(University of Michigan International Spectrum, 2016)

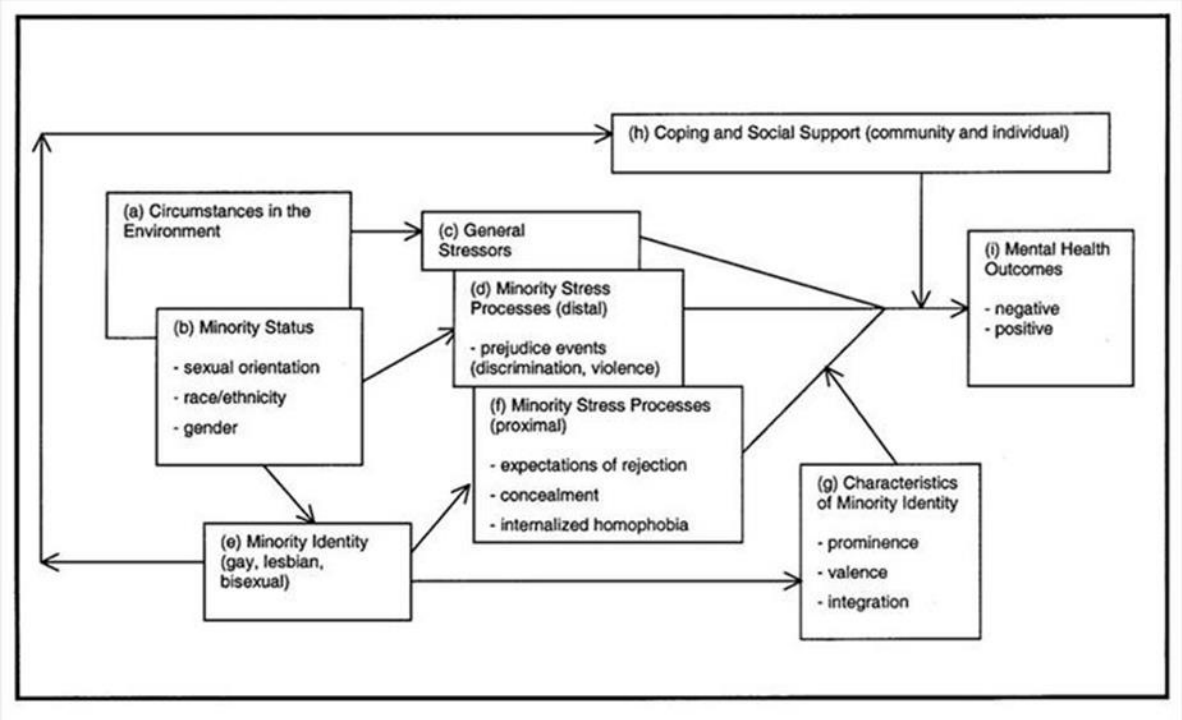
Because of the controversial nature of the term "queer," the primary umbrella terms I will be using in this review are "gender minorities" and "sexual minorities."

Causes of Disparity

Much of the literature examines the potential causes of the mental health disparities experienced by gender and sexual minorities. These causes are important to identify, in order to determine how to prevent and treat mental health problems in these populations more effectively.

Minority Stress

One major cause, encompassing numerous more specific factors, is the phenomenon of minority stress. Minority stress occurs when stressors, created by a discriminatory and marginalizing environment lead to poor mental health outcomes in minority populations (Tebbe & Moradi 2016).



(Meyer, 2003)

The minority stressors that the literature focused on were stigma, both structural and interpersonal, discrimination and oppression, internalized heterosexist or cissexist attitudes, hate-based victimization, identity concealment, and social rejection or lack of social support.

Stigma. Stigma is a set of negative beliefs or attitudes about someone or something held by a society or by an individual, and it is one of the most overarching factors that contributes to minority stress. Stigma and discrimination have been found to be a fundamental causes of health disparities (Poteat, German, & Kerrigan, 2013). One type of stigma is interpersonal stigma, which describes the shaming, blaming, othering attitudes one person expresses toward another based on identity or perceived group membership. This type of stigma around sexual and gender minority identities, when it appears in authority figures, and especially health care providers, can greatly increase the stress that these individuals face in their daily lives (Poteat, German, &

Kerrigan, 2013). Another type of stigma is structural stigma, which are policies and institutions that systematically disadvantage or invalidate certain groups of people. Structural stigma has been shown to increase the already existing disparities in mental health risk behaviors such as drug use (Hatzenbuehler, Jun, Corliss, & Austin, 2015). One of the reasons minority stress is so significant is that it can encompass both distal stressors, meaning external causes of stress in someone's environment as well as proximal stressors, meaning internal, more covert causes of stress within someone's own mind (Walch, Ngamake, Bovornusvakool, & Walker, 2016).

Discrimination. Perceived discrimination, another important minority stressor, is a distal stressor that has an adverse effect on both mental and physical health for lesbian, gay, and bi people (Walch, Ngamake, Bovornusvakool, & Walker, 2016) Discrimination is when someone is treated unfairly by an institution or an individual with authority based on identity or perceived group membership, such as someone not being hired because of their gender identity, or a same-sex couple not being served in a restaurant.

Victimization. Another distal minority stressor is victimization on the basis of sexual or gender identity, what is commonly referred to as a hate crime, or in the case of school environments, bullying. There are many mental health consequences of victimization based on sexual orientation that contribute to the mental health disparity, such as feeling unsafe, lowered self-worth and self-efficacy, distress, anger, loss of trust in others and suicidality (Hein & Scharer, 2012; D'Augelli 2002). In addition, victims of LGBTQIA2S+ hate crimes are more likely to experience indifference and abuse from law enforcement when attempting to report the crime, another example of structural stigma which could compound the stress of being victimized in the first place (Hein & Scharer, 2012).

Internalized homophobia/ transphobia. An example of a proximal stressor is internalized homophobia, which, like perceived discrimination, can also have an impact on sexual minorities' mental health (Walch, Ngamake, Bovornusvakool, & Walker, 2016). However, people may be less likely to be aware of its effect on them since it is an internalized part of their own psyche, rather than something outside of them that they are conscious of experiencing.

Identity concealment and discordance. Another proximal stressor is identity concealment, which causes an individual to feel pressured or forced to conceal their sexual identity, which has been shown to contribute indirectly to poorer mental health (Walch, Ngamake, & Bovornusvakool, 2016). A related phenomenon is sexual orientation discordance, which causes dissonance between how someone identifies themselves and their sexual behavior or experience of attraction. Sexual orientation discordance is associated with symptoms of depression (Lourie & Needham, 2016).

Social rejection. Finally, social rejection and lack of social support are also minority stressors. Lesbian, gay, and bi youth whose parents had a negative reaction to learning about their orientation reported more mental health symptoms (D'Augelli 2002), and lack of community or social support more broadly is shown to impact the mental health of sexual and gender minorities (Flanders, Dobinson, & Logie).

On the positive side, minority stressors are something that can be changed over time. So, if policies and institutions are changed to be more inclusive, steps are taken to prevent and respond better to hate-based violence and victimization, and people become more inclusive of their sexual and gender minority community members, mental health disparities may likely decrease, due to fewer minority stressors.

Risk Behavior

A mediating factor of the relationship between minority identity and mental health is risk behavior that may be associated with minority stressors. These behaviors help explain the relationship between sexual orientation and/or gender identity and mental health disparity. For example, risky sexual behavior mediated the relationship between sexual orientation and mental health for sexual minority women in one study (Persson, Pfaus, & Ryder, 2014). Risky sexual behavior may also be a response to, or otherwise related to, exposure to stigma or other minority stressors, e.g. a coping mechanism individuals use to deal with the stressors that they face.

Discrimination in Health Care Institutions

A more direct cause of mental health disparities for gender and sexual minorities may be discrimination from within healthcare institutions themselves. As mentioned earlier, health care professionals sometimes perpetuate stigmatizing attitudes on gender and sexual minority clients, such as blaming individuals for their own health issues, shaming and othering them for their identities, and treating them in discriminatory ways (Poteat, German, & Kerrigan, 2013). The mental health profession has a history of pathologizing gender and sexual minorities. The DSM, which in some ways determines what is considered by society to be "normal" or "healthy," has long excluded gender and sexual minorities from these definitions (Boskey, 2013). With this history still not entirely behind the field, LGBTQIA2S+ people may, reasonably, mistrust the mental health profession, fearing discrimination and pathologization. In particular, asexual individuals experience stress talking to health professionals due to fear of pathologization and worry they won't be able to advocate for themselves and their identities (Foster & Scherrer, 2014). Gender minorities often also see mental health professionals as "gatekeepers" to gender-affirming medical care, due to therapy often being mandated for trans individuals to pursue

medical transition, and due to the persistence of "gender dysphoria" in the DSM (Bockting, 2016). Additionally, many asexuals report having negative experiences and mistrusting mental health professionals as a result of the practitioners seeing asexuality as something to be "fixed" (Foster & Scherrer, 2014).

Protective Factors

After identifying what the mental health disparities are, and the minority stressors and discrimination in health care institutions that contribute to them, the next step is to identify protective factors that help prevent and minimize these disparities. The primary protective factor supported by most of the research was social support. Social support from friends was found to be a protective factor against minority stress for trans people, and was associated negatively with depression (Tebbe & Moradi, 2016). Researchers also found that supportive interpersonal relationships help bisexual women with the lack of support that they face in broader society (Flanders, Dobinson, & Logie 2015). Additionally, a study found that in gender minority participants, the variable of belongingness in communities mitigates unhealthy behavior and emotional distress and was positively associated with wellbeing (Barr, Budge, & Adelson, 2016). The idea of community belongingness is specifically relevant in individuals with marginalized identities, since they often find much-needed social support among groups of people who share their identity. Asexuals, for example, found that participating in a same-identity community was a source of strength and support (Foster & Scherrer, 2014).

Differences between Identities

The mental health disparities for gender and sexual minorities overall is well-established, and there are a number of potential causes and factors that contribute to these disparities. However, some gender and sexual minorities experience more minority stress, more

discrimination from mental health care institutions, and barriers to the protective factors that help protect mental health. Asexual, bisexual, and trans people experience more marginalization in society in general, and although this marginalization extends to psychological research, the research that has been done shows that mental health disparities are more severe for these particular groups.

Asexual Identity

Research has found that asexual people have more difficulty with interpersonal relationships and mental health markers than other non-heterosexual groups (Yule, Brotto, & Gorsalka, 2013).

These mental health difficulties can be attributed to increased experience of minority stressors. Asexuality is a marginalized identity in a society like ours that places so much emphasis on sex, resulting in asexual identity being disbelieved and invalidated (Foster & Scherrer, 2014). When comparing the different types of negative attitudes and bias of heterosexuals toward different sexual minority identities, it was found that regardless of whether bias was based on "right wing authoritarianism," (bias based on ideology) or "social dominance orientation," (bias based on cultural norms) heterosexuals had most negative attitudes and bias toward asexuals, followed by bisexuals, with homosexuals as the sexual minority receiving the least bias and negativity (MacInnis & Hodson, 2012). This demonstrates that there is more individual bias toward the more marginalized identities in order of marginalization, so bisexuals experience more negativity and bias directed toward them than gay or lesbian people, and asexuals experience even more. It is possible that this bias is directed toward identities perceived as more "deviant": asexuals may be more deviant because they do not conform to the social expectation that everyone is interested in sex (MacInnis & Hodson, 2012). It was also found that

asexuals were seen in dehumanizing terms by the participants, who labeled them as lacking both "uniquely human" and "human nature" qualities, meaning they were seen as inhuman in both animalistic and machine-like ways (Macinnis & Hodson, 2012). These negative attitudes contribute to interpersonal stigma, a minority stressor.

Asexuals also report being mistreated by mental health professionals on the basis of their identity. They report that mental health counselors diagnose them with sexual disorders, citing the fact that the asexual client's sexual identity causes them distress, but don't acknowledge that the source of their distress is social rejection and lack of understanding, not the identity itself (Foster & Scherrer, 2014). Due to these experiences, asexual individuals may not be able to access adequate mental health care, widening mental health disparities for this community.

Bisexual Identity

Bisexuality can be a difficult label to study because in the past it has been "subsumed under the label homosexuality," and in some cases bisexual people will be secretive about their identities, allowing others to assume they are either straight or gay/lesbian, depending on the relationship they happen to be in (Schick & Dodge, 2012). But despite this lack of visibility, psychological research has found evidence that the mental health disparity between bisexual and straight individuals is more severe than between lesbian/gay and straight individuals, (e.g., Colledge, Hickson, Reid, & Weatherburn, 2015; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; King & McKeown, 2003; Schrimshaw, Siegel, Downing, & Parsons, 2013) and more specifically, bisexual people experience more social anxiety than straight, gay, or lesbian individuals (Wadsworth & Hayes-Skelton, 2015).

One reason for the increased disparity is likely that bisexuals experience more minority stress than lesbian and gay individuals. According to one study, two-thirds of bisexual

individuals reported stress related to their sexual orientation (Page, 2004). Bisexuals are not as accepted within the sexual minority community as their lesbian and gay peers, so they are dealing with dual rejection, both from mainstream heteronormative society and the LGBTQIA2S+ community (Flanders, Dobinson, & Logie 2015). And, as mentioned above, bisexuals were the second-most negatively viewed sexual identity (after asexuals) in a 2012 study, possibly due to a perception of bisexuals as more deviant because they do not conform to the binary notion of either being gay or straight (MacInnis & Hodson, 2012). Bisexuals were also seen by participants as lacking "uniquely human" qualities, meaning they were dehumanized in an animalistic sense, more so than homosexual individuals (MacInnis & Hodson, 2012).

Additionally, non-monsexual (e.g. anyone who is neither exclusively heterosexual nor exclusively homosexual) women reported more childhood abuse and risky sexual behavior than monosexual women, indicating there are many factors related to mental health that affect the bisexual/non-monosexual community disproportionately (Persson, Pfaus, & Ryder, 2014).

Finally, bisexual people tend to experience more discriminatory service in health care than less marginalized groups, with clinicians who lack knowledge about bisexual issues, and see bisexuality as inherently unstable or unhealthy (Page, 2004). So, many of the factors that contribute to mental health disparities for sexual and gender minorities in general are experienced more severely bi bisexual individuals.

Trans Identity

There is significant evidence that gender minorities are more heavily impacted by health disparities than sexual minorities. In a 2016 study, gender minority individuals reported a 14% higher prevalence of clinically significant depression and anxiety, and higher depressive and anxious scores, than non-gender minority individuals (Reisner, Katz-Wise, Gordon, Corliss, &

Austin, 2016). In another study, trans patients were more likely to have attempted suicide as well as experience social stressors than non-transgender patients (Reisner, White, Bradford, & Mimiaga, 2014).

Once again, a likely cause of the increased mental health disparity trans people face is minority stress. Trans people experience higher rates of prejudice and discrimination, and these are associated with adverse mental health consequences, as well as suicide (Tebbe & Moradi, 2016). Trans people are also more often a target of hate crimes, meaning they are likely more affected by the adverse mental health effects of hate crimes, as were mentioned above (Hein & Scharer, 2012).

Additionally, the impact of discrimination within the mental health field itself on trans individuals' mental health is likely most severe because pathologization of gender identity is more recent than pathologization of sexuality, and even continues today (Boskey, 2013). Although gender identity disorder was removed from the DSM, its replacement with gender dysphoria is still pathologizing (Boskey, 2013). Trans people are also less likely to have access to health care in general, and when they do, professionals are often not adequately trained to help them (Poteat, German, & Kerrigan, 2013).

Barriers to Social Support

Finally, in addition to experiencing more minority stressors and discrimination in health care, and poorer mental health outcomes as a result, than lesbian, gay, and straight individuals, asexual, bisexual, and trans individuals also have more barriers to accessing the protective factors of social support and community belongingness. The problem with social and community support as a protective factor for the most marginalized gender and sexual identities is that they are less likely to find support within the overall LGBTQIA2s+ community, because oftentimes

their identities are invalidated or disparaged even by other sexual minorities. Bisexual people in study after study reported not feeling welcome in traditionally "lesbian and gay" spaces (e.g., Barker, 2015; Persson & Pfaus, 2015). Trans people have also historically been excluded from the "gay rights" movement, and asexual people are often ignored or viewed as not really being part of the sexual minority community (Foster & Scherrer 2014; Barr, Budge, & Adelson, 2016). So another risk factor for these identities may be that they do not have access to the social support needed to protect against some of the adverse effects of minority stress, which is another reason that they tend to have the most severe mental health disparities.

Summary and Conclusions

In summary, mental health disparities for gender and sexual minorities exist, and these disparities, as well as the factors that contribute to them, tend to be more severe for people with identities farther outside the norm, such as bisexual, asexual and transgender people. Institutionalized discrimination and stigma, victimization, social exclusion, identity concealment, limited access to health care, and discriminatory treatment by healthcare practitioners and institutions, all affect the more marginalized gender and sexual minorities more severely (e.g., MacInnis & Hodson, 2012; Flanders, Dobinson, & Logie, 2015; Reisner, Katz-Wise, Gordon, Corliss, & Austin, 2016). Whether these differences are due to perceptions of deviance, pathologization of certain identities, stigma due to unfamiliarity, or another cause is difficult to determine because of the limited research on the topic and the discrepancy in operational definitions used to define different identities. There are protective factors that help limit the impact of these stressors on gender and sexual minorities' mental health, such as seeking social support (Tebbe & Moradi, 2016; Barr, Budge, & Adelson, 2016). However, these protective factors may not be equally accessible to people of all identities, since people of some identities

may be rejected from "queer" community spaces as well as mainstream straight society (Klesse, 2011; Flanders, Dobinson, & Logie, 2015). There are also ways for mental health practitioners to help protect against these disparities, but this requires counselors to be aware of the existence of sexual and gender minorities, the mental health discrepancies that they experience, and the fact that some of their clients may fall into these categories.

Limitations

As mentioned earlier, one of the major limitations of this review is the lack of research focusing on individuals with more marginalized gender and sexual identities. Without that research, it is difficult to draw conclusions about mental health as it relates to those identities, compared to the groups more commonly studied.

Another challenge in studying mental health as it relates to different gender and sexual identities is that these identities are not always clearly defined, discrete categories. It is difficult in many cases to point specifically to the differences in mental health disparities between different identities because these differences are often complex and not clear-cut. For example, in psychological literature, sexuality is operationally defined in many different ways. One study may determine identity by asking how a person labels themselves, and another study may determine it by asking about their sexual behavior. The inability to determine who should belong in specific groups results in differing information about the health disparities of those groups (Matthews, Blosnich, Farmer, & Adams, 2014).

It is important to remember that sexual and gender identities can be fluid and complex. They are more accurately represented by continuums than binaries or discrete categories (Barker, 2015). Additionally, the way people choose to identify themselves may not directly correspond with marginalization, since some identities are very similar in what they denote about who

someone is attracted to, but differ depending on personal preference. For example, pansexuality is similar to bisexuality, but the label of pansexuality was created with the goal of not reinforcing the gender binary (*Diva Magazine*, 2015). People may choose their identity label based on various factors; one person could identify as "mostly straight," "bisexual," or "pansexual" with the same sexual behavior and attraction. Whether that person's experience of stigma and other minority stressors would change depending on which of those labels they used, or if they are more tied to other factors, such as who the person is in a relationship with, has not been sufficiently examined, so it is unclear whether using the more marginalized identity label would actually result in poorer mental health outcomes. Therefore, attempting to discuss the difference between identities in terms of mental health is necessarily complicated by the difficulty of defining sexual and gender identities, and discerning which factors surrounding gender and sexuality actually have the most impact on mental health.

Implications for Counseling

Discrimination within mental health care is one of the most significant causes of mental health disparities for gender and sexual minorities, which means that it is a responsibility of mental health practitioners to make changes in order to combat this discrimination and lessen mental health disparities. Recommendations that counselors should consider in order to better serve their LGBTQIA2S+ clients, especially their asexual, bisexual, and trans clients, are as follows.

Acknowledgment of Own Bias

The first important step for counselors to take is to be aware of their own stigma and bias and work to challenge and eliminate it, perhaps by learning more about gender and sexual

minority communities and dispelling personally held stereotypical beliefs, so they don't reinforce stigma with their clients (Tebbe & Moradi, 2016).

LGTBQIA2S+ Cultural Competence

Additionally, since practitioners being unprepared to work with gender and sexual minorities is one of the primary causes of inadequate health care for LTBQIA2S+ individuals (Poteat, German, & Kerrigan, 2013, it is extremely important that counselors become multiculturally competent with gender and sexual minorities, of all identities, not just lesbian and gay people. This means that mental health practitioners should become familiar with the everyday challenges that different sexual and gender minorities face and work to dispel any myths or stereotypes they may have about them. Specific identities are especially important when it comes to multicultural competence, namely asexual, bisexual, and trans identities, because these groups tend to be pathologized more often for their sexuality or gender identity, and if a practitioner is not culturally competent with these groups, it may result in the continuation of this pathologization (Foster & Scherrer, 2014). Markers of cultural competency with asexuals include being positive, non-judgmental and affirming when it comes to asexual identities, including asexuality as an option for sexual orientation on forms, not ignoring stress a client may have related to stigma about asexuality, and making space to talk about issues relevant to being asexual, such as how it may be more difficult to navigate romantic relationships as an asexual person (Foster & Scherrer, 2014). For bisexual clients, counselors can be accepting of nontraditional relationships, and normalize the idea of someone being attracted to more than one gender, as well as viewing bisexuality as a healthy part of someone's identity, rather than inherently unhealthy or unstable due to stereotypes about bisexuality (Smiley, 1997; Page, 2004). Counselors can become culturally competent with trans individuals by including gender identity

as part of basic patient history, since minority stress may be a factor in their mental health concerns (Reisner, Vetters, Leclerc, Zaslow, Wolfrum, Shumer, & Mimiaga, 2014), and not assuming the gender identity or pronouns of clients (Foster & Scherrer, 2014).

Advocacy

Since the effects of minority stress are caused by stigma and discrimination at an institutional level as well as at a cultural level, counselors should be involved in advocacy within their own communities to attempt to combat discriminatory policy and stereotypical, negative attitudes toward gender and sexual minorities. Many researchers suggest that clinicians engaging in advocacy is one of the most important things they can do for their LGBTQIA2s+ clients' mental health (Tebbe & Moradi, 2016).

Help Clients Find Support

Finally, because social support is a protective factor against minority stress, counselors should encourage and help clients to find social support and same-identity communities in which they can find belongingness. Counseling strategies recommended for bisexual clients include finding "opportunities for mutual encouragement," for example, support groups or advocacy organizations (Smiley, 1997). Primary care providers should also be aware of community resources that are available so they are able to recommend their clients spaces to go to find support (Reisner, Vetters, et. al., 2014). Clinicians can also help with and encourage support systems that clients already have present in their personal lives, such as groups of friends or family (Tebbe & Moradi 2016).

Future Research

In order to determine how mental health disparities affect different identities specifically, more research needs to be conducted about why people use the labels they use, how different

operational definitions and different labels influence how people are impacted by minority stress, and in general on the diversity of sexual and gender identities. Research needs to answer the question of whether gender and sexual minorities' experience of minority stress and other detriments on mental health are impacted more by the identity label they choose to use, by their sexual behavior and relationships, or other factors. For example, knowing whether people who identify as pansexual experience any difference in minority stressors or mental health outcomes from people who identify as bisexual would shed significant light on what aspects of someone's identity are most relevant to their mental health. This will help determine what exactly about different sexual and gender identities relates to differences in minority stressors and in the resulting mental health outcomes, which in turn will help practitioners learn how best to treat individuals with these identities, and how to prevent the disparities from occurring in the first place.

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