Implications and Considerations of Sexual and Gender Identities in Dynamic Psychotherapies

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KEYWORDS

• Gender • Sexuality • Psychotherapy • Alliance • LGBTQIA+ • Youth

KEY POINTS

- LGBTQIA+ youth are at higher risks of mental health issues, largely due to minority stress from societal stigma and discrimination.
- Intersectionality is crucial in understanding the experiences of LGBTQIA+ youth, as multiple aspects of identity interact to create unique challenges and vulnerabilities.
- Family support is critical for the mental health of LGBTQIA+ youth, so clinicians must build dual therapeutic alliances with both the youth and their families.
- Create a safe and inclusive therapeutic environment through visual cues, gender-neutral facilities, and inclusive intake forms to foster a welcoming space.

INTRODUCTION

In the United States, the number of young people endorsing concerns about their gender and/or sexual identity is rising. Population estimates like those released by The University of California, Los Angeles Williams Institute, which state that around 10% of American adolescents between the ages of 13 and 17 identify as lesbian, gay, bisexual, transgender (LGBT) , reflect this.[1] The need for inclusive, affirming, and culturally competent mental health care is growing as more and more young people identify as lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and other diverse gender and sexual identities (LGBTQIA+) or lesbian, gay, bisexual, transgender, queer, questioning, and other identities (LGBTQ+).

While individual experiences differ, LGBTQIA+ youth navigate a range of stressors across multiple social settings, such as bullying at school, rejection from family, and

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Abbreviations	
APA	American Psychiatric Association
CBT	cognitive behavioral therapy
DSM	Diagnostic Statistical Manual

exposure to anti-LGBTQ+ policies and rhetoric. LGBTQIA+ youth have a disproportionately high risk of mental health issues such as depression, suicide, and substance use.[2–4] In their 2024 survey of LGBTQ+ young people, the Trevor Project found that 39% of LGBTQ+ youth ages 13 to 24 years old "seriously contemplated attempting suicide in the past year," a number that included an alarming 46% of transgender and gender nonbinary youth.[5] These disproportionate outcomes are best explained by the minority stress model, which describes how marginalized populations, such as LGBTQIA+ people, gradually internalize their exposure to external discrimination and stigma, resulting in internal distress that can eventually lead to the development of negative physical, mental, and functional health outcomes.[2,3,6]

The notable increase in anti-LGBTQIA+ rhetoric and policies, nationally and globally, further drives distress as external environments become increasingly nonaffirming and hostile.[3,7] While clinicians have a duty to help support LGBTQIA+ youth, mental health leadership in the United States has not historically supported this community. Organizations as prominent and powerful as the American Psychiatric Association (APA) pathologized homosexuality and gender diversity, by defining those identities as psychiatric diagnoses in earlier publications of the Diagnostic Statistical Manual (DSM). While homosexuality has been removed as a diagnosis from the DSM II, more work needs to be done on behalf of our transgender and gender diverse patients.[8,9] This distressing legacy, in combination with the growing anti-LGBTQIA+ global climate, can deter many individuals from seeking mental health care they might need and certainly deserve. As mental health clinicians, it is our duty to help reshape our field to foster environments that are affirming, supportive, and safe for our LGBTQIA+ youth as they explore this critical phase of their identity development.

There is emerging evidence for the use of psychotherapy for LGBTQIA+ individuals. Studies have evaluated the evidence for using cognitive behavioral therapy (CBT) approaches in treating depressive symptoms and reducing anxiety. Some of these studies reframed coping with stress as a "challenge" rather than receiving it as a threat (Craig). Studies reviewing CBT and non-CBT interventions are focused on addressing mental health concerns and substance use.

Data regarding the psychodynamic psychotherapy for LGBTQIA+ youth are limited. However, the principles of psychodynamic therapy focusing on supporting the youth's autonomy, their individual experiences in relational and societal contexts remain salient. Psychodynamic psychotherapy for gender diverse youth focuses on enhancing reflective capacity, helping the youth safely explore their inner emotional and psychological states and conflicts. Acceptance and unconditional regard are the foundation on which LGBTQIA+ youth can learn to work through their challenges, enhance their internal psychological resources and progress to make adaptive and positive change toward their health and wellbeing.

PREPARING TO SEE THE PATIENT

Identity

Intersectionality

It is important for clinicians to develop an understanding of how each of our own identities develops and intersects, particularly for marginalized populations. The

framework of intersectionality, introduced by Kimberlé Crenshaw, emphasizes how multiple, interlocking systems of oppression—such as racism, sexism, and heterosexism—create distinct vulnerabilities for individuals with intersecting marginalized identities.[10] LGBTQIA+ youth of color, for example, face distinct forms of discrimination as compared with their white peers due to the complex interaction of numerous facets of identity, such as race, gender, sexuality, culture, and family—and many more. Therefore, the increasing racial, cultural, and gender variety among youth emphasizes the need for therapists to stay open to exploring how various identities interact in a patient's life. Clinicians should be mindful of avoiding assumptions about a patient's identity or what aspects of the patient's identity carry meaning and importance as such assumptions can adversely impact the therapeutic relationship and hinder deeper exploration and understanding.[7,11–13] Remember, when in doubt, simply ask—do not assume.

Our identities as clinicians

Self-reflection is an essential part of preparation for clinicians prior to meeting with any patient, but it is particularly important to reflect on one's own intersecting identities and how they influence interactions with LGBTQIA+ patients.[7,12,14]

Therapists may, for instance, occasionally overidentify with their patients, which can result in a sense of personal responsibility that exceeds what is sustainable from a professional standpoint. In turn, this can lead to burnout, problems with boundaries, or a failure to critically examine the therapeutic dynamics. Implicit biases and presumptions might affect therapy when a therapist and a patient are seen to be similar, such as both identifying as LGBTQIA+.[15,16] The patient may also avoid more in-depth investigation, presuming that their shared identification is known, while the therapist may believe, "Because I'm also a lesbian, I don't need to ask what that identity means to my patient." These assumptions can take many different forms, such as assuming that a patient's sexual orientation or gender identity is their main treatment issue, that family relationships are fundamentally unsupportive, or that a patient's identity development proceeds in a linear fashion.[11,15,16] These presumptions run the risk of limiting the therapeutic approach and obstructing a more thorough exploration of the patient's lived experience.

When therapists unintentionally shield themselves from discomfort, uncertainty, or challenges to their worldview, defensive reactions occur. For instance, a therapist may overemphasize resilience to diminish the patient's distress or avoid having more in-depth conversations on identity out of fear of saying the wrong thing. In certain situations, therapists may unintentionally focus the discussion on their own unresolved issues rather than the patient's needs by projecting their own experiences onto the patient.[7,11,14,15] By restricting the patient's capacity to explore their identity in a way that feels secure and affirming, these defensive responses have the potential impede fruitful therapeutic work.

Unresolved internal biases, including unconscious homophobia or transphobia, can show up during session in a range of instance such as overcorrecting in an effort to seem encouraging, avoidance of particular subjects, or subtle (or sometimes overt) invalidation. Such biases are not always obvious and may occur in covert ways, like pressing for disclosure to family members before the patient is ready, stressing conformity, or assuming that distress is only caused by identity stressors rather than environmental stressors. However, they may also manifest in other ways such as uneasiness when talking about sexuality, a propensity to shift gender-related worries onto more general mental health problems, or an excessive focus on the "phase" story.[7,15,16] Given that some practicing therapists received their training during

periods where the field of mental health pathologized LGBTQIA+ identities, it is important that a therapist continue to seek out training and education opportunities to provide LGBTQIA+ competent care.[9,13,14] It is equally as important for therapist, regardless of who they are working with, to always be reflective on how their own biases may be impacting therapeutic interaction.

External pressure to pair patients with clinicians who share their identities also exists in clinical practice; for example, LGBTQIA+ patients are paired with LGBTQIA+ therapists, or people of color are paired with other people of color. Although these collaborations may provide solace, they may also restrict the scope of investigation when both sides assume that apparent parallels negate the need for further conversation. For instance, because they are also LGBTQIA+, the patient may use a term like "pansexual" and believe or wish that the physician already knows what they mean, and be free of having to explore meanings more deeply. In a similar vein, a Colombian patient might not feel the need to inform a Puerto Rican therapist about their cultural identification. Building an alliance can benefit from perceived sameness, but it may also inadvertently prevent a patient's identity from being explored and understood more thoroughly. It may be appropriate, and prudent, to assign a patient to a therapist based on perceived sameness. However, this decision should be carefully considered. It may be reasonable to consider *how* the patient may benefit from this assignment, versus the assumption that a patient *will* benefit from this assignment based on the aspects of externally presumed shared identity (ie, "In what specific ways can shared aspects of identity enhance meaningful therapeutic work for this patient?").

In order to understand how these elements may affect their practice, therapists need to reflect on both overt and hidden facets of their identities. While more observable traits like education, work experience, or race may influence how LGBTQIA+ adolescents view them, less observable, more intimate traits like sexual orientation, gender identity, and even political or religious identifications may play a role—whether they are not they are perceived by the patient. The therapist's capacity to develop empathy, control countertransference, and avoid biases is influenced by these aspects of identity.[7,14,15] Clinicians might gain a deeper understanding of the dynamics that emerge in their therapeutic encounters with LGBTQIA+ youth by reflecting on their own identities. This practice can be useful for all patient populations, not just LGTBQIA+ youth, and can occur either through intentional, internal, and personal reflection, or external professional supervision.

Language

For every patient we see, clinicians should be mindful of the language used during interactions, especially when meeting with LGBTQIA+ youth. Employing gender-neutral language when referring to individuals, their families, or romantic partners may prove useful in avoiding assumptions and unwittingly reinforce binary gender norms. Using terms like "partner" in place of gendered "boyfriend" or "girlfriend," avoids assumption and creates an inclusive environment in which patients might feel free to share their partners' identities.[7,14,17]

Additionally, pronouns play a significant role in affirming a youth's identity. From the start, clinicians should ask about and honor the pronouns and names of LGBTQIA+ youth.[7,17–19] Misgendering or using incorrect names can incur painful experiences for youth and result in youths feeling nonaffirmed and invalidated by clinicians. Such experiences are reflected in the body of research by Russell and colleagues who demonstrated that transgender and gender diverse youth reported over a 50% increase in symptoms of depression and suicidality when their chosen names and pronouns were affirmed across multiple settings.[20] A helpful strategy during initial

meetings is for clinicians to offer their own pronouns during introductions and ask patients how they wish to be addressed. Doing so sets a tone of mutual respect from the beginning of the relationship.

Adopting gender-affirming language also requires changes at the institutional level. Challenges may arise when patients are minors and either have not come out to their families or have not been able to change their names legally.[21] The former presents an additional challenge, as guardians have access to their child's medical record. If the youth is not out to their family, and shares their identified name and pronouns with the therapist, the therapist should confirm with the youth what name and pronouns they feel safe with being used in their medical record. This can be challenging for therapists wishing to create an affirming environment and adequately manage a patient's medical record that may not fully reflect a youth's identified name or pronouns.

Environment

Preparing the environment with prominently displayed "safe zone/space" or rainbow signs and waiting room literature can provide nonverbal messages of a safe environment for disclosure. All gender, or gender-neutral bathrooms are important to create a safe and inclusive space, diminish anxiety and prevent discrimination.[22] Gender-neutral office forms, children's books, magazines, or periodicals that challenge traditional gender norms, can also create a welcoming atmosphere. Although intake forms and insurance information may be restrictive, openly acknowledging the administrative constraints of registering legal names, and simultaneously using asserted names can help build confidence in the therapeutic relationship.

THERAPY WITH LGBTQIA+ YOUTH

Developing a Therapeutic Alliance

Building a therapeutic alliance begins with understanding why patients seek help. As clinicians, our goal is to facilitate conversations that assist patients in clarifying their areas of concern, recognizing that they may not always have a clear idea of what those problems are. Some patients may seek therapy to explore concerns regarding their gender or sexual orientation, whether they identify as LGBTQIA+ or not. Similarly, individuals within the LGBTQIA+ community may seek care from clinicians for concerns seemingly unrelated to their gender or sexual identities. In these circumstances, physicians must respect the patient's primary focus while remaining open to discussing identity-related issues when they arise naturally.[12,17,19]

Navigating these complexities requires a thoughtful approach. Sometimes, young people may fixate on their gender or sexual identity as a way to avoid confronting deeper or distinct issues. It is the clinician's job to recognize this and to guide patients toward a more comprehensive exploration of their experiences. Exploration of previous experiences in therapy is also a useful strategy with patients, as this can educate clinicians regarding approaches that have been identified as helpful or harmful to patients in the past.

Many LGBTQIA+ youth may have experienced discrimination or insensitivity from therapists and health care providers in the past, leading to distrust and reluctance to share personal information.[18,19,23,24] These experiences have occurred in the form of outright invalidation, minimization or dismissal of concerns related to gender or sexuality, avoidance of discussion of these topics, and limited education in LGTBQIA+ health needs. While some of these occurrences are being addressed through intentional education on LGBTQIA+ health needs, therapists and providers should seek out additional opportunities to further their understanding and comfort.

Furthermore, by approaching each interaction with an open mind and avoiding assumptions, therapists can foster a trusting therapeutic relationship. This includes being attentive to how youth describe their concerns and how their families describe them, as these narratives can provide valuable insights into the youth's experiences and needs.

Patients who identify as LGBTQAI+ may also request therapists who share their racial, gender, or sexual identities in efforts to feel safer and more understood. This is particularly common in psychotherapy, where patients often prefer therapists from their own communities who can relate to their lived experiences. As mentioned previously, this is a complex consideration that should be engaged with actively by those involved.

Affirmative practice, which can involve asking open-ended questions about why a patient chose the clinician and what aspects of their identity they feel are essential to address in therapy, can lead to a deeper understanding of the patient's expectations and needs.[7,14,19] It is also crucial in the care for LGBTQIA+ youth for both alliance building and the therapeutic work itself. Affirmative psychotherapy serves to validate the experiences of LGBTQIA+ youth, allowing them to feel understood, and addressing the mental health impacts of minority stressors, while continuing to utilize active listening, empathy, and clarification when needed.[25] Mindful use of the patient's identified name and pronouns demonstrates support for the individual and opens the door to an environment that allows patients to express and explore their authentic selves.

Difficult Topics

It is not uncommon for individuals to endorse feelings of shame around their sexual and gender identities, particularly if they have internalized environmental stigmatization. Open discussion of gender and sexuality by the clinician may facilitate exploration of these dynamics. Additionally, such conversations can lead to discussion of a patient's experiences with partners including sexual preferences and fantasies. These areas may reflect dynamics of power, safety, and vulnerability. Many LGBTQIA+ youth have limited avenues to explore topics related to gender and sexuality.[7,26] Therefore, by creating a safe, affirming environment, clinicians can help these patients better understand themselves and build a foundation for future self-acceptance.

Clinician comfort with discussing topics related to sexuality and gender diversity may also facilitate increasing patient receptivity to guidance about risk reduction such as consent, boundaries, sexual violence, and contraception.[7,12,26] Being open to exploring these topics with LGBTQIA+ youth not only helps to affirm their identity but can also help further the therapeutic alliance and support identity exploration (**Fig. 1**).

Missteps

Unintentional microaggressions by the clinician can arise during therapy with LGBTQIA+ youth. These can trigger a multitude of aversive feelings in patients who may already have faced systemic discrimination and hinder therapeutic work. Common microaggressions encountered by LGBTQIA+ youth in therapy include falsely assuming race, ethnicity, gender, or sexuality, misgendering, and minimizing the significance of a youth's stated identity.[7,13] It is important for clinicians to acknowledge discomfort in discussing topics such as race, ethnicity, gender, or sexuality, and to approach them openly with patients. Asking about how identities—such as race and culture—shape their experiences in school, family, or community can facilitate this dialogue without burdening the patient.

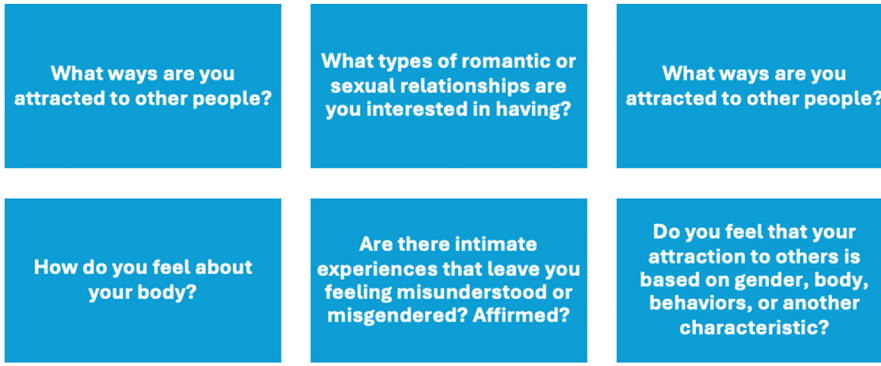

Fig. 1. Open-ended approaches to conversations around sexuality.

A particularly common example of a misstep is misgendering a patient, which can occur through incorrect pronoun or name use. As many individuals associate their pronouns and names with their gender identity, using them incorrectly, whether intentionally or by mistake, is considered misgendering. If a clinician mistakenly uses the wrong name or pronoun for a patient, the clinician should immediately acknowledge it. This can be done in a few ways, either by quickly apologizing, or by replying with "thank you" if the patient corrects the clinician. Afterward, the clinician should politely move forward with the conversation following the patient's lead.[14,18,19] Mistakes will happen during the course of our interactions, even to the most mindful clinician. What is important is that the clinician takes responsibility for the mistakes and moves forward while taking steps to be mindful in future interactions. Other examples of therapeutic missteps and advice on how to approach them are listed in the tables later (**Tables 1** and **2**).

WORKING WITH FAMILIES OF LGBTQIA+ YOUTH

The optimal mental health and wellness of LGBTQ youth relies heavily on family support and involvement.[27] This requires establishing and maintaining a dual therapeutic alliance with both the youth and their families. Deliberate efforts toward relationship

Table 1
Common "missteps" in therapy with LGBTQIA+ youth

Educational burden	Expecting patients to take on the task of educating the therapist about LGBTQIA+ issues. This experience can be exhausting and invalidating for the patient
Inflation or avoidance	Focusing too much or too little on a patient's gender or sexual identity
Misgendering	Using the incorrect pronouns or name to address a patient
Lack of cultural humility	Failing to recognize personal biases or gaps in knowledge about LGBTQIA+ issues
Repairing	Treating a patient's gender or sexual identity as something to be "fixed"
Generalizing	Overlooking the diversity in LGBTQIA+ experiences and assuming LGBTQIA+ individuals are all the same

Data from Mizock et al. (2016), Quiñones et al. (2017), and Bauman et al. (2020).

Table 2
Strategies for approaching missteps

Acknowledge	If a mistake is made, such as using incorrect pronouns or making assumptions about a patient's identity, it is crucial to acknowledge the error, or offer a "thank you," followed by correcting the error quickly and moving forward. This demonstrates respect and a willingness to correct the mistake
Seek feedback	Encourage patients to provide feedback on their experiences in therapy. This can help identify areas where the therapist may need to improve and shows the patient that their comfort and well-being are prioritized
Use appropriate names and pronouns	Using the incorrect pronouns or name to address a patient
Use inclusive language	Consistently use inclusive language and avoid assumptions about patients' relationships or identities
Engage in continuous learning	Clinicians should seek additional training, consultation, and supervision to enhance their understanding of LGBTQIA+ issues and provide affirmative care
Practice cultural humility	Embrace cultural humility by recognizing the limits of one's knowledge and being open to learning from patients about their unique experiences and identities

Data from Mizock et al. (2016), Quiñones et al. (2017), Bauman et al. (2020), and the American Psychological Association (2021).

building among the therapist, youth, and family are central to this process. Empathy, validation, and acceptance are critical in helping the family embrace their child as they are rather than how they might have imagined their child would be.[28]

Cultural Competence

Clinicians are tasked with maintaining cultural humility, curiosity and an openness to recognizing diverse backgrounds and values, in order to practice with cultural competence. A stance of respect, willingness to learn, and attunement to their experiences is central to this endeavor.[13] Youth and families increasingly have different racial and ethnic backgrounds, religious, and spiritual beliefs, as well as social identities. Perceived cultural pressures, sense of individual, and collective identity, all influence beliefs and behaviors. It is important to acknowledge that English-speaking, American or Western ideas of individual happiness may not apply to diverse youth and their families.

For youth of color, cultural factors can impact their comfort in coming out, and identity integration.[29] In addition to navigating their gender and sexual identity, they also face the impact of minority stress.[30] This highlights the need to have their family and community as an ally in navigating a hostile world. Many young people of color may not feel comfortable readily sharing their sexual identities or participating in social activities or support groups for sexual and gender minority youth given their racial or ethnic minority status. This further fosters their need to rely on their family as a center for fulfillment and support. Other youth might attempt to conform to cultural norms and hide their authentic selves for fear of perceived rejection from groups that have been integral to their survival.

It is also critical not to generalize cultural predilections and stereotypes to individual youth and their families. Each family brings their own unique values, dynamics, and skills into the therapeutic space. It is incumbent on the clinician to maintain an other-oriented stance and create a safe space where the youth and their family can feel safe in sharing and processing their challenges.

Family Reactions

Families have hopes and expectations of what they would like their child to be. Many young people internalize this expectation during their development and may worry about disappointing their caregivers. Conversely, young people may also feel a sense of disappointment when their caregivers do not live up to the universal wish for accepting and loving parents.

Families that accept their children's emerging identity can still experience disappointment and dashed hopes for a different imagined future for their child. This may be driven by underlying fears of the challenges their child will have to face, or by unconscious biases they have suppressed. Other families might demonstrate more clearly struggles with accepting a child's decisions. Inevitably, it is a therapist's task in working with the youth to encourage families to explore or acknowledge their fears, hopes, and expectations. Many clinicians find it prudent to separately create a space for parents to mourn the loss of the idealized child, coming to terms with accepting and embracing the real child in front of them.[31]

Conflicts can occur when the youth and their family's values, religious beliefs, perception of social stigma, and priorities do not align. In such instances, creating space for different perspectives to be expressed and explored in the hope of creating mutual respect and understanding is beneficial. However, it is important to recognize that acceptance and support do not equal understanding. Acknowledgment and validation of the youth's identity are important, as well as a deeper understanding of the youth's experience of and hopes for their gender and sexual identity. These efforts toward understanding may prove protective.

SUMMARY

LGTBQIA+ youth face increased risk for adverse health outcomes, including adverse mental health outcomes, making it important for these youth to have access to mental health care that is both informed and validating. Providing psychotherapy for LGBTQIA+ youth is an important aspect of this care. When preparing to meet with these youth, and regularly throughout treatment, therapists must take careful consideration of how their own identities and biases may influence therapeutic interactions, and aspects of transference and countertransference dynamics. In their work with LGBTQIA+ youth, clinicians can incorporate intersectionality into their formulations to appreciate the complex interaction between the various facets of the youth's identity such as gender, sexuality, race, culture, and family systems. Cornerstone to the work is establishing an affirming environment where the youth may feel safe enough to engage in self-exploration while also acknowledging system, legal, and environmental constraints. As with any potential therapeutic interaction, missteps may occur on part of the therapist. A clinician's humility and sincerity may deepen the therapeutic alliance. Furthermore, therapists must continue to refine their practices through continuing their own education. Seeking out training and learning opportunities on LGBTQIA+ youth health may widen their clinical acumen, inform their work with youth, and facilitate effective advocacy in a global climate that is ever changing and at times unwelcoming.

CLINICS CARE POINTS

- The therapeutic relationship is central to psychodynamic psychotherapy through which efforts for psychological wellbeing of LGBTQIA+ youth is delivered.
- An approach implementing trauma-informed care is crucial in establishing trust and addressing the effects of minority stress and discrimination.
- A nonjudgmental and neutral stance from the therapist that conveys respect, and empathic stance is essential to create to a safe environment that allows for exploration of issues related to gender and sexual identity.
- Practicing cultural competence and recognizing intersectionality of how multiple aspects of identity interact and influence a patient's experiences is key in understanding the youth's experience.
- Clinicians must engage in self-reflection about their own identities and potential biases to provide effective care and avoid assumptions that may hinder deeper exploration of patients' experiences.

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