the best available data and knowledge regarding LGBT health. I encourage the members of the ACP Health and Public Policy Committee to revisit the policy statement on regular intervals for updates to fill the many gaps in our knowledge about LGBT health.

Future revisions of the policy statement should pay careful attention to details not necessarily called out in the current policy's executive summary. For example, policy statement 2 calls for the ACP to "recommend that all public and private health benefit plans include comprehensive transgender care services and provide all covered services to transgender persons as they would all other beneficiaries."1 The authors continue to describe the impact of arbitrary or blanket exclusions for transgender health services in their example of hysterectomy coverage for a cisgender patient, but exclusion for a transgender patient. Yet in the policy statement, the ACP falls short of stating that such hormonal and/or surgical care is medically necessary. Moreover, the term "comprehensive" is an unclear term in this context. For optimal health outcomes, comprehensive care would need to be inclusive of all medically necessary care including primary care, mental health care, transgender hormonal care, transgender-related and non-transgender-related surgical care, and HIV care.

The policy authors write in policy statement 6 that the ACP supports data collection and research into the understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities. This statement particularly important as there exist few nationally representative datasets describing LGBT population health. In fact, Healthy People 2020 still prioritizes collecting data on LGB and Transgender populations in their four objectives.2 To date, only the 2013 National Health Interview Survey has collected nationally representative data on lesbian, gay and bisexual people.3 Federal nationally representative surveys continue to exclude transgender respondents by not collecting gender identity/expression as part of the respondents' demographic variables. Unfortunately, the majority of electronic health records also fail to provide fields for collection of sexual orientation and gender identity (SOGI) data. Cahill et al found that integrating SOGI data collection into the meaningful use requirements was both acceptable to diverse samples of patients, including heterosexuals, and feasible.4 The ACP should consider supporting inclusion of SOGI data collection in Meaningful Use as another strategy to improve LGBT health data collection.

Daniel et al write in position statement 7 that "Medical Schools, residency programs, and continue medical education programs should incorporate LGBT health issues into their curriculum. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to other LGBT medical students, residents, and practicing physicians."1 Creating the next generation of culturally and clinically competent health professionals and internists is central to improving LGBT health. Nationally, few health organizations and hospitals have actively implemented comprehensive programs to create LGBT affirming environments, educate health professionals and staff on LGBT health, or create sustainable supportive infrastructure. There continues to be a great need for LGBT safe space programs, LGBT 101 cultural competency education, and inclusion of LGBT topics in academic discourse and mentorship. Homophobia, transphobia, few visible LGBT health professional

mentors and lack of institutional support for LGBT health scholarship serve as barriers to growing a cadre of academic internists adequately prepared to care for LGBT populations.5 The College can continue to champion LGBT health by supporting inclusion of LGBT health content in internal medicine certification examination questions, internal medicine in-training examination questions and promotion of additional LGBT health education resources like Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health.6

Finally, the ACP should consider adding an additional statement which addresses and acknowledges the intersectionality of our patients' identities as noted by IOM report.7 Sexual orientation and gender identity/expression do not exist within a vacuum and are part of the multidimensionality of our identities as people.

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Disclosures: I am the President of GLMA: Health Professionals Advancing LGBT Equality

Hilary Daniel • American College of Physicians • 13 May 2015

FDA Releases Draft Guidance on Blood Donation by MSM

On Tuesday May 12, 2015 the Food and Drug Administration released the document "Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products: Draft Guidance for Industry." The proposed recommendations would replace the lifetime deferral period on blood donation by men who have sex with men (MSM) with a 12-month deferral period from most recent sexual contact. The FDA is accepting public comment on the guidance for 60 days.

PREVIOUS ARTICLE NEXT ARTICLE

POSITION PAPER | VOLUME 52, ISSUE 4, P506-510, APRIL 01, 2013

Recommendations for Promoting the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Adolescents: A Position Paper of the Society for Adolescent Health and Medicine

Society for Adolescent Health and Medicine DOI: https://doi.org/10.1016/j.jadohealth.2013.01.015

Abstract

Adolescent health care providers frequently care for patients who identify as lesbian, gay, bisexual, or transgendered (LGBT), or who may be struggling with or questioning their sexual orientation or gender identity. Whereas these youth have the same health concerns as their non-LGBT peers, LGBT teens may face additional challenges because of the complexity of the coming-out process, as well as societal discrimination and bias against sexual and gender minorities. The Society for Adolescent Health and Medicine encourages adolescent providers and researchers to incorporate the impact of these developmental processes (and understand the impacts of concurrent potential discrimination) when caring for LGBT adolescents. The Society for Adolescent Health and Medicine also encourages providers to help positively influence policy related to LGBT adolescents in schools, the foster care system, and the juvenile justice system, and within the family structure. Consistent with other medical organizations, the Society for Adolescent Health and Medicine rejects the mistaken notion that LGBT orientations are mental disorders, and opposes the use of any type of reparative therapy for LGBT adolescents.

Positions

ociety for Adolescent Health and Medicine supports the following positions:

- All health care providers who care for adolescents should be trained to provide competent and nonjudgmental care for lesbian, gay, bisexual, or transgendered (LGBT) youth. Competency in this area should include an understanding of adolescent sexuality development, the ability to identify mental health issues related to either the coming-out process or victimization, and familiarity with physical and sexual health issues related to sexual orientation or gender identity.

- Health care providers should understand that the majority of LGBT young people are healthy and well-adjusted teenagers and young adults. The high-risk behaviors exhibited by some LGBT teens more often reflect reactions to social stigma and non-acceptance by peers and society.

- Sexual orientation and gender identity are dynamic constructs. Health care providers, educators, policy makers, and researchers should be cautious in assigning labels to an adolescent's sexual orientation, because this may evolve over time. Providers should ask adolescents how they self-identify, and should be guided by the youth's language and self-concept.

- Family connectedness and support are important protective factors against depression, drug use, and high-risk sexual behavior in LGBT adolescents. However, practitioners also should understand that not all LGBT adolescents may be ready to disclose their sexuality to their family. When LGBT teens decide to disclose their sexuality or gender identity, providers should aim to assist families with acceptance of their LGBT teenagers.

- Lesbian, gay, bisexual, or transgendered youth may be at increased risk of bullying and victimization by peers and adults, including teachers, coaches, and family members; and victimization is associated with an increased risk for depression and suicide. Health care providers should be comfortable discussing these issues with their LGBT patients and should take an active role in educating the schools and community on prevention efforts to prevent and stop victimization. The Society for Adolescent Health and Medicine believes that sexual minority adolescents should have full and appropriate legal protection from victimization under both local and federal laws.

- Because victimized LGBT youth are at increased risk of depression and suicidality, providers should screen for these mental health issues and intervene as appropriate.

- Antidiscrimination policies should be implemented to protect LGBT youth in foster care settings. Municipalities should disseminate policy guidelines to ensure appropriate care for LGBT youth in out-of-home venues.

- ian, gay, bisexual, or transgendered youth in juvenile detention settings are at r
ssment and bullying from fellow detainees as well as staff. Local juvenile justice

systems should adopt policies to ensure the physical and mental well-being of incarcerated youth.

- For youth who are struggling with sexual orientation or gender identity, affirmative therapeutic approaches can help adolescents explore their identities in a healthy manner. Reparative "therapy," which attempts to change one's sexual orientation or gender identity, is inherently coercive and inconsistent with current standards of medical care.
- Adolescent health care providers should be educated regarding the health care needs of sexually active LGBT teenagers. Guidance for screening individuals who are sexually active with members of the same sex is described in the Center for Disease Control's *Sexually Transmitted Disease Treatment Guidelines 2010* [[1]].
- Future research on all of these aspects of LGBT health is needed to direct provider interventions, education, and community policy.

Background

Given wider access to information and more positive media images, anecdotal data suggest that LGBT adolescents are coming out at younger ages than previous generations of LGBT adults. As a result, providers are more likely to serve LGBT adolescents in a wide range of settings. This offers many opportunities to identify LGBT youth at risk and to provide appropriate services and foster positive development.

Sexual orientation includes multidimensional constructs involving three primary dimensions: sexual attraction, behavior, and identity (i.e., heterosexual, bisexual, lesbian/gay) [[2]]. Each dimension may exist on a wide spectrum [3, 4] and a person's experience of each dimension may evolve throughout adolescence and adulthood [[5]]. Thus in adolescence, sexual orientation and gender identity should be viewed as a multifaceted and dynamic part of one's persona. Researchers, clinicians and policy makers should consider these multiple dimensions of sexual orientation when interacting with all adolescents, to provide the highest level of care in these settings.

Methods

The stated positions result from a review of the scientific literature as well as expert consensus from lists involved in research, teaching, and providing care to LGBT adolescents.

Statement of problem/information

Families and LGBT youth

Family connectedness is essential for healthy development of adolescents in general, and it has also been shown to be an important correlate of health outcomes among lesbian, gay, and bisexual youth [[6]]. Although parents may react negatively to their child's disclosure of a non-heterosexual orientation, research also shows that many family relationships improve after parents become sensitized to their children's needs and well-being [[7]].

Research from the Family Acceptance Project has found that specific parental and care giver reactions to an adolescent's LGBT identity have a compelling impact on their LGBT children's health, mental health, and well-being [[8]]. Those who report high levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared with peers from families that report no or low levels of family rejection [[9]].

Conversely, LGBT youth who report family acceptance during adolescence show better general health and well-being than peers who were not accepted by their families [[10]]. Specifically, this research shows that family acceptance is associated with higher levels of self-esteem, social support, and general health, and is protective against depression, substance abuse, and suicidal ideation and suicide attempts in young adulthood. Providers may help to facilitate disclosure by youth to their families, and should emphasize the importance of providing support to their children.

Lesbian, gay, bisexual, or transgendered victimization. Lesbian, gay, bisexual, or transgendered youth frequently experience bullying and violence based on their actual or perceived sexual orientation and gender expression. Although most data focus on victimization at school, LGBT youth may be victimized in other social settings, such as online [[11]]. In a recent national community survey of middle and high school LGBT students, more than 85% of responders reported that they had been victims of verbal harassment, 40% experienced physical harassment, and 19% had been physically assaulted at school in the previous year [[12]]. In the same survey, nearly two thirds reported feeling unsafe in school because of their sexual orientation.

Victimization at school is common among LGBT students [13, 14, 15]. For example, the 2009 New York City Youth Risk Behavior Survey reported that students who identified as LGBT were twice as [illegible] be bullied online or electronically (cyber-bullied) than heterosexual students.

Bullying can range from verbal harassment to physical violence or even sexual abuse. Lesbian, gay, bisexual, or transgendered victims of bias-related violence may fear additional victimization if the cause of the attack is revealed; as a result, they may not disclose the attack or its cause. In these instances, this denial may prevent them from getting adequate external support needed to recover from the attack. Reactions to victimization may include post-traumatic stress disorder, sleep disturbances, anxiety, depression, nightmares, somatization, and illegal drug use as well as suicide attempts [[11]].

Victimization independently correlates with past suicide attempts [[16]] as well as sexual risk behaviors and substance use. Data from the National Longitudinal Study of Adolescent Health specifically suggest that the association between sexual orientation and suicidality is mediated by victimization, among other suicidal risk factors. Furthermore, the association between victimization and depression/suicide risk is attenuated by family support and self-acceptance [[17]].

The Gay, Lesbian, and Straight Education Network's 2005 online survey revealed that having a school harassment policy specific to sexual orientation or gender identity/expression is associated with increased perception of student safety and decreased harassment at school. However, 10% of students reported not mentioning harassment to school staff because they believed that the teachers were powerless to improve the situation. This suggests a notable gap between observed incidents and those that are reported by students [[18]].

Although little is documented about youths' disclosure of anti-LGBT bullying in the clinical setting, experience suggests that health care providers should screen youth for homophobic victimization and associated effects. Health care providers should educate schools about the adverse health effects of bullying and victimization, the importance of intervening to stop harassment when observed, and the importance of encouraging youth to report incidents. In addition, health care providers should continue to advocate for both local and national anti-bullying policy and legislation that includes anti-LGBT bullying.

Lesbian, gay, bisexual, or transgendered youth in foster care settings

According to child welfare professionals, LGBT youth are disproportionately represented in foster care, although the exact number is unknown [[19]]. Lesbian, gay, bisexual, or transgendered youth enter foster care for various reasons, but many enter either directly or indirectly because of conflict, mistreatment, or neglect related to their sexual orientation or gender identity. These youth may report harassment by other children and staff in group and foster homes, especially when placed

ıre givers who are poorly prepared to deal with their sexual orientation or gende tity

Legislation such as the United States' Adoption and Safe Families Act of 1997 emphasizes permanency (e.g., placement of youth in stable and loving homes), safety, and well-being for youth in the foster care system. Until more recently, however, attention on improving services for LGBT youth in custodial care has been limited, resulting in uneven practices across jurisdictions, inappropriate and discriminatory care, little attention to permanency, and unstable home placements for these teens. One United States study reported that the average time in each foster care setting for a sample of LGBT youth was two to three times shorter then the federal government's suggested placement duration [[20]]. Lesbian, gay, bisexual, or transgendered youth may also run away from foster homes and shelters, adding to the disproportionate numbers of homeless LGBT youth. These homeless youth report greater victimization, alcohol abuse, survival sex, and suicidal ideation than their non-LGBT homeless peers [[21]].

In 2006, the Child Welfare League of America published the *Best Practice Guidelines for LGBT Adolescents in Out-of-Home Care* [[19]]. These practices cover a range of issues, including positive youth development, development and expression of sexual orientation and gender identity, positive social and recreational outlets, and prohibiting practices that pathologize and discriminate against LGBT youth. These guidelines can be applied in any country that provides foster care services for youth.

Providers can help families, care givers, and foster parents understand the need to reduce rejecting behaviors that put LGBT youth and risk and increase supportive behaviors that promote well-being. Permanency should be an important priority for LGBT youth, as with non-LGBT youth.

Lesbian, gay, bisexual, or transgendered youth in juvenile justice facilities

There is limited research on LGBT youth in the juvenile justice system, but LGBT youth are also reported to be disproportionately overrepresented in juvenile detention and probation facilities, and policies have been developed to guide their placement and care [[19]]. The following outlines, issues, and recommendations address the unique issues related to this population.

Lesbian, gay, bisexual, or transgendered youth who enter detention and correctional settings frequently face challenges stemming from overt hostility of other youths and/or institutional staff. Youth with gender variant behaviors are at highest risk for bullying. Because LGBT youth tend to be viewed negatively by juvenile courts and juvenile corrections staff, their concerns may place them at risk for physical isolation or their concerns may be ignored [[19]].

ender youth present a complex set of concerns within residential, detention, and correctional s, especially with regard to housing. Transgender youth housed with peers of the

gender may be more likely to be assaulted by their peers, whereas staff may have concerns about sexual activity when transgender youth are housed with youth of the opposite birth gender. Institutional care guidelines published by legal experts on transgender youth can help facilities respond appropriately [[22]].

Continuation of hormone treatment may be an issue that transgender youth face when incarcerated. Whether these teens arrive at a juvenile justice facility receiving medications to suppress puberty or are taking cross-gender hormones, they frequently require ongoing medical hormonal treatment. Facility clinicians may need to contact the teen's outside practitioner for guidance in managing hormone therapy.

Institutional administrators should provide training for staff and develop and implement policies and procedures to protect incarcerated LGBT youth. In addition, trained staff should provide education to all youth to promote and maintain a culture of support and understanding, to prevent and respond to potential bullying [[23]]. Recent guidelines provide policy guidance for serving transgender and gender-nonconforming youth in group care facilities, including detention and correctional facilities [24, 25].

Juvenile justice facilities should work with the local public health community so that appropriate expertise can be developed within the institution. At the time of release, LGBT youth should also be referred to appropriate programs that will help them successfully adjust after release.

Reparative therapy

Sexual orientation conversion therapy or reparative “therapy” refers to the practice of attempting to change an individual's sexual orientation and attractions from members of the same gender to those of the opposite gender. In 1973, “homosexuality” was removed from the *Diagnostic and Statistical Manual of Mental Disorders*, thus eliminating it as a mental disorder [[26]].

In 2000, the American Psychiatric Association issued a position statement opposing the practice of reparative therapy [[27]], and augmented its 1998 statement, which stated:

> The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as ative or conversion therapy which is based upon the assumption that

homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation [[28]].

In 2009, the American Psychological Association published a resolution advocating against reparative therapy after conducting an extensive study that evaluated 83 research studies. They concluded that the efficacy of reparative therapy was poor and, in many cases, harmful [[29]]. The American Psychological Association further reinforced that same-sex attractions are a normal variant of sexuality, and recommended that practitioners avoid reparative therapy as a viable treatment option [[29]]. In addition, global organizations such as the Pan American Health Organization have condemned reparative therapy, stating that “Purported therapies aimed at changing sexual orientation lack medical justification and are ethically unacceptable” [[30]].

The Society for Adolescent Health and Medicine firmly believes that LGBT adolescents fundamentally experience the same physical, developmental and emotional hurdles as do their non-LGBT adolescent peers. However, non-acceptance or victimization by peers, family members, or their community creates an added dimension of stress, which can lead to mental health problems and/or high-risk behaviors. Because reparative therapy is an unsubstantiated and harmful option, it should not be considered or recommended for teenagers who are dealing with issues surrounding their sexual orientation or gender identity. Rather, providers who work with teens should be trained to recognize the adolescent's external stressors, which may increase risks, and provide supportive counseling to promote self-acceptance and healthy growth.

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Footnotes

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Related Articles

American Mental Health Counselors Association

AMHCA Publications

AMHCA Statement on Reparative or Conversion Therapy

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Whitney Meyerhoeffer

AMHCA Statement on Reparative or Conversion Therapy

Adopted by the Board of Directors

July 10, 2014

"Reparative" or "conversion" therapy, are practices by mental health providers that seek to change an individual's sexual orientation or gender identity. These practices include efforts to change behaviors or to eliminate or reduce sexual or romantic attractions and/or feelings toward individuals of the same sex.

Reparative therapy does not include psychotherapies that aim to provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices. Nor does reparative therapy include counseling for a person seeking to transition from one gender to another.

There is virtually no credible evidence that any type of psychotherapy can change a person's sexual orientation, gender identity or expression, and, in fact, these efforts pose critical health risks to lesbian, gay, bisexual, and transgender people, including depression, shame, decreased self-esteem, social withdrawal, substance abuse, risky behavior, and suicidality.

As mental health advocates,AMHCA knows that sexual and gender minorities seeking therapy can benefit from interventions that reduce and counter internalized stigma, and increase active coping.

We are concerned that reparative therapy has been documented to do exactly the opposite by increasing internalized stigma and potentially resulting in numerous negative side effects. Additionally, some treatment programs using reparative therapy may provide inaccurate scientific information on sexual orientation and/or gender identity, and may be fear-based, again with the potential to increase distress in treatment participants. Moreover, reparative therapy is scientifically flawed since it is based on the notion that homosexuality is not a normal sexual expression.

AMHCA recommends that counseling around sexual orientation or gender identity follows the framework of an "affirmative therapeutic intervention." This approach means that the therapist addresses the stress-inducing stigma experienced by sexual and gender minorities with interventions designed to reduce that stress, including helping the client overcome negative attitudes about themselves.

Reparative therapy reinforces negative attitudes about sexual minority status and has been shown to increase stress by reaffirming stigma.

Existing law provides for licensing and regulation of various mental health professionals. Additionally, many state laws already prohibit certain types of controversial psychological therapies, including psychosurgery, convulsive therapy, and experimental treatments or behavior modification programs that involve aversive stimuli or deprivation of rights.

AMHCA supports initiatives that will curb harmful practices that have documented iatrogenic effects, and will thus help ensure the overall health and safety of LGBT youth.

Tags and Keywords

Attachment(s)

Reparative_Therapy_Statement.pdf 40 KB 1 version
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Related Entries and Links

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NASP
NATIONAL ASSOCIATION OF School Psychologists

Key Messages and Talking Points for School Psychologists: Advancing Social Justice

For school psychologists, social justice is both a process and a goal that requires action. School psychologists work to ensure the protection of the educational rights, opportunities, and well-being of all children, especially those whose voices have been muted, identities obscured, or needs ignored. Social justice requires promoting non-discriminatory practices and the empowerment of families and communities. School psychologists enact social justice through culturally-responsive professional practice and advocacy to create schools, communities, and systems that ensure equity and fairness for all children and youth.[1]

Why it's important. NASP is committed to advocating for the civil rights, well-being, educational and mental health needs of *all* students. This is accomplished by ensuring that all students are able to attend schools and live in communities that are safe, supportive, and free of bullying, harassment, discrimination, and violence. NASP opposes efforts that seek to systematically discriminate against or segregate children or youth on the basis of actual or perceived characteristics, including race, ethnicity, color, religion, ancestry, age, national origin, immigration status, socioeconomic status, language, disability, gender, gender identity, gender expression, sexual orientation, cognitive capabilities, social–emotional skills, developmental level, chronic illness, or any other personal identity or distinguishing characteristic. Unfortunately, systematic discriminatory policies and practices continue to exist. However, school psychologists can play a critical role in leading important conversations and actions necessary to achieve equity for all students.

Your voice is critical to this advocacy. The following talking points reflect NASP policy and best practice. They can be used for:

- Building an Understanding of Race and Privilege
- Supporting LGBTQ+ Youth
- Supporting Immigrant and Refugee Youth
- Addressing Disproportionality in Discipline and Ending the School to Prison Pipeline

Select and adapt talking points to address your particular context. Talking points are organized by each broad issue and may overlap. Depending on the context of your community, you may not need to engage in advocacy in all of these areas. Following the talking points are suggested specific 'asks' that you could make of your building principal, superintendent/school board, state/federal policy makers, and other audiences. Related NASP resources containing additional, more in-depth information are provided at the end of this document.

[1] Definition of social justice as adopted by the NASP Board of Directors, April, 2017

Understanding Race and Privilege

Key message: Racism and discrimination have severely negative mental health, academic and social consequences for students of color.

- Discrimination based on race is associated with poorer school attendance, lower self-esteem, higher rates of depression, and higher risk for suicide.
- Stereotypes often become self-fulfilling prophecies resulting in lower academic achievement and negative outcomes.
- Black and Hispanic students are more likely to be enrolled at a school that employs a law enforcement officer but not a school counselor or other mental health professional.
- Black students are four times as likely to be suspended than White students for similar behaviors
- Children of color experience greater chronic stress yet are significantly less likely to receive mental health care than their White peers

Key message: Privilege and implicit bias often lead to educational inequity for students of color and students with disabilities.

- Long-standing research findings have documented that students of color are disproportionately placed in special education and subsequently spend less time in the general education environment.
- Educational disparities are linked to minority/majority status and contribute to large-scale achievement gaps.
    - On average, Black students' test scores are roughly two grade levels lower than White students in the same district; Hispanic students are roughly 1.5 grade levels below their White peers
    - Students with disabilities have and continue to score lower than their non-disabled peers on state and national tests. Sixty-seven percent of students with disabilities graduate from high school compared to the national graduation rate of 84.6 percent.
- The effects of implicit bias are seen as early as the preschool years with Black students being suspended at much higher rates than White preschool students.
- Many students of color experience oppressions which are intensified when one accounts for how their race intersects with other identities they hold, such as socioeconomic status

Key asks:

- Develop policies to establish and maintain racial, cultural, and linguistic diversity among school personnel.
- Develop pedagogical curricula and approaches (e.g. culturally responsive teaching practices) to incorporate race and an understanding of privilege at the classroom, school, and district levels.

- Implement research-based programs that reduce racial achievement gaps.
- Implement research-based strategies that mitigate the effects of racism, prejudice, and discrimination and result in resilience and educational excellence (e.g. restorative practices).
- Promote ongoing evaluation of institutional policies that may unintentionally contribute to negative outcomes for certain groups of students
- Systematically evaluate student growth, grades, and test scores to ensure equity of educational access and achievement; implement interventions to address areas of disparity

Supporting LGBTQ+ Youth

Key message: LGBTQ+ youth experience significantly higher rates of harassment, bullying, and discrimination than their heterosexual and cisgender peers, which can lead to safety concerns and contribute to a host of negative academic and social-emotional outcomes.

- Within schools, higher levels of victimization for LGBTQ+ youth are associated with poorer school attendance, lower grade point averages, fewer plans for postsecondary education, lower self-esteem, higher rates of depression, greater substance abuse, and higher risk for suicide.
- When LGBTQ+ youth develop in positive school climates, which include various supports such as a Gender and Sexuality Alliance (GSA), an LGBTQ+ inclusive curriculum, comprehensive anti-bullying policies, and supportive educators, allies, and role models, they report greater physical and psychological safety and improved educational outcomes.
- Some LGBTQ+ youth experience family rejection, which may include abuse, exclusion, being forced to leave home, or efforts to change a youth's sexual orientation or gender identity, which is associated with higher risk for depression, self-injury, suicide and substance abuse.
- LGBTQ+ youth are highly affected by ever-changing shifts in social attitudes, public policies, and laws related to LGBTQ+ rights; especially youth living in communities that espouse more conservative religious, familial, and political values

Key message: Efforts to exclude or discriminate against transgender and gender non-conforming youth are unnecessary and harmful.

- Among LGBTQ+ students, transgender students face the highest levels of victimization and discrimination at school and are most likely to miss school or change schools because of safety concerns. Furthermore they are most likely to consider dropping out of school and encounter the highest rates of school discipline.
- Title IX of the Education Amendment Act of 1972 prohibits harassment of students on the basis of sex. Federal courts have affirmed that these discrimination protections apply to transgender youth and that schools have an obligation to affirm a student's gender identity and grant them access to programs and facilities on the basis of their affirmed gender identity, not their biological sex.

- Comprehensive anti-harassment policies that include protections for transgender and gender non-conforming students are helpful for all students because when one student feels unsafe, others question their own safety
- Dozens of courts over the last two decades have affirmed the full rights and identities of transgender people as well as their need for protection.

Key message: Conversion (or reparative) therapy is an unscientific, unproven and unethical practice that harms LGBTQ+ youth.

- Conversion therapy has been shown to worsen internalized homophobia, interrupt healthy identity development, increase depression, anxiety, self-hatred, and self-destructive behaviors, and create mistrust of mental health professionals.
- There is no valid or methodologically sound research that demonstrates sexual orientation change efforts are effective or beneficial to the person.
- Homosexuality is not a mental disorder, and thus, there is no need for a "cure."
- Conversion therapy amplifies the shame and stigma that LGBTQ+ youth already experience.
- Parents may seek conversion therapy for children after witnessing the distress or mistreatment their child has experienced as a result of homo/transphobic commentary or action which can lead to feelings of self-doubt and insecurity. It is therefore necessary for school psychologists to inform parents of the dangers of conversion therapy and assist them in finding evidenced-based mental health supports.

Key asks:

- Develop and implement comprehensive anti-bullying, harassment, and discrimination policies that specifically protect individuals based on actual or perceived sexual orientation, gender identity, and gender expression.
- Provide ongoing professional learning opportunities to educate school personnel about LGBTQ+ issues, to know how to recognize and intervene when LGBTQ+ related harassment and bullying occur, and to develop skills and strategies to serve as supportive allies.
- Implement policies that allow for GSAs on school campuses which are mandated under the Equal Access Act
- Support efforts to create a supportive school environment, including developing inclusive curricula in which appropriate and accurate information regarding LGBTQ+ people, history, and events are included, and creating gender neutral spaces, safe zones, and the ability for them to use the bathroom that aligns with their gender identity.
- Any effort to redefine sex under Title IX as solely irrevocably male or female at birth should be opposed.
- Conversion therapy should be banned in all 50 states.
-

Addressing Disproportionality in Discipline and Ending the School to Prison Pipeline

- Students of color, and students with disabilities, are disproportionately represented in exclusionary discipline consequences, such as suspension, expulsion and referral to law enforcement. Such discipline in turn is associated with student dropout and entry into the prison system.
    - During the 2015–16 school year, black students represented 15 percent of the total student enrollment, and 31 percent of students who were referred to law enforcement or arrested – a 16 percentage point disparity.
    - Students with disabilities (IDEA) represented 12 percent of the overall student enrollment and 28 percent of students referred to law enforcement or arrested.
- Out-of-classroom suspension, which has proven to be ineffective in achieving behavioral change or stronger educational outcomes, was given to 2.7 million K-12 students in the 2015-2016 school year. Over 120,000 students received expulsions.
    - Being suspended or expelled from school increases the likelihood of being arrested in that same month
- Zero tolerance policies are ineffective and have not been proven to reduce violence or promote learning, and negatively impact a disproportionately large number of minority students
- Positive approaches to discipline, including positive behavioral interventions and supports and restorative justice techniques, have been proven to address students' misbehavior effectively

Key asks:

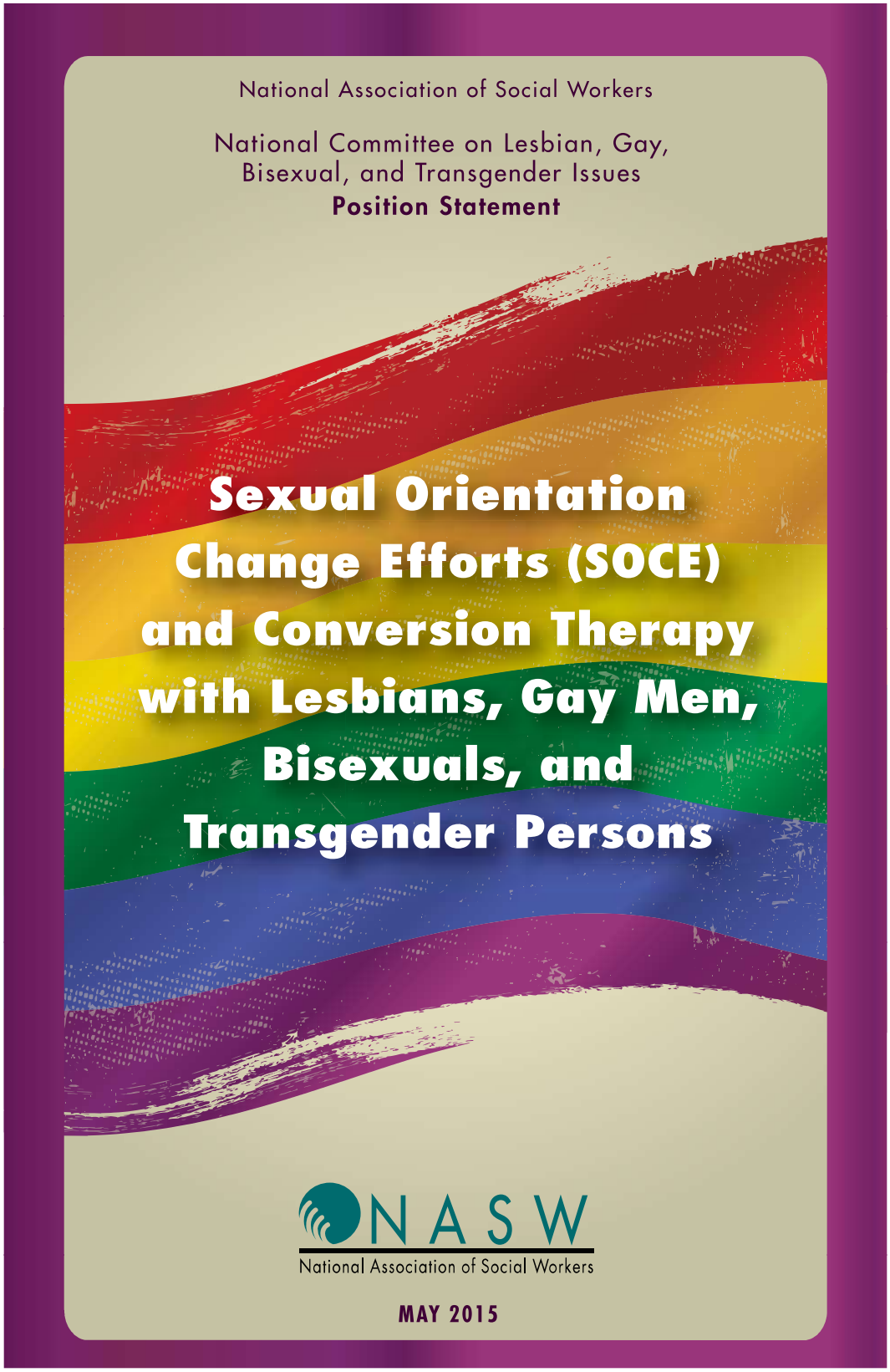
- Develop policies that seek to end the use of harmful and ineffective exclusionary discipline practices.
- Promote the implementation of effective and positive discipline practices (e.g., PBIS, restorative practices).
- Support policies that hold schools and districts accountable for addressing disproportionality in discipline (e.g., disaggregating discipline data by race/ethnicity and disability status).
- Create MOUs that clearly outline the appropriate role of SROs and other school based law enforcement and explicitly prohibit their involvement in discipline.

All Policies

Reparative or Conversion Therapy

The American Academy of Family Physicians (AAFP) opposes the use of "reparative" or "conversion" therapy for sexual and gender minority individuals of all ages. The AAFP recommends that patients and their families seek services that provide accurate information on sexual orientation and sexuality, gender identity, and increase social support, and reduce stigma and rejection of sexual and gender minority persons.

(2007) (April 2021 BOD)


National Association of Social Workers
National Committee on Lesbian, Gay, Bisexual, and Transgender Issues
Position Statement
Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons
NASW
National Association of Social Workers
MAY 2015

The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world. NASW works to enhance the professional growth and development of its members, to create and maintain standards for the profession, and to advance sound social policies. NASW also contributes to the well-being of individuals, families and communities through its advocacy.

The National Association of Social Workers (NASW) is located at 750 First Street, NE, Suite 800, Washington, DC 20002. Telephone: 202.408.8600. Website: SocialWorkers.org

Approved by the National Association of Social Workers Board of Directors. May 1, 2015.

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BACKGROUND

In 1992, the NASW National Committee on Lesbian and Gay Issues (NCLGI) issued a ground-breaking document focused on the negative and stigmatizing impact of the use of 'transformational ministries' or 'conversion or reparative therapies' in an attempt to change or modify a person's sexual orientation (NASW, 1992). Later that decade, the NASW National Committee on Lesbian, Gay, and Bisexual Issues (NCLGBI) updated the position statement. In 2000 the National NASW Board of Directors passed a 'motion to adopt' the *Reparative and Conversion Therapies for Lesbians and Gay Men Position Statement* (NASW, 2000). As advocacy efforts have grown, both for and against the use of conversion therapy, so has the need to educate clients and communities about the impact of these practices on individuals and families, and the implications for social work practice. In 2015, the NASW National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI) updated the position statement utilizing the umbrella term *sexual orientation change efforts (SOCE).*

INTRODUCTION

Reparative therapy, conversion therapy, or transformational ministries (increasingly included within the term *sexual orientation change efforts (or SOCE),* received wider attention against the backdrop of a growing conservative religious political climate in the 1990s, and through ongoing social media supported by the Focus on the Family and affiliates (NASW, 1992; Johnston, J., 2011). Proponents of reparative therapy and conversion therapy claim that their processes are supported by scientific data. Of note is that an often cited researcher, Robert Spitzer, admitted flaws in his research and in 2012 formally retracted his 2001 study that claimed gay men and lesbians could switch their sexual orientation (Hein, L. & Matthews, A., 2010). Despite the lack of scientific evidence, supporters of these practices continue to believe sexual orientation can be successfully changed (Panozzo, D., 2013). While there is increased effort at the state and local level to pass laws against the use of *SOCE*, there is a growing movement to pass

legislation that will limit implementation of state law banning the use of *SOCE* with minors. Under the guise of 'parental and family rights', the proposed legislation will limit the ability for state governments to prohibit certain types of counseling for minors, with specific reference to the parental right to access SOCE for 'counseling' (Southern Poverty Law Center, 2014; Kern, S., and Brecheen, J., 2015). *SOCE, conversion therapy and reparative therapy* have been discredited or highly criticized by all major medical, psychiatric, psychological and professional mental health organizations, including the National Association of Social Workers.

What are sexual orientation change efforts?

The term *sexual orientation change efforts (or SOCE)* include any practice seeking to change a person's sexual orientation, including, but not limited to, efforts to change behaviors, gender identity, or gender expressions, or to reduce or eliminate sexual or romantic attractions or feelings toward a person of the same gender. Within this position statement, SOCE includes any form of *reparative therapy, conversion therapy*, and/or *transformational ministries* that use interventions claiming to "repair" or "convert" a person in order to reduce or eliminate a person's sexual desire for a member of his or her own gender. The use of SOCE can include use of psychotherapy, medical approaches, aversion therapy, religious and spiritual approaches, as well as the use of sexual violence (referred to as 'corrective rape). There are no studies of adequate scientific rigor to conclude whether or not SOCE or conversion therapy can modify or change sexual orientation or gender identity or expression (APA, 2009).

What are sexual orientation, sexual identity, gender identity, and gender expression?

According to NASW's "Definitions: A Primer" (2009), *sex* is assigned at birth and determined usually by external, physical genitals. Additional sex markers include chromosomes and internal and external reproductive organs. *Gender* is an ascribed social status assigned at birth, which is

assumed to be congruent with the assigned birth sex, but may or may not be congruent with the anatomical sexual identifiers.

Sexual orientation is defined by whom people are emotionally, romantically, and erotically attracted to, for the most part and over a period of time. It exists on a continuum of feelings and attractions, and is not necessarily congruent with behavior.

Sexual identity refers to a person's self-perception of his or her sexual orientation, and *sexual behavior* refers to a person's sexual activities.

Gender Identity refers to the gender with which one identifies regardless of one's assigned sex at birth. *Gender expression* is the communication of gender through behaviors (mannerisms, speech patterns, etc.) and appearance (clothing, hair, accessories, etc.) culturally associated with a particular gender.

Can therapy change sexual orientation or gender identity?

People seek mental health services for many reasons. Accordingly, it is fair to assert that people who have same-sex attraction seek therapy for the same reasons that heterosexual people do. However, media campaigns, often coupled with coercive messages from family and community members, can create an environment in which LGBT persons are pressured to seek conversion therapy. The stigmatization of LGBT persons creates a threat to the health and well-being of those affected which, in turn, produces the social climate that pressures some people to seek change in sexual orientation or gender identity (Haldeman, D.,1994; HRC, 2015). However, no data demonstrate that SOCE or reparative therapy or conversion therapy is effective, rather have succeeded only in short term reduction of same-sex sexual behavior and negatively impact the mental health and self-esteem of the individual (Davison, G., 1991; Haldeman, D., 1994, APA, 2009).

The NASW National Committee on Lesbian, Gay, Bisexual, and Transgender Issues believes that SOCE can negatively affect one's mental health and cannot and will not change sexual orientation or gender identity.

Why is this issue relevant to the social work profession?

Social workers should have a broad-based knowledge about human sexuality, human sexual development across the life cycle, a high degree of comfort and skill in communicating and responding to such issues, and knowledge of appropriate community services (Harrison, D., 1995).

Social workers across fields of practice, including foster care, mental health, corrections, substance abuse, school social work, and prevention education, will encounter lesbian, gay, bisexual and transgender (LGBT) clients. Providing culturally competent services with LGBT youth and adults calls for a shift or transformation from reparative to affirmative practice and interventions (Hunter, S. & Hickerson, J., 2003; Mallon, G., 2009).

What are the value and ethical implications for social workers?

In discussing ethical decisions for social work practice, Loewenberg & Dolgoff (1996) stress "the priority of professional intervention at the individual level will be to help people achieve self-actualization, rather than helping them to learn how to adjust to the existing social order."

The practice of SOCE violates the very tenets of the social work profession as outlined in the NASW *Code of Ethics*. The NASW *Code of Ethics* (1998) enunciates principles that address ethical decision making in social work practice with lesbians, gay men, bisexual, and transgender people; for example: 1) social workers' commitment to clients' self-determination and competence, and to achieving cultural competence and understanding social diversity, 2) social workers' ethical responsibilities to colleagues, their commitment to interdisciplinary collaboration, and their responsibility to report unethical conduct of colleagues, 3) social workers' ethical responsibilities as professionals—maintaining competence, fighting discrimination, and avoiding misrepresentation, and 4) social workers' ethical responsibilities to the social work profession, to evaluation, and to research.

The National Committee on LGBT Issues asserts that conversion therapy or SOCE are an infringement of the guiding principles inherent to social worker ethics and values; a position affirmed by the NASW policy statement on "Lesbian, Gay, and Bisexual Issues" (NASW 2014).

How can I practice the nondiscrimination tenets of my profession?

As stated in the original NASW National Committee on Gay and Lesbian Issues - Position Statement on Reparative Therapy, "If a client is uncomfortable about his/her sexual orientation, the sources of discomfort must be explored, but without prior assumption that same-sex attraction is dysfunctional" (1992). Social workers must advocate against policy or practice interventions that create or reinforce the prejudice and discrimination towards gay men, lesbians, bisexual, and transgender persons and their families. Social workers are obligated to use nonjudgmental attitudes and to encourage nurturing practice environments for lesbians, gay men, bisexual, and transgender persons.

What policy exists to help guide social work practice?

The NASW Policy Statement on Lesbian, Gay, and Bisexual (LGB) Issues and the NASW Policy Statement on Transgender and Gender Identity Issues provide a "blueprint" for social work practice with gay, lesbian, bisexual, transgender clients and communities.

The policies state, "NASW supports the adoption of local, state, federal, and international policies and legislation that ban all forms of discrimination based on sexual orientation and gender identity" (NASW 2008), and further adds "NASW condemns the use of SOCE or so-called reparative therapy by any person identifying as a social worker or any agency that identifies as providing social work services. Public dollars should not be spent on programs that support SOCE" (NASW, 2014). The National Association of Social Workers reaffirms its stance against therapies and treatments designed to change sexual orientation or gender identity and against referring clients to practitioners or programs that claim to do so (NASW, 2014).

Position statement authored by members of the National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI), National Association of Social Workers (NASW) and NASW staff.[1]

[1] Paula Foster, LCSW, Kristina Smith, LCSW, James Martin, PhD, Zander Keig, MSW, ASW, Marshall Wong, MSW; and (past members): Heather Craig-Oldsen, MSW, Josephine Tittsworth, LMSW, Eleni Carr, MSW. (Staff): Evelyn Tomaszewski, MSW

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RESOURCES

Gay and Lesbian Alliance Against Defamation
121 West 27th Street, Suite 804, New York, NY 10001; 212.629.3322 or 212.727.0135; glaad.org

Gay and Lesbian Medical Association
1326 18th Street NW, Washington, DC 20036; 202.600.8037; glma.org

Gay, Lesbian and Straight Education Network
90 Broad St., New York, NY 10004; 212.727.0135; glsen.org

Healthy Lesbian, Gay, and Bisexual Youth Project, American Psychological Association: Public Interest Directorate
750 First Street, NE, Washington, DC 20002-4242; 202.336.5977; apa.org/pi/lgbt/programs/hlgbsp/index.aspx

Human Rights Campaign
1640 Rhode Island Ave., NW, Washington, DC 20036; 202.628.4160; hrc.org

National Association of Social Workers, National Committee on Lesbian, Gay, Bisexual and Transgender Issues
750 First Street, NE, Suite 800, Washington, DC 20002-4241; 202.408.8600; socialworkers.org

National Center for Lesbian Rights
870 Market Street, Suite 370, San Francisco, CA 94102; 415.392.6257; nclrights.org; Born Perfect Project: nclrights.org/explore-the-issues/bornperfect/

Sexuality Information and Education Council of the United States
130 West 42nd Street, Suite 350, New York, NY 10036; 212.819.9770; siecus.org; siecus@siecus.org

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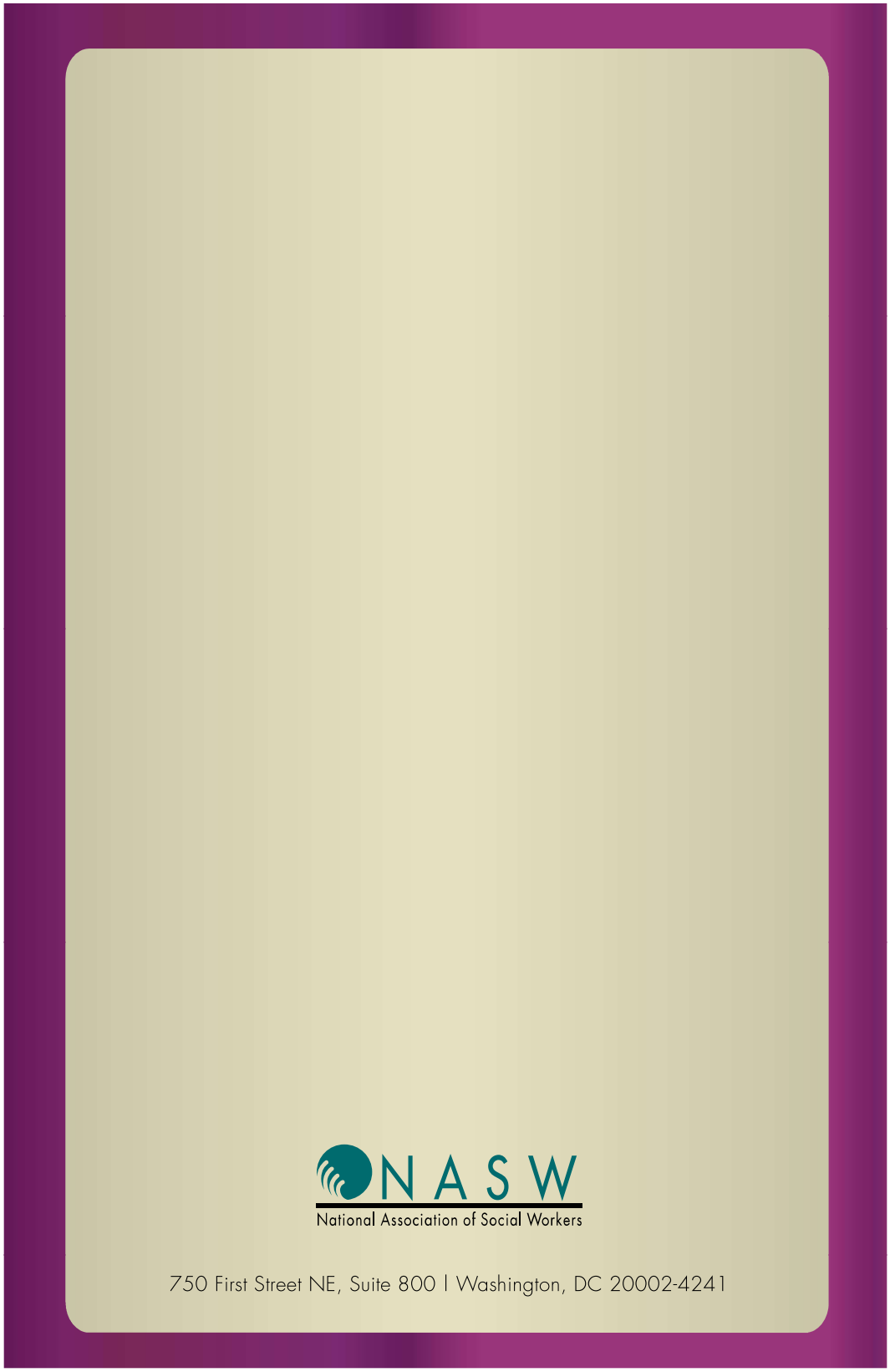
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CONVERSION THERAPY BANS

Conversion or reparative therapy is the discredited practice of using "therapy" to attempt to change someone's sexual orientation.The American Counseling Association opposes conversion therapy because it does not work, can cause harm, and violates our Code of Ethics. It is an attempt to treat something that is not a mental illness.

Conversion therapy has been banned in California, Oregon, Illinois, Vermont, New Jersey, New Mexico, Connecticut, Nevada, Rhode Island, Washington, Maryland, New Hampshire, Hawaii, Delaware, New York, Massachusetts, Colorado, Maine, and Washington DC. ACA will continue to support state legislation that bans this discredited practice.

Testimony by President Gerard Lawson on Virginia Conversion Therapy Legislation

Monday, July 18, 2022

American Academy of Nursing Opposes Reparative Therapy and Employment Discrimination Against LGBT Individuals

Academy Releases Two Statements in Support of LGBT Rights

WASHINGTON, D.C. (PRWEB) JUNE 17, 2015

American Academy of Nursing

The American Academy of Nursing released two statements in support of LGBT rights in its May/June issue of its academic journal, Nursing Outlook, opposing reparative therapy and employment discrimination for LGBT individuals.

The Academy's statement on reparative therapy opposes and condemns its use for homosexuality, calling the practice ineffective, unethical, abusive and harmful.

"The Academy concludes that reparative therapies aimed at "curing" or changing same-sex orientation to heterosexual orientation are pseudo-scientific, ineffective, unethical, abusive and harmful practices that pose serious threats to the dignity, autonomy and human rights as well as to the physical and mental health of individuals exposed to them. Based on sound scientific evidence, its commitment to human rights and dignity, and its mission of promoting positive health outcomes for lesbian, gay, bisexual, transgender and queer (LGBTQ) individuals, the Academy concludes that efforts to "repair" homosexuality, by any means, constitute health hazards to be avoided and are to be condemned as unethical assaults on human rights and individual identity, autonomy and dignity," the Academy said in its statement on reparative therapy.

The statement cited strong scientific evidence concluding that techniques used in reparative therapies are ineffective by failing to achieve intended results and imparting inherently harmful effects on mental and physical health on individuals being pressured to change.

"The Academy is proud to issue a strong statement opposing reparative therapy and we look forward to working with our fellows and other professionals in the health care community to ultimately end this practice," said Academy President, Diana J. Mason, PhD, RN, FAAN.

In its statement opposing employment discrimination based on sexual orientation and gender identity, the Academy said, "Employment discrimination adversely affects physical and mental health. By perpetuating social stigma and adding to minority stress, it contributes to health disparities among lesbian, gay, bisexual and transgender (LGBT) people."

The Academy cited that there are no federal laws barring employment discrimination that include protections for LGBT people.

"The lack of federal law barring employment discrimination against LGBT people leaves millions at risk of losing or being denied employment based on sexual orientation or gender identity," the Academy said in its statement.

Federal anti-discrimination legislation has been introduced in Congress multiple times since 1994 and has never been passed.

"The Academy supports efforts to end employment discrimination based on sexual orientation or gender identity," Mason said. "We will work with other nursing and health professional organizations to move toward the goal of ending employment discrimination for LGBT people in the public and private sectors."

The Academy also states that employment discrimination negatively influences opportunities for acquiring or keeping employer-sponsored insurance (ESI). LGBT adults are more likely than non-LGBT adults to be uninsured. The disparity, likely due to employment discrimination, contributes to reduced access to ESI.

The Academy's position statements on reparative therapy and employment discrimination for LGBT people were prepared by its fellows on the LGBTQ expert panel, comprised of health experts from academia, and public and private-sector organizations.

About the American Academy of Nursing
The American Academy of Nursing (http://www.AANnet.org) serves the public and the nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. The Academy's more than 2,300 fellows are nursing's most accomplished leaders in education, management, practice, policy, and research. They have been recognized for their extraordinary contributions to nursing and health care.

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Psychotherapies

Overview

Psychotherapy (sometimes called "talk therapy") is a term for a variety of treatment techniques that aim to help a person identify and change troubling emotions, thoughts, and behavior. Most psychotherapy takes place with a licensed, trained mental health professional and a patient meeting one-on-one or with other patients in a group setting.

You might seek out psychotherapy for different reasons including:

- You might be dealing with severe or long-term stress from a job or family situation, the loss of a loved one, or relationship or family issues.
- You might have symptoms with no physical explanation: changes in sleep or appetite, low energy, a lack of interest or pleasure in activities that you once enjoyed, persistent irritability, worry, or a sense of discouragement or hopelessness that won't go away.
- A health care provider may suspect or have diagnosed depression, anxiety, bipolar disorder, post-traumatic stress disorder, or other conditions or symptoms that may be interfering with your life, and recommended psychotherapy as a first treatment or to go along with medication.
- You may be seeking treatment for a family member or child who has been diagnosed with a condition affecting mental health and for whom a health care provider has recommended treatment.

An exam by a health care provider can ensure there is nothing in your or your loved one's overall health that would explain symptoms. This step is important because sometimes symptoms like a change in mood or trouble concentrating can be due to medical conditions.

Psychotherapies and Other Treatment Options

Psychotherapy can be an alternative to medication or can be used with other treatment options, such as medications. Choosing the right treatment plan should be based on a person's individual needs and medical situation and under a mental health professional's care.

Even when medications relieve symptoms, psychotherapy and other interventions can help a person address specific issues. These might include self-defeating ways of thinking, fears, problems interacting with other people, or dealing with situations at home, school, or work.

Elements of Psychotherapy

A variety of different types of psychotherapies and interventions have been shown to be effective for specific disorders. For example, the treatment approach for someone who has obsessive-compulsive disorder is different for someone who has bipolar disorder. Therapists may use one primary approach or incorporate other elements depending on their training, the condition being treated, and the needs of the person receiving treatment.

Elements of psychotherapies may include:

understand how they affect emotions and behavior, and change self-defeating patterns. This approach is central to a type of psychotherapy called cognitive behavioral therapy (CBT).
- Identifying ways to cope with stress and developing specific problem-solving strategies.
- Examining a person's interactions with others and offering guidance with social and communication skills.
- Mindfulness and relaxation techniques, such as meditation and breathing exercises.
- Exposure therapy for people with anxiety disorders. In exposure therapy, a type of CBT, a person spends brief periods in a supportive environment, learning to tolerate the distress caused by certain items, ideas, or imagined scenes cause. Over time, the fear associated with these things may dissipate.
- Tracking emotions and behaviors to raise awareness and the impact of each on the other.
- Supportive counseling to help a person explore troubling issues and provide emotional support.
- Creating a safety plan to help someone who has thoughts of self-harm or suicide recognize warning signs and use coping strategies such as contacting friends, family, or emergency personnel.

Note that there are many different types of psychotherapy. Other therapies are often variations on an established approach, such as CBT. There is no formal approval process for psychotherapies like there is for the use of medications from the Food and Drug Administration.

However, for many therapies, research involving large numbers of patients has provided evidence that treatment is effective for specific disorders. These "evidence-based therapies" have been shown in research to reduce symptoms of depression, anxiety, and other disorders. NIMH's health topic pages about specific disorders list some of the evidence-based therapies for those disorders.

What to Consider When Looking for a Therapist

Therapists have different professional backgrounds and specialties. See below for information that can help you find out about the different credentials of therapists and resources for locating therapists.

The approach a therapist uses depends on the condition being treated and the training and experience of the therapist. Also, therapists may combine and adapt elements of different approaches.

Once you've identified one or more possible therapists, a preliminary conversation with a therapist can help you understand how treatment will proceed and whether you feel comfortable with the therapist. Rapport and trust are important. Discussions in therapy are deeply personal, and it's important that you feel comfortable with the therapist and have confidence in their expertise. These preliminary conversations may happen in person, by phone, or virtually. Consider trying to get answers to the following questions:

- What are the credentials and experience of the therapist? Do they have a specialty?
- What approach will the therapist take to help you? Do they practice a particular type of therapy? What is the rationale for the therapy and its evidence base?
- Does the therapist have experience in diagnosing and treating the age group (for example, a child) and the specific condition for which treatment is being sought? If a

- Are medications an option? Is this therapist able to prescribe medications?
- Are the meetings confidential? How is confidentiality assured? Are there limits to confidentiality?

Finding a Therapist

Many different types of professionals offer psychotherapy. Examples include psychiatrists, psychologists, social workers, counselors, and psychiatric nurses. Information on the credentials of providers is available from the National Alliance on Mental Illness. In addition, you can find resources to help find a therapist on the NIMH's Help for Mental Illnesses webpage.

Your health insurance provider may have a list of mental health professionals who participate in your plan. Other resources on the Help for Mental Illnesses webpage can help you look for reduced-cost health services. When talking with a prospective therapist, ask about treatment fees, whether the therapist participates in insurance plans, and whether there is a sliding scale for fees according to income.

The following professional organizations have directories or locators on their websites for mental health care professionals:

- Academy of Cognitive Therapy
- Association for Behavioral and Cognitive Therapies
- American Academy of Child & Adolescent Psychiatry
- American Association Board of Clinical Social Work
- American Association for Geriatric Psychiatry
- American Association for Marriage and Family Therapy
- American Board of Professional Psychology
- American Psychiatric Association
- American Psychological Association
- National Association of Social Workers
- National Register of Health Service Psychologists
- Society of Clinical Psychology
- Psychology Today

National advocacy organizations have information on finding a mental health professional, and some have practitioner locators on their websites. Examples include:

- Anxiety and Depression Association of America
- Attention Deficit Disorder Association
- Children and Adults with Attention Deficit Hyperactivity Disorder
- Depression and Bipolar Support Alliance
- International OCD Foundation
- Mental Health America
- National Alliance on Mental Illness

Note: *NIMH does not evaluate the professional qualifications and competence of individual practitioners listed on these websites. These resources are provided for informational purposes only. These are not comprehensive lists and do not constitute an endorsement by NIMH, the National Institutes of Health, the U.S. Department of Health and Human Services, or the U.S. government.*

or psychology departments. You can also go to your state or county government website and search for the health department for information on mental health-related programs within your state.

The goal of therapy is to gain relief from symptoms, maintain and/or improve daily functioning, and improve quality of life. If you have been in therapy for what feels like a reasonable amount of time and feel you are not getting better, talk to your therapist or look into other mental health professionals or approaches.

Digital Health Options

The telephone, internet, and mobile devices have created new opportunities to provide more readily available and accessible interventions, including in areas where mental health professionals may not be physically available. Some of these approaches involve a therapist providing help at a distance. Still, others—such as web-based programs and mobile apps—are designed to provide immediate information and feedback in the absence of a therapist. For an overview, see NIMH's Technology and the Future of Mental Health Treatment webpage.

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What is Psychotherapy?

Psychotherapy, or talk therapy, is a way to help people with a broad variety of mental illnesses and emotional difficulties. Psychotherapy can help eliminate or control troubling symptoms so a person can function better and can increase well-being and healing.

Problems helped by psychotherapy include difficulties in coping with daily life; the impact of trauma, medical illness or loss, like the death of a loved one; and specific mental disorders, like depression or anxiety. There are several different types of psychotherapy and some types may work better with certain problems or issues. Psychotherapy may be used in combination with medication or other therapies.

Therapy Sessions

Therapy may be conducted in an individual, family, couple, or group setting, and can help both children and adults. Sessions are typically held once a week for about 30 to 50. Both patient and therapist need to be actively involved in psychotherapy. The trust and relationship between a person and his/her therapist is essential to working together effectively and benefiting from psychotherapy.

Psychotherapy can be short-term (a few sessions), dealing with immediate issues, or long-term (months or years), dealing with longstanding and complex issues. The goals of treatment and arrangements for how often and how long to meet are planned jointly by the patient and therapist.

Confidentiality is a basic requirement of psychotherapy. Also, although patients share personal feelings and thoughts, intimate physical contact with a therapist is never appropriate, acceptable, or useful.

Psychotherapy and Medication

Psychotherapy is often used in combination with medication to treat mental health conditions. In some circumstances medication may be clearly useful and in others psychotherapy may be the best option. For many people combined medication and psychotherapy treatment is better than

either alone. Healthy lifestyle improvements, such as good nutrition, regular exercise and adequate sleep, can be important in supporting recovery and overall wellness.

Does Psychotherapy Work?

Research shows that most people who receive psychotherapy experience symptom relief and are better able to function in their lives. About 75 percent of people who enter psychotherapy show some benefit from it.[1] Psychotherapy has been shown to improve emotions and behaviors and to be linked with positive changes in the brain and body. The benefits also include fewer sick days, less disability, fewer medical problems, and increased work satisfaction.

With the use of brain imaging techniques researchers have been able to see changes in the brain after a person has undergone psychotherapy. Numerous studies have identified brain changes in people with mental illness (including depression, panic disorder, PTSD and other conditions) as a result of undergoing psychotherapy. In most cases the brain changes resulting from psychotherapy were similar to changes resulting from medication.[2]

To help get the most out of psychotherapy, approach the therapy as a collaborative effort, be open and honest, and follow your agreed upon plan for treatment. Follow through with any assignments between sessions, such as writing in a journal or practicing what you've talked about.

Types of Psychotherapy

Psychiatrists and other mental health professionals use several types of therapy. The choice of therapy type depends on the patient's particular illness and circumstances and his/her preference. Therapists may combine elements from different approaches to best meet the needs of the person receiving treatment.

Cognitive behavioral therapy (CBT) helps people identify and change thinking and behavior patterns that are harmful or ineffective, replacing them with more accurate thoughts and functional behaviors. It can help a person focus on current problems and how to solve them. It often involves practicing new skills in the "real world." CBT can be helpful in treating a variety of disorders, including depression, anxiety, trauma related disorders, and eating disorders. For example, CBT can help a person with depression recognize and change negative thought patterns or behaviors that are contributing to the depression.

Interpersonal therapy (IPT) is a short-term form of treatment. It helps patients understand underlying interpersonal issues that are troublesome, like unresolved grief, changes in social or work roles, conflicts with significant others, and problems relating to others. It can help people

learn healthy ways to express emotions and ways to improve communication and how they relate to others. It is most often used to treat depression.

Dialectical behavior therapy is a specific type of CBT that helps regulate emotions. It is often used to treat people with chronic suicidal thoughts and people with borderline personality disorder, eating disorders and PTSD. It teaches new skills to help people take personal responsibility to change unhealthy or disruptive behavior. It involves both individual and group therapy.

Psychodynamic therapy is based on the idea that behavior and mental well-being are influenced by childhood experiences and inappropriate repetitive thoughts or feelings that are unconscious (outside of the person's awareness). A person works with the therapist to improve self-awareness and to change old patterns so he/she can more fully take charge of his/her life.

Psychoanalysis is a more intensive form of psychodynamic therapy. Sessions are typically conducted three or more times a week.

Supportive therapy uses guidance and encouragement to help patients develop their own resources. It helps build self-esteem, reduce anxiety, strengthen coping mechanisms, and improve social and community functioning. Supportive psychotherapy helps patients deal with issues related to their mental health conditions which in turn affect the rest of their lives.

Additional therapies sometimes used in combination with psychotherapy include:

- **Animal-assisted therapy –** working with dogs, horses or other animals to bring comfort, help with communication and help cope with trauma
- **Creative arts therapy –** use of art, dance, drama, music and poetry therapies
- **Play therapy –** to help children identify and talk about their emotions and feelings

Finding and Choosing a Psychotherapist

Psychotherapy can be provided by a number of different types of professionals including psychiatrists, psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, psychiatric nurses, and others with specialized training in psychotherapy. Psychiatrists are also trained in medicine and are able to prescribe medications.

Finding a psychiatrist or other therapist with whom an individual can work well is important. Sources of referrals include primary care physicians, local psychiatric societies, medical schools, community health centers, workplace Employee Assistance Programs (EAP), and online resources (see links to online locators below).

Federal law requires that in most cases mental health services, including psychotherapy, be covered by health insurance similar to other medical care costs. (Read more about insurance coverage of mental health care)

Online Locators for Psychotherapy/Counseling:

- Find a Psychiatrist
- SAMHSA Treatment Locator - Mental Health and Substance Abuse treatment locators
- ADAA Find a Therapist - Anxiety and Depression Association of America

More Information

- Academy of Cognitive and Behavioral Therapies
- American Association for Marriage and Family Therapy
- American Psychoanalytic Association
- American Academy of Psychoanalysis and Dynamic Psychiatry
- Association for Behavioral and Cognitive Therapies

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Guide to Psychiatry and Counseling

By Joseph Saling

Medically Reviewed by Smitha Bhandari, MD on December 08, 2021

Psychiatry and psychology are overlapping professions. Practitioners in both -- psychiatrists and psychologists -- are mental health professionals. Their area of expertise is the mind -- and the way it affects behavior and well-being. They often work together to prevent, diagnose, and treat mental illness. And both are committed to helping people stay mentally well.

But there are differences between psychiatry and psychology. And people sometimes find those differences confusing, especially when they are looking for help. To make matters even more confusing, psychiatrists and psychologists aren't the only mental health professionals you can choose from. There are mental health counselors, social workers, nurses and nurse practitioners, and others who deal with issues of mental health. And if you consider the multiple approaches to treatment, ranging from counseling to various forms of psychotherapy, the whole mental health system begins to look like a maze that's nearly impossible to navigate.

But here's a guide you can use to help you make your way through that maze.

Where to Start

Issues with mental health, especially if they're chronic (persistent or recurring often), can be debilitating. Your body can respond physically to depression or anxiety much like it does to physical illness. And sometimes, mental problems can actually be caused by a physical condition. So the first person to see if you think you are having a mental problem is your primary care doctor.

Your doctor will ask about your symptoms, how long you've been having them, and whether they're constant or come and go. Your doctor will check for physical problems that could be causing your symptoms and help you decide what type of mental health professional and what kind of therapy might be best for you.

Types of Mental Health Professionals

Your doctor might refer you to any of the following mental health professionals:

Psychiatrist. A psychiatrist is a medical doctor (M.D. or D.O.) who specializes in preventing, diagnosing, and treating mental illness. A psychiatrist's training starts with four years of medical school and is followed by a one-year internship and at least three years of specialized training as a psychiatric resident. A psychiatrist is trained to differentiate mental health problems from other underlying medical conditions that could present with psychiatric symptoms. They also monitor the effects of mental illness on other physical conditions (such as problems with the heart or high blood pressure), and the effects of medicines on the body (such as weight, blood sugar, blood pressure, sleep, and kidney or liver functioning).

As a medical doctor, a psychiatrist is licensed to write prescriptions. Many mental disorders -- such as depression , anxiety , ADHD, or bipolar disorder -- can be treated effectively with specific drugs. If you are working with a psychiatrist, a lot of the treatment may be focused on medication management. Sometimes medication alone is enough to treat the mental

illness. Sometimes a combination of medication and psychotherapy or counseling is needed. If that is the case, the psychiatrist may provide the psychotherapy, or the psychiatrist may refer you to a counselor or other type of mental health professional.

Psychologist. A psychologist has a doctoral degree (PhD, PsyD, or EdD) in psychology, which is the study of the mind and behaviors. Graduate school provides a psychologist an education in evaluating and treating mental and emotional disorders. After completing graduate school, a clinical psychologist completes an internship that lasts two to three years and provides further training in treatment methods, psychological theory, and behavioral therapy.

Licensed psychologists are qualified to do counseling and psychotherapy, perform psychological testing, and provide treatment for mental disorders. They are not, though, medical doctors. That means that, with the exception of a few states, psychologists cannot write prescriptions or perform medical procedures. Often a psychologist will work in association with a psychiatrist or other medical doctor who provides the medical treatment for mental illness while the psychologist provides the psychotherapy.

Licensed Mental Health Counselor. A psychological counselor is a mental health professional who has a master's degree (MA) in psychology, counseling, or a related field. In order to be licensed, the professional counselor also needs two additional years' experience working with a qualified mental health professional after graduate school. A mental health counselor is qualified to evaluate and treat mental problems by providing counseling or psychotherapy.

Clinical Social Worker. A clinical social worker has at least a master's degree in social work and training to be able to evaluate and treat mental illnesses. In addition to psychotherapy, social workers can provide case management and hospital discharge planning as well as work as an advocate for patients and their family.

Psychiatric or Mental Health Nurse. Some nurses have had special training in providing mental health services. Depending on their level of training and certification, they can evaluate patients for mental illness and provide treatment in the form of psychotherapy. In some states, they are also licensed to prescribe and monitor medications, sometimes independently and sometimes under the supervision of a medical doctor. Nurses also provide case-management services and serve as patient advocates.

The Difference Between Counseling and Psychotherapy

Although the terms counseling and therapy are often used interchangeably, there is a difference between psychotherapy and psychological counseling. Counseling focuses on specific issues and is designed to help a person address a particular problem, such as addiction or stress management. The focus may be on problem solving or on learning specific techniques for coping with or avoiding problem areas. Counseling is also usually more short-term than therapy.

Psychotherapy is more long-term than counseling and focuses on a broader range of issues. The underlying principle is that a person's patterns of thinking and behavior affect the way that person interacts with the world. Depending on the specific type of psychotherapy that is being used, the goal is to help people feel better equipped to manage stress, understand patterns in their behavior that may interfere with reaching personal goals, have more satisfying relationships, and better regulate their thinking and emotional responses to stressful situations. If someone has a form of mental illness such as depression , bipolar disorder , schizophrenia, or an anxiety disorder, psychotherapy also addresses ways in which the