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Supporting sexual and gender minority health: Research priorities from mental health professionals

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ABSTRACT

Sexual and gender minority (SGM) people experience significant disparities in mental health and substances use disorders. This study reached out to mental health professionals (MHPs) who treat SGM people to determine mental health priorities for research that would better inform their clinical practice. MHPs were surveyed and asked to rate items based on a likert-type scale. Open-ended questions were also queried and analyzed qualitatively. Five items had the highest mean scores: “stressors related to SGM status,” “lifestyle factors that support emotional resilience and wellbeing,” “depression,” “intimate relationships,” and “suicide.” Intersecting identities and sexual relationships emerged as qualitative themes.

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Introduction

Mental health disparities for sexual and gender minority (SGM) people (*i.e.*, people who are not heterosexual and/or people who self-identify as transgender, gender non-conforming and/or expansive, respectively) exist, such as higher rates of anxiety, mood disorders, substance use, and suicidal ideation (Institute of Medicine, 2011; King et al., 2008; Valentine & Shipherd, 2018). These higher rates of mental health disparities have been attributed to minority stress experienced among SGM people including discrimination, anticipation of discrimination, concealment of identity, and internalized stigma (Hendricks & Testa, 2012; Meyer, 2003). Substance use has been found to be used as a coping mechanism for mental health concerns and the stigma and stress experienced as members of marginalized

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communities (Livingston, Flentje, Heck, Szalda-Petree, & Cochran, 2017; Paradies, 2006; Reisner et al., 2015). In addition, people who identify as both sexual minority and gender minority (*i.e.*, have intersectional SGM identities) may experience elevated rates of depression, suicidality, and substance use compared to people who identify as sexual minority alone (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Zelle & Arms, 2015).

The elevated rates of mental health problems experienced by SGM people require mental health professionals (MHPs) to be knowledgeable about issues related to SGM mental health. Improving MHPs' knowledge requires adequate SGM health research to inform clinical practice; unfortunately, SGM people often remain unidentified in health studies and in treatment efficacy data (Heck, Mirabito, LeMaire, Livingston, & Flentje, 2017; Institute of Medicine, 2011). Extant research on substance use, anxiety, and mood disorders has not reported participants' sexual orientation and gender identity, making application of research findings to SGM people unsupported (Flentje, Bacca, & Cochran, 2015; Heck et al., 2017). For example, an MHP who is trying to identify what intervention is the best approach for a specific condition for their gender minority patient will have to use studies that haven't included or been tested among gender minority people. Further, the intervention that they choose will likely not take the unique contextual factors of the patient into account including mistreatment by health systems or ongoing minority stress exposure. Clinicians who serve marginalized or under-researched communities are important stakeholders in prioritizing research as they are working directly with the communities (Concannon et al., 2014; Logie & Lys, 2015; Morris et al., 2018). Research agendas are frequently developed without the involvement of clinicians who are directly providing care (Sinha, Smyth, & Williamson, 2011). However, including clinicians as a part of research planning and prioritization may improve the applied utility of clinical research and inform clinical practice (Brownson, Kreuter, Arrington, & True, 2006). Organizations, such as the Patient-Centered Outcomes Research Institute (PCORI) and Institute of Medicine, acknowledge the importance of centering patient and stakeholder perspectives in the setting of research priorities that will best affect the treatment of populations, yet this important foundational work has not been done with MHPs that serve SGM communities (Institute of Medicine, 2009; Patel, 2010; Selby, Beal, & Frank, 2012).

The purpose of this study is to identify the SGM mental health research priorities directly from MHPs. These MHP-defined research priorities were queried to inform the design of mental and social health questions within The PRIDE Study, a national longitudinal SGM health cohort study with over 13,000 participants; however, they may also inform a broader SGM

research agenda that is relevant and applicable to clinical settings. This study will identify the highest research priorities among surveyed MHPs and will determine whether the highest priorities differ by MHP type or the population density where the MHP's practice is located. Finally, we will report other areas for research that MHPs identify as needing additional research to inform clinical practice with SGM patients.

Methods

Recruitment

MHPs were recruited through an email sent to 22 professional e-mail distribution lists, clinical and/or community organizations serving SGM people. Snowball sampling was also used by contacting clinicians known to serve SGM people. The email contained a link to an anonymous, web-based survey managed through Qualtrics and an explanation was provided that we were soliciting assistance in the design of The PRIDE Study to find out research priorities from the MHP perspective. The survey was open for responses from September 2015 through January 2016. This study was deemed exempt per University of California, San Francisco Institutional Review Board policies as no identifying personal information was collected about study participants. Informed consent was obtained by a disclosure contained on the first screen of the survey.

Survey

Participants were queried regarding their professional practice, including MHP type, education, years of experience in mental health, work setting, type of SGM mental health services provided, population density where services were provided, frequency with which the participant works with subgroups of SGM people, number of SGM clients seen in course of career, and the percentage of SGM clients. The study was aimed at identifying which research areas were most relevant to MHPs' practices. Sixty-two (62) mental and social health issues were provided for MHPs to indicate how important research in each area was to their professional practice. The questions were developed by two doctoral level psychologists and reviewed for content validity by four doctoral level health care professionals. The survey used a six-point Likert scale ranging from "not at all" (1) important to "extremely" (6) important. The 62 items were broken into seven categories: "presenting problems in mental health," "stressors," "substances," "health promoting or risk behaviors," "health behaviors," "medical service issues," and "social, community, and family issues." Participants were also prompted "What issues **not** mentioned above is it important for research

to address for sexual and gender minorities?” with an open-ended response field.

Analysis

The 62 mental and social health issues were assigned ordinal importance ratings based on mean score. Ranking was performed for all 62 mental and social health issues overall and within each of the seven categories. Cronbach's alpha was computed for each of the seven categories (Gliem & Gliem, 2003). Because variables did not meet the assumptions for parametric testing (Skewness/Kurtosis tests for Normality calculated $p < .05$ for all items), a Friedman test was used to compare the between-category differences using the mean of the participants' responses within each category. A Kruskal-Wallis test was used to examine differences between the five health issues with the highest overall mean and MHP type (*i.e.*, psychologist, psychiatrist, clinical social worker, counselor, and marriage and family therapist [MFT]). MHP types with fewer than 10 respondents were not included in this analysis. A Kruskal-Wallis test was also used to analyze differences between the ratings of the five health issues with the highest overall mean and the population density where services were provided (*i.e.*, rural areas, urban cities with >500,000 people). Population densities with fewer than 10 respondents were not included in this analysis.

Respondents were asked to write-in important SGM health topics not mentioned in the survey. Two coders identified themes and independently coded responses using content analysis (White & Marsh, 2006). Disagreements were discussed collaboratively, and any remaining disagreements were decided by a third reviewer. Open-ended responses were assigned more than one code if their content addressed multiple themes.

Results

Participants

One hundred and sixty-three MHPs responded (Table 1). Thirty percent ($n = 45$) of respondents were psychiatrists, 18.5% ($n = 28$) were MFTs, 18% ($n = 27$) were psychologists, 13% ($n = 20$) were clinical social workers, 13% ($n = 19$) were mental health counselors, and the rest ($n = 12$) were divided among 4 other roles. Over half (52%, $n = 81$) held a doctoral degree, 44% ($n = 69$) a Master's degree, and 4% ($n = 6$) a Bachelor's degree or less. Nearly all (99%; $n = 162$) worked in outpatient settings, and 14% ($n = 23$) worked in inpatient settings. Most (79%; $n = 129$) respondents indicated that they provided mental health interventions and counseling in their professional practice; 42% ($n = 68$) indicated that they provide substance use

Table 1. Professional characteristics of mental health professionals.

Characteristic	Respondents (<i>N</i> = 163 [*])	
	<i>N</i>	%
Provider type:	151	
Clinical Social Worker	20	13
Psychologist	27	18
Psychiatrist	45	30
Marriage & Family Therapist	28	18.5
Counselor	19	13
Psychiatric Nurse Practitioner/Physician's Assistant	5	3
Administration	3	2
Pre-Licensure Student	3	2
Research	1	.5
Highest Degree Earned	156	
High school or less	1	.5
Associates Degree	3	2
Bachelor's Degree	2	1.5
Master's Degree	69	44
Doctoral Degree	81	52
Years of Mental/Behavioral Health Experience	154	
1 year or less	6	4
2–5	41	27
6–10	24	16
11–20	42	27
21+	41	26
Settings Worked Once/Week or More		
Inpatient	23	14
Partial Hospitalization	12	7
Outpatient	162	99
Clinical Research	11	7
Administration	3	2
Academic	10	6
Emergency Room	5	3
Private Practice	2	1
Other	16	10
Provides Clinical Care for LGBTQ or SGM		
Yes	151	90
No	17	10
Type of Services Provided to LGBTQ or SGM		
Mental Health intervention/counseling	128	79
Substance Use intervention/counseling	68	42
Pharmacotherapy	41	25
Case Management/Social work services	27	17
Family therapy	45	28
Couples therapy	75	46
Group therapy	40	25
Gender Therapy	3	2
Other	18	11

Note: Some items may reflect more or less than 100% of sample due to allowance of multiple responses or respondents not endorsing an item

counseling; 46% ($n = 75$) offered couples therapy; and 25% ($n = 41$) indicated that they provide pharmacotherapy.

Overall priority rankings

The item, “stressors related to gender and sexual minority status,” was ranked as the most important to MHP’s clinical practice ($m = 5.45$, $SD = 0.79$), followed by “lifestyle factors that support emotional resilience

and wellbeing” ($m = 5.31$, $SD = 0.91$), “depression” ($m = 5.28$, $SD = 0.99$), “intimate relationships” ($m = 5.25$, $SD = 0.92$), and “suicide” ($m = 5.214$, $SD = 1.03$). The least important items were “sun exposure” ($m = 3.15$, $SD = 1.36$), “psychedelics use” ($m = 3.54$, $SD = 1.49$), “stressors related to ‘sexting’” ($m = 3.77$, $SD = 1.35$), “inhalant use” ($m = 3.82$, $SD = 1.52$), and “intravenous drug use” ($m = 3.93$, $SD = 1.45$). All items, ordered by descending mean within their category, are presented in [Table 2](#).

Analysis of categories of mental health issues

The Cronbach alpha coefficient for all 7 categories indicated that the items have high internal consistency ($\alpha = 0.87\text{--}0.93$). There were differences in the mean ratings between the 7 categories of items ($W = 0.59$; $p < 0.001$), suggesting that the categories were rated differently by MHPs. The category with the highest mean was “Social, Community, & Family Issues” ($m = 4.74$), while the category with the lowest mean was “Aspects of Physical Health” ($m = 4.04$).

Mental health professional type

Clinical social workers and psychiatrists cited the same top three items as most important. “Suicide” was the highest rated item ($m = 5.71$, $SD = 0.47$; $m = 5.51$, $SD = 0.77$, respectively), followed by “substance use” ($m = 5.69$, $SD = 0.48$; $m = 5.37$, $SD = 0.87$, respectively) and “stressors related to SGM status” ($m = 5.63$, $SD = 0.72$; $m = 5.35$, $SD = 0.78$, respectively). Psychologists identified “stressors related to SGM status” to be most important ($m = 5.58$, $SD = 0.65$) followed by “lifestyle factors that support emotional resilience and wellbeing” ($m = 5.45$, $SD = 1.08$) and “post-traumatic stress disorder” (PTSD, $m = 5.3$, $SD = 0.81$). MFTs identified “intimate relationships” ($m = 5.48$, $SD = 0.51$) to be most important followed by “lifestyle factors that support emotional resilience and wellbeing” ($m = 5.48$, $SD = 0.65$) and “depression” ($m = 5.42$, $SD = 0.86$). Counselors rated “intimate relationships” as the most important ($m = 5.57$, $SD = 0.65$), then “stressors related to SGM status” ($m = 5.5$, $SD = 0.52$) and “lifestyle factors that support emotional resilience and wellbeing” ($m = 5.5$, $SD = 0.76$). Inferential statistical tests showed that, among the top 5 most highly rated items ([Table 3](#)), “Stressors related to SGM status” ($\chi^2 = 3.21[4]$, $p = .52$), “depression” ($\chi^2 = 4.01[4]$, $p = .41$), and “suicide” ($\chi^2 = 5.63[4]$, $p = .23$) were not ranked differently by MHP type. However, “lifestyle factors that support emotional resilience and wellbeing” ($\chi^2 = 11.10[4]$, $p = .03$) had a significant relationship with MHP type. “Intimate relationships” also had a significant relationship with MHP type ($\chi^2 = 11.89[4]$, $p = 0.02$).

Table 2. Categories and Items Contained Question Stem: “How important to **your** professional work would it be for us to address each of the following in our study” (i.e., The PRIDE Study).

Category Item (rated by ascending importance, 1–5)	Mean (SD)
Presenting Problems in Mental Health	4.80
Suicide	5.31 (1.03)
Depression	5.28 (0.99)
Anxiety	5.23 (0.93)
Substance Use	5.16 (1.02)
Post-traumatic stress disorder	5.12 (1.08)
Emotional regulation/coping with unwanted emotions	4.95 (0.99)
Body image concerns	4.89 (0.97)
Deliberate self-harm	4.81 (1.41)
Eating disorders	4.41 (1.05)
Anger management	4.18 (1.12)
Severe mental illness (e.g. psychosis)	4.16 (1.27)
Substances	4.30
Alcohol use	5.09 (1.00)
Stimulant use (e.g. cocaine, crack)	4.59 (1.00)
Marijuana use	4.54 (1.17)
Tobacco use	4.38 (1.48)
Club drug use (e.g. MDMA, ecstasy)	4.36 (1.47)
Opiate use (e.g. heroine, prescription pain meds)	4.27 (1.37)
Sedatives (e.g. benzodiazepines such as valium)	4.14 (1.36)
Inhalant use (e.g. “poppers,” solvents)	3.82 (1.52)
Psychedelics (e.g. LSD, psilocybin)	3.54 (1.49)
Aspects of Physical Health	4.04
Exercise	4.48 (1.15)
Nutrition	4.37 (1.21)
Obesity	4.18 (1.36)
Sun exposure	3.15 (1.36)
Social, Community, and Family Issues	4.74
Lifestyle factors that support emotional resilience and wellbeing	5.31 (0.91)
Intimate relationships	5.25 (0.92)
Coming-out	4.96 (1.04)
Friendships	4.85 (1.02)
LGBTQ community engagement	4.79 (1.03)
LGBTQ parenting (e.g. parents who are SGM)	4.73 (1.20)
Families of origin	4.67 (1.21)
Personal faith/spirituality	4.38 (1.33)
Dating via mobile and internet technology	4.36 (1.31)
Involvement in religious/spiritual groups (e.g. church)	4.19 (1.34)
Stressors	4.70
Stressors related to SGM status	5.45 (0.79)
Stressors related to victimization	5.04 (1.07)
Stressors related to coming out	5.01 (1.09)
Stressors related to sexual assault	4.85 (1.11)
Stressors related to bullying in school	4.83 (1.31)
General stressors	4.81 (1.03)
Stressors related to discrimination in the workplace	4.75 (1.29)
Stressors related to social media/cyberbullying	4.63 (1.29)
Stressors related to aging care	4.51 (1.27)
Stressors related to police interactions	4.04 (1.32)
Stressors related to “sexting”	3.77 (1.35)
Health Promoting or Risk Behavior	4.36
Condom use	4.76 (1.27)
Use of substances leading to unplanned sexual behavior	4.73 (1.27)
Sex with partners met online/through apps	4.66 (1.35)
Use of substances to purposely facilitate sexual enjoyment	4.37 (1.33)
Transactional sex	4.23 (1.43)
Use of substances with strangers	4.22 (1.38)
Internet pornography	3.98 (1.48)
IV drug use	3.93 (1.45)

(continued)

Table 2. Continued.

Category Item (rated by ascending importance, 1–5)	Mean (SD)
Medical Service Issues	4.58
Seeing a primary care provider for regular checkups	4.84 (1.91)
Following through on medical recommendations made by physician	4.80 (1.21)
Screening/testing for HIV and other STIs	4.79 (1.19)
Medical decision making (e.g. advanced directives)	4.64 (1.38)
Adherence to HIV medications	4.51 (1.59)
Adherence to non-HIV medications	4.48 (1.34)
Use of Pre-exposure prophylaxis (PrEP) for prevention of HIV infection	4.39 (1.55)
Reproductive health issues (e.g. family planning)	4.19 (1.47)

Table 3. Results of inferential statistical analyses of overall top 5 items and mental health professional type.

Item mental health professional type	Means	χ^2 Results
Stressors Related to SGM Status		$\chi^2[4] = 3.21, p = .52$
Psychologists	5.58	
Psychiatrists	5.35	
Clinical Social Workers	5.63	
Counselors	5.50	
Marriage & Family Therapists	5.42	
Depression		$\chi^2[4] = 4.01, p = .41$
Psychologists	5.25	
Psychiatrists	5.14	
Clinical Social Workers	5.59	
Counselors	5.21	
Marriage & Family Therapists	5.42	
Suicide		$\chi^2[4] = 5.63, p = .23$
Psychologists	5.25	
Psychiatrists	5.51	
Clinical Social Workers	5.71	
Counselors	5.24	
Marriage & Family Therapists	5.00	
Lifestyle Factors That Support Emotional Resilience and Well-being		$\chi^2[4] = 11.10, p = .03$
Psychologists	5.48	
Psychiatrists	5.00	
Clinical Social Workers	5.56	
Counselors	5.50	
Marriage & Family Therapists	5.48	
Intimate Relationships		$\chi^2[4] = 11.89, p = .02$
Psychologists	5.26	
Psychiatrists	5.00	
Clinical Social Workers	5.63	
Counselors	5.57	
Marriage & Family Therapists	5.48	

Population density

Categories of population density we represented by more than 10 participants included: “urban areas with >500,000 people,” “urban areas with 50,000 < 500,000 people,” and “urban areas with >500,000 people and surrounding suburbs.” The five items with the highest means did not have a relationship with the population density of respondent’s practice areas (“stressors related to SGM status,” “suicide,” “lifestyle factors that support emotional resilience/wellbeing,” “depression,” and “intimate relationships”; $p > .05$; Table 4).

Table 4. Results of inferential statistical analyses of overall top 5 items and population density where respondent practices.

Item population density	Means	χ^2 Results
Stressors Related to SGM Status		$\chi^2[4] = 3.21, p = .52$
Urban areas with >500,000 people	5.58	
Urban areas with 50,000 < 500,000 people	5.35	
Urban areas with >500,000 people and surrounding suburbs	5.63	
Depression		$\chi^2[4] = 4.01, p = .41$
Urban areas with >500,000 people	5.25	
Urban areas with 50,000 < 500,000 people	5.14	
Urban areas with >500,000 people and surrounding suburbs	5.59	
Suicide		$\chi^2[4] = 5.63, p = .23$
Urban areas with >500,000 people	5.25	
Urban areas with 50,000 < 500,000 people	5.51	
Urban areas with >500,000 people and surrounding suburbs	5.71	
Lifestyle Factors That Support Emotional Resilience and Well-being		$\chi^2[4] = 11.10, p = .03$
Urban areas with >500,000 people	5.48	
Urban areas with 50,000 < 500,000 people	5.00	
Urban areas with >500,000 people and surrounding suburbs	5.56	
Intimate Relationships		$\chi^2[4] = 11.89, p = .02$
Urban areas with >500,000 people	5.26	
Urban areas with 50,000 < 500,000 people	5.00	
Urban areas with >500,000 people and surrounding suburbs	5.63	

Open-ended responses

Fifty-three percent of MHPs provided open-ended responses reporting additional research priorities. Twelve themes emerged from participants' 87 open-ended responses (Table 5). Two responses were eliminated due to the content being addressed within the survey already, and one was removed due to the content being unrelated to the question. Eighty-four responses remained for content analysis. The most frequently reported themes were relationships ($n = 20$), intersectionality ($n = 18$), wellbeing ($n = 13$) and access to health care ($n = 10$).

Relationships

Relationships were referred to in 24% ($n = 20$) of the open-ended responses. These responses represented three subcategories: sexual relationships, familial relationships, and community relationships. Responses related to sexual relationships (75%; $n = 15$) conveyed MHP interest into how relationships among SGM people differ from relationships among heterosexual people. The most prevalent interest within the sexual relationship subcategory (53%; $n = 8$ of sexual relationship responses) was for further research regarding non-monogamous or polyamorous relationships and participation in kink and/or bondage, discipline, sadism, and masochism (BDSM). Responses related to familial relationships (15%; $n = 3$ of relationship responses) related to dynamics including the children in the family group. One respondent stated, "I have recently had many early adolescent [sex assigned at birth] females come out as transgender in middle school or

Table 5. Themes from open-ended responses.

Theme	Frequency	Example
Relationships	20 (24%)	"Polyamory and non-monogamy are important factors to look at, as studies show that 50–65% of gay men are in open relationships, and 28–33% of lesbians and bisexual people are in open relationships. This is important to study so that counselors can better help these groups"
Intersectionality	18 (22%)	"Addressing the additional challenges of racial and ethnic differences in our community, which can impact nearly every area you have identified in this study"
Well-being	13 (16%)	"Positive LGBT identity - LGB-PIM (measure)"
Access to Care	10 (12%)	"Seeking culturally competent care that is inclusive of LGBTQ status AND geriatric health/mental health needs."
Marginalized SGM Identities	8 (9%)	"Being sure to represent the broad spectrum of sexual and gender diversity, including [not] only LGBTQ, but also asexual and queer identities, androgynous experiences, and relational diversity ..."
Abuse & Trauma	7 (8%)	"I work mostly with sexual minorities who have experienced severe ongoing trauma, and questions about trauma history or general life story would be useful"
Legal Issues	5 (6%)	"Legal support in gender expression, marriage and benefits and corrections/law enforcement, education, employment etc ..."
Adolescent Care Needs	4 (5%)	"What would be very important data for me at present would be long-term follow up on children and adolescents presenting as gender variant or transgender"
Power Differentials	3 (3%)	"Prevalence of sexual involvement with those in authority, or adults while still a minor ..."
Personal Capital	2 (2%)	"education & employment resources"
Therapy Concerns	2 (2%)	"What medications are people taking? Are they having side effects such as sexual dysfunction or metabolic syndrome? Have they had adherence issues with treatment protocols due to side effects or expense of medications? "

high school ... Many families are working hard to be supportive, but often want to know the long-term outcome." Responses related to community relationships (20%; $n = 4$ of relationship responses) spoke to the integration of SGM clients into the SGM community, referencing "community-acceptance and rejection" and "the impact of cultural norms among [SGM] communities ... on individual patients."

Intersectionality

Intersectionality, that is when a person's intersecting identity characteristics (e.g., Asian, genderqueer) may compound societal discrimination and oppression (Carbado, Crenshaw, Mays, & Tomlinson, 2013; De Vries, 2012), accounted for 22% ($n = 18$) of open-ended responses. One respondent explained their concerns for SGM immigrants: "A major part of my volunteer work and [outreach] is with LGBTI asylum applicants-who are from other countries/cultures-I am very interested in their mental health issues." Another respondent mentioned the intersections of SGM status with disability, military service, and current or previous religious experiences and how this may be important for MHPs to be knowledgeable of the concerns and experiences from these perspectives.

Wellbeing

Wellbeing accounted for 16% ($n = 13$) of open-ended responses. Responses in this category were diverse, speaking to the importance of physical and emotional wellbeing. Entries related to physical wellbeing (31%; $n = 4$ of all wellbeing responses) included mention of body acceptance and homelessness. One respondent wrote, “body acceptance/health at every size...” implying that self-esteem regarding body image is important. Mentions of mental wellbeing (69%; $n = 9$ of wellbeing responses) centered on resilience in the face of adversity and authenticity to oneself. One respondent wrote of the importance addressing “... Acceptance of ‘gray area’ and ambiguity in one’s identity.... Self-awareness.”

Access to care

Access to health care accounted for 12% ($n = 10$) of responses. Responses in this category fell into three subcategories: accessing health care professionals, accessing services, and access to treatments for SGM people. Access to health care professionals (40%; $n = 4$ of all access to health care responses) included whether SGM people have access to health care professionals with whom they feel comfortable and who are inclusive of SGM patients. One respondent stated “Can they be open and comfortable with their health care providers? Have they avoided treatment due to issues regarding the sexual or gender orientation?” Responses regarding accessing services (40%; $n = 4$ of all access to care responses) related to insurance availability, access to psychiatric care, and availability of culturally competent older adult caregiving. Lastly, access to treatments (30%; $n = 3$ of all access to health care responses) centered on medication-related access and testing for sexually transmitted infections, HIV, and insurance coverage for gender-related transition treatment needs.

Discussion

Overall, MHPs ranked “stressors related to SGM status,” “suicide,” “depression,” “intimate relationships,” and “lifestyle factors that support emotional resilience and wellbeing” as the most important research priorities to inform their clinical practice. These same issues consistently received high mean scores across different MHP types and population densities where services were provided. The consistency indicated among the ranking of these items echoes the mental health issues most prevalent among SGM people (Institute of Medicine, 2011; James et al., 2016). Four of these same high-priority areas are focus areas in existing SGM mental health research as evidenced by the presence of systematic literature reviews on the topics with the exception of “intimate relationships,” for which we

were unable to locate a systematic review (Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler & Pachankis, 2016; Valentine & Shipherd, 2018; Woodward, Banks, Marks, & Pantalone, 2017). In sum, opportunities remain in the development of SGM focused interventions to address these high priority areas. Further, expanded efforts could disseminate relevant research directly to MHPs. The identification of these high priority areas by MHPs provides a foundation for the justification of additional research funding in these areas to improve the lives of SGM patients.

Relationship types and experiences among SGM people were mentioned frequently as a needed SGM research area (23%). Items relating to romantic and sexual relationships included polyamory, kink, and BDSM practices. Limited information is available regarding the prevalence of polyamorous relationships, especially among SGM people (Rubel & Burleigh, 2018). Further, there is a paucity of research guidance available to MHPs on providing efficacious services (e.g., couples therapy) within the context of polyamorous relationships. MHPs have previously indicated little experience treating people who participate in kink or BDSM sexual behaviors; however, our findings indicate that this is a topic where additional research and discourse is desired to inform clinical practice (Kelsey, Stiles, Spiller, & Diekhoff, 2013).

Intersectionality was a frequently mentioned area of concern for MHPs (21%). In this study, MHPs communicated that intersectionality is relevant to the SGM patients whom they treat and requires additional research focus. We know that heteronormative (the assumption that all people are heterosexual) biases from society, cisgenderism (the assumption that all people belong to a binary gender identity that aligns with the sex assigned to them at birth), racism, and other forms of stigma are linked to increased health disparities (Wallace & Santacruz, 2017). By incorporating research agendas that are cognizant of the intersecting identities that affect the experiences and health outcomes of SGM people, MHPs can incorporate research results into their clinical practices that provide more nuanced context and are representative of their patients. As it stands, research that accounts for only one aspect of a patient's identity raises the question of the generalizability of the results to patient populations with multiple intersecting identities.

Future research

Our results pointed to several SGM research areas prioritized by MHPs. Systematic reviews have been conducted on four of the top five items with the highest means in our study ("stressors related to gender and sexual

minority status,” “depression,” “intimate relationships,” and “suicide”) suggesting that there has been a significant focus on SGM-specific research regarding these topics, yet these research efforts focus on the existence of these problems and do not provide specific treatment guidance. Both MHPs and researchers have focused on these topics because they are important to the health of SGM people and represent significant health disparities among SGM people (e.g., suicidality, depression, and minority stress; Hatzenbuehler & Pachankis, 2016; Plöderl & Tremblay, 2015; Valentine & Shipherd, 2018; White Hughto, Reisner, & Pachankis, 2015). While work on the existence of these health disparities is an important first step, additional work is required to provide guidance to empirically supported treatments for these important focus areas. Additionally, MHPs called for more information on relationships (i.e., sexual, familial, and community), suggesting that more work can be done on understanding these social structures and relationships among SGM people. Our results also suggest the need for additional focus on intersectional identities, wellbeing, and access to health care among SGM people.

One of the greatest barriers to implementation of evidence-based practice standards, aside from the paucity of diversity within the available research itself, is the dissemination of relevant practice recommendations and current research to health care professionals (Oh et al., 2015; Okamura, Nakamura, Mueller, Hayashi, & Higa-McMillan, 2016). Future research could identify how MHPs seek to update their knowledge and treatment methods, so that research results can successfully be disseminated and optimized to reach MHPs in a timely manner, offering SGM patients the most up-to-date practice recommendations in their treatment.

Limitations

This study has several limitations. Sampling bias is present due to the lack of random sampling (e.g., the use of professional organizations as a means of recruitment). This omits potential respondents who are not members of SGM-focused professional organizations but may still treat a significant number of SGM people in their practice. This sampling bias may limit the generalizability of these findings. A significant portion of the participants work in outpatient settings (74%), also limiting generalizability to other settings such as inpatient treatment. Rural MHPs were largely absent from the study sample, limiting knowledge regarding research priorities among SGM people who may be most isolated. The use of a Likert-scale does not yield qualitative information on the reasoning behind participants’ topic prioritization and we also observed a tendency toward rating a high number of items as “extremely” important.

Conclusion

“Stressors related to SGM status,” “suicide,” “substance use,” “intimate relationships,” and “lifestyle factors that support emotional resilience and wellbeing” were respondents’ highest research priorities and were aligned with current SGM health research, affirming continued research in these areas. Expansion is needed to enhance the clinical implications of this research through intervention-based studies among SGM people. MHPs expressed a need for research that addresses the variations in the composition of relationships (familial, sexual, and community), the nuances of intersectional identities related to race/ethnicity or other identities, the wellbeing of SGM people, and access to care including health care professionals, services, and treatments. This is an area that has received limited attention and MHPs have communicated the importance of these topics to their clinical practice treating SGM patients. Continuation of MHP involvement in research prioritization will generate a research agenda that is in line with what clinicians observe in practice that will be most relevant for the patient populations they serve.

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References

- Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*(5), 943–951. doi:[10.2105/AJPH.2013.301241](https://doi.org/10.2105/AJPH.2013.301241)

- Brownson, R. C., Kreuter, M. W., Arrington, B. A., & True, W. R. (2006). Translating scientific discoveries into public health action: How can schools of public health move us forward? *Public Health Reports*, 121(1), 97–103. doi:[10.1177/003335490612100118](https://doi.org/10.1177/003335490612100118)
- Carbado, D. W., Crenshaw, K., Mays, V., & Tomlinson, B. (2013). INTERSECTIONALITY: Mapping the movements of a theory. *Du Bois Review: Social Science Research on Race*, 10(2), 303–312. doi:[10.1017/S1742058X13000349](https://doi.org/10.1017/S1742058X13000349)
- Concannon, T. W., Fuster, M., Saunders, T., Patel, K., Wong, J. B., Leslie, L. K., & Lau, J. (2014). A systematic review of stakeholder engagement in comparative effectiveness and patient-centered outcomes research. *Journal of General Internal Medicine*, 29(12), 1692–1701. doi:[10.1007/s11606-014-2878-x](https://doi.org/10.1007/s11606-014-2878-x)
- Flentje, A., Bacca, C. L., & Cochran, B. N. (2015). Missing data in substance abuse research? Researchers' reporting practices of sexual orientation and gender identity. *Drug and Alcohol Dependence*, 147, 280–284. doi:[10.1016/j.drugalcdep.2014.11.012](https://doi.org/10.1016/j.drugalcdep.2014.11.012)
- Gliem, J. A., & Gliem, R. R. (2003). *Calculating, interpreting, and reporting Cronbach's alpha reliability coefficient for likert-type scales*. In Midwest Research to Practice Conference in Adult, Continuing, and Community Education, The Ohio State University, Columbus, OH. pp. 82–88.
- Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2014). Minority stress and substance use in sexual minority adolescents: A meta-analysis. *Prevention Science*, 15(3), 350–363. doi:[10.1007/s11121-013-0393-7](https://doi.org/10.1007/s11121-013-0393-7)
- Hatzenbuehler, M. L., & Pachankis, J. E. (2016). Stigma and minority stress as social determinants of health among lesbian, gay, bisexual, and transgender youth. *Pediatric Clinics of North America*, 63(6), 985–997. doi:[10.1016/j.pcl.2016.07.003](https://doi.org/10.1016/j.pcl.2016.07.003)
- Heck, N. C., Mirabito, L. A., LeMaire, K., Livingston, N. A., & Flentje, A. (2017). Omitted data in randomized controlled trials for anxiety and depression: A systematic review of the inclusion of sexual orientation and gender identity. *Journal of Consulting and Clinical Psychology*, 85(1), 72–76. doi:[10.1037/ccp0000123](https://doi.org/10.1037/ccp0000123)
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*, 43(5), 460–467. doi:[10.1037/a0029597](https://doi.org/10.1037/a0029597)
- Institute of Medicine. (2009). *Initial national priorities for comparative effectiveness research*. *Critical Values*, 3, 16–19. doi:[10.1093/criticalvalues/3.1.16](https://doi.org/10.1093/criticalvalues/3.1.16)
- Institute of Medicine. (2011). *Health of lesbian, gay, bisexual, and transgender populations*. Washington, DC: The National Academies Press. doi:[10.17226/13128](https://doi.org/10.17226/13128)
- James, S. E. E., Herman, J. L. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. transgender survey*. Washington, DC: DC.
- Kelsey, K., Stiles, B. L., Spiller, L., & Diekhoff, G. M. (2013). Assessment of therapists' attitudes towards BDSM. *Psychology and Sexuality*, 4(3), 255–267. doi:[10.1080/19419899.2012.655255](https://doi.org/10.1080/19419899.2012.655255)
- King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8(1), 70. doi:[10.1186/1471-244X-8-70](https://doi.org/10.1186/1471-244X-8-70)
- Livingston, N. A., Flentje, A., Heck, N. C., Szalda-Petree, A., & Cochran, B. N. (2017). Ecological momentary assessment of daily discrimination experiences and nicotine, alcohol, and drug use among sexual and gender minority individuals. *Journal of Consulting and Clinical Psychology*, 85(12), 1131–1143. doi:[10.1037/ccp0000252](https://doi.org/10.1037/ccp0000252)
- Logie, C. H., & Lys, C. (2015). The process of developing a community-based research agenda with lesbian, gay, bisexual, transgender and queer youth in the Northwest

- Territories, Canada. *International Journal of Circumpolar Health*, 74(1), 28188. doi:[10.3402/ijch.v74.28188](https://doi.org/10.3402/ijch.v74.28188)
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. doi:[10.1037/0033-2909.129.5.674](https://doi.org/10.1037/0033-2909.129.5.674)
- Morris, R. L., Stocks, S. J., Alam, R., Taylor, S., Rolfe, C., Glover, S. W., ... Campbell, S. M. (2018). Identifying primary care patient safety research priorities in the UK: A James Lind Alliance Priority Setting Partnership. *BMJ Open*, 8(2), e020870. doi:[10.1136/bmjopen-2017-020870](https://doi.org/10.1136/bmjopen-2017-020870)
- Oh, S. S., Galanter, J., Thakur, N., Pino-Yanes, M., Barcelo, N. E., White, M. J., ... Burchard, E. G. (2015). Diversity in clinical and biomedical research: A promise yet to be fulfilled. *PLoS Medicine*, 12(12), e1001918. doi:[10.1371/journal.pmed.1001918](https://doi.org/10.1371/journal.pmed.1001918)
- Okamura, K. H., Nakamura, B. J., Mueller, C., Hayashi, K., & Higa-McMillan, C. K. (2016). An Exploratory factor analysis of the knowledge of evidence-based services questionnaire. *The Journal of Behavioral Health Services & Research*, 23(2), 214–232. doi:[10.1007/s11414-013-9384-5](https://doi.org/10.1007/s11414-013-9384-5)
- Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology*, 35, 888–901. doi:[10.1093/ije/dyl056](https://doi.org/10.1093/ije/dyl056)
- Patel, K. (2010). Health reform's tortuous route to the patient-centered outcomes research institute. *Health Affairs*, 29(10), 1777–1782. doi:[10.1377/hlthaff.2010.0874](https://doi.org/10.1377/hlthaff.2010.0874)
- Plöderl, M., & Tremblay, P. (2015). Mental health of sexual minorities. A systematic review. *International Review of Psychiatry*, 27(5), 367–385. doi:[10.3109/09540261.2015.1083949](https://doi.org/10.3109/09540261.2015.1083949)
- Reisner, S. L., Pardo, S. T., Gamarel, K. E., Hughto, J. M. W., Pardee, D. J., & Keo-Meier, C. L. (2015). Substance use to cope with stigma in healthcare among U.S. female-to-male trans masculine adults. 2(4), 324–332. doi:[10.1089/lgbt.2015.0001](https://doi.org/10.1089/lgbt.2015.0001)
- Rubel, A. N., & Burleigh, T. J. (2018). Counting polyamorists who count: Prevalence and definitions of an under-researched form of consensual nonmonogamy. *Sexualities*, 1–25. doi:[10.1177/1363460718779781](https://doi.org/10.1177/1363460718779781)
- Selby, J. V., Beal, A. C., & Frank, L. (2012). The Patient-Centered Outcomes Research Institute (PCORI) national priorities for research and initial research agenda. *JAMA*, 307(15), 1583–1584. doi:[10.1001/jama.2012.500](https://doi.org/10.1001/jama.2012.500)
- Sinha, I. P., Smyth, R. L., & Williamson, P. R. (2011). Using the Delphi technique to determine which outcomes to measure in clinical trials: Recommendations for the future based on a systematic review of existing studies. *PLoS Medicine*, 8(1), e1000393. doi:[10.1371/journal.pmed.1000393](https://doi.org/10.1371/journal.pmed.1000393)
- Valentine, S. E., & Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology Review*, 66, 1–15. doi:[10.1016/j.cpr.2018.03.003](https://doi.org/10.1016/j.cpr.2018.03.003)
- Vries, K. M. (2012). Intersectional identities and conceptions of the self: The experience of transgender people. *Symbolic Interaction*, 35(1), 49–67. doi:[10.1002/symb.2](https://doi.org/10.1002/symb.2)
- Wallace, B. C., & Santacruz, E. (2017). LGBT psychology and ethnic minority perspectives: Intersectionality. In R. Ruth & E. Santacruz (Eds.), *LGBT psychology and mental health: Emerging research and advances* (pp. 87–108). Santa Barbara, CA: ABC Clío.
- White, M. D., & Marsh, E. E. (2006). Content analysis: A flexible methodology. *Library Trends*, 55(1), 22–45. doi:[10.1353/lib.2006.0053](https://doi.org/10.1353/lib.2006.0053)
- White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, 147, 222–231. doi:[10.1016/j.socscimed.2015.11.010](https://doi.org/10.1016/j.socscimed.2015.11.010)

- Woodward, E. N., Banks, R. J., Marks, A. K., & Pantalone, D. W. (2017). Identifying resilience resources for HIV prevention among sexual minority men: A systematic review. *AIDS and Behavior*, 21(10), 2860–2873. doi:[10.1007/s10461-016-1608-2](https://doi.org/10.1007/s10461-016-1608-2)
- Zelle, A., & Arms, T. (2015). Psychosocial effects of health disparities of lesbian, gay, bisexual, and transgender older adults. *Journal of Psychosocial Nursing and Mental Health Services*, 53(7), 25–30. doi:[10.3928/02793695-20150623-04](https://doi.org/10.3928/02793695-20150623-04)