Queer Cyprus Association

MENTAL HEALTH BOOKLET

OCTOBER | 2020

The Diversity of Colours Project is funded by the European Union under the Cypriot Civil Society in Action VI Grant Scheme and implemented by the Queer Cyprus Association. This publication was produced with the financial support of the European Union. Its contents are the sole responsibility of the Queer Cyprus Association and do not necessarily reflect the views of the European Union.

QUEER CYPRUS

LGBT|+ DIVERSITY OF COLOURS

ABOUT THE DIVERSITY OF COLOURS PROJECT:

Diversity of Colours Project: towards a Cyprus where all colours, lesbian, gay, bisexual, trans, intersex and many more (LGBTI+), can be together! The Diversity of Colours Project aims to prevent discrimination and make human rights for LGBTI+ more accessible in the northern part of Cyprus. The Diversity of Colours Project, which started in December 2018 and will continue for three years, is funded by the European Union under the Cypriot civil society in action VI grant scheme and is implemented by Queer Cyprus Association.

CONTENT:

FOREWORD

As Queer Cyprus Association, we have been working to eliminate discrimination towards individuals of diverse sexual orientations and gender identities including lesbian, gay, bisexual, trans, intersex and beyond, and ensuring equal access to human rights in the northern part of Cyprus for years. Besides our rights-based struggle, we also work on the topic of mental health which is reflected through the services we provide. Therefore, we provide psychological, legal and social services support to individuals who contact us via the Solidarity Line.

While LGBTI+ existences were questioned as to whether or not they were "diseases" during the recent history of the literature on psychology, recent scientific studies have raised awareness and come to be more inclusive. The booklet, which begins with the historical process, tackles a variety of issues such as mental health of LGBTI+ youth, social stigmatization, coming out to family, romantic relationships, intimate partner violence, discrimination and coping strategies.

Us LGBTI+'s are exposed to different forms of prejudice, discrimination, stigmatization and violence in various stages of our lives which begins before our birth and may even continue after our death. Needless to say, experiencing such situations may have a severe negative influence on our mental health in addition to our physical well being. We are aware that although health may seem individual, it is highly connected to societal structures which means that societal pressures impact mental health. Therefore, this booklet on mental health aims to explore the topic which is frequently ignored and to provide a new resource to the literature on mental health.

Prof. Dr. Şenel Hüsnü Raman, Dr. Seven Kaptan and Psychologist Ziba Sertbay, MSc. worked tirelessly to prepare this booklet. The combination of Prof. Dr. Şenel Hüsnü Raman's literature review and Dr. Seven Kaptan's field experience, Queer Cyprus Association's first booklet on LGBTI+ Mental Health, which you are currently holding, was created. We would like to thank our authors for their tireless efforts to fit the extensive topic of mental health in a booklet.

Queer Cyprus Association

HISTORICAL CONTEXT OF HOMOSEXUALITY AND TRANSGENDER & GENDER NONCONFORMİNG

In 1975, the American Psychiatric Association (APA) adopted a resolution stating that "homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities" and urging "all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations".[1] Prior to this, APA's Diagnostic and Statistical Manual of Mental Disorders (DSM) listed homosexuality as a "sociopathic personality disturbance".[2] This historic removal was partly based on pioneering research on the prevalence of same-sex sexuality[3,4,5] as well as research conducted by Evelyn Hooker (1957) [6] who matched gay men with their heterosexual counterparts to assess their psychological functioning. She further asked a panel of professional psychologists to rate the mental health of the men and predict who was gay and who was heterosexual. She found no significant differences in the mental health ratings and the panel of experts was unable to predict the sexual orientations of the men. Slowly, similar empirical evidence began to accumulate and challenge the historical assumption of differences in psychological adjustment between individuals based on sexual orientation, including cognitive, abilities[7], psychological functioning,[8,9] psychological well-being and self-esteem,[10-12] and psychopathology. [13] Furthermore, analyses of research claiming differences between heterosexuals and gay, lesbian or bisexual people have found serious flaws in methodology as well as psychometric measurement tools used.[8] Any differences that have been found between homosexual and heterosexual individuals with regards to psychological adjustment and functioning have been linked to exposure to stigma and discriminatory practices[14 ,15,16] and to the deleterious effects of stress related to stigmatization based on sexual orientation.[17]

As for transgender and gender nonconforming (TGNC), debates continue regarding the diagnoses of gender identity as a disorder. Gender identity disorder (GID) of children (GIDC) and transsexualism was introduced into the third edition of DSM[18]. However, the DSM-IV[19] combined diagnoses of GIDC and transsexualism into GID. Further criticism due to the stigma and restrictions associated with GID, led the American Psychiatric Association (2013) [20] to adopt

gender dysphoria in the DSM-5 instead of GID. Some have celebrated the introduction of gender dysphoria for removing the pathologizing nature of GID and recognizing instead the distress associated with the discordance between assigned sex at birth and gender identity, as well as acknowledging a gender spectrum of many gender identities and expressions.[21] Others however have argued that any form of diagnosis still pathologizes as well as labels individuals as having a 'disorder'.[22] Further concerns have been shared that removal of a gender identity diagnosis altogether might restrict or eliminate insurance coverage of gender-affirming medical treatment such as hormone treatment or body modifications.[23] In a historical move in 2018, the World Health Organization (WHO) announced that the International Statistical Classification of Diseases and Related Health Problems (ICD), now in its 11th edition, had redefined gender-identity related health by removing gender incongruence out of the 'mental and behavioral disorders' chapter to 'conditions related to sexual health' lending evidence to the fact that diverse gender-identities are no longer considered conditions of mental health-related disorders. This recognition by WHO and ICD-11 also aims to ensure gender-affirmative health care by trans and gender non-conforming people.[24]

Today, the scientific community is in agreement that sexual orientation and gender identity are diverse variants of human nature. A person's sexual orientation does not always have clear cut, definable categories such as 'heterosexual' 'gay' 'lesbian' or 'bisexual' and recognizes that sexuality instead occurs on a continuum [25,26,27] and might be fluid for some, particularly women.[28,29] Similarly, gender expression may or may not be consistent with the gender roles prescribed by one's society, and may or may not reflect one's gender identity. In this handbook, we focus on sexual orientations and gender identities that have been investigated most commonly by the scientific community while recognizing that we have not been able to cover the full diverse spectrum.

MENTAL HEALTH OF LGBTI+ YOUTH

Social Stigma

More recently, the focus of the psychological community has moved from linking mental health to homosexuality but instead on addressing the social factors associated with LGBTI+ mental health. One such factor is stigmatization or homo-, bi- and transphobia. The term homophobia has been widely used to describe cultural stigma aimed at gay, or, lesbian individuals (LG); while the term transphobia has been used to refer to stigma against transgender individuals.[30] Biphobia, on the other hand, can be defined as negative attitudes about bisexuality and bisexual individuals[31] and is thought to differ from homophobia, since bisexual individuals are thought to face "double discrimination" from both heterosexuals and LGs.[32] Transphobia is distinct from homophobia and biphobia; while transphobia is a fear of non-conformity with expected gender and gender identity, homophobia and biphobia is concerned with one's sexual orientation.[33,34] Over the past three decades, a growing body of literature has increased understanding of sexual stigma against LGB's or sexual minorities. A more limited amount of information is available regarding stigma related to gender minorities or transgenders, with some suggestion that transgenders and LGB's who violate gender-role norms may be among the most marginalized of sexual minorities. [35,36]

Risk Factors

An overwhelming body of evidence shows that LGB persons are at greater risk for poor mental health, including increased rates of depression and mood disorders [37,38], anxiety disorders [15] posttraumatic stress disorder [39], alcohol use and abuse,[40] and suicide ideation and attempts.[15,16]

Transgender individuals have on the other hand been found to be even more stigmatized in society than lesbian, gay, and bisexual youth,[41] therefore, being at a higher risk of victimization[42] and mental health issues including post traumatic stress disorder (PTSD) and suicidal ideation. [42,43] Some transgender individuals might also experience marked distress or impairment resulting from the discrepancy of their assigned sex (at birth) and their own gender identity.[20] Relatedly, adding to their victimization, many transgender people report experiences of mistreatment in healthcare settings, including being denied medical care simply due to being transgender,[44] exposure to harsh language, blame for their health issues, or not being called by preferred pronouns [45,46,47] Such stigma can lead to more mental health problems. This might also lead to a lack of necessary medical care, often leading to some transgender people to resort to using hormones acquired through someone other than a doctor.[48] Such 'street hormones' can pose severe health risks if they contain a dangerous substance, which is likely since they are not regulated. [49,50]

Mental health issues are exacerbated with certain risk factors, for instance living in contexts in which anti-bullying policies are not prevalent,[51] residing in places in which LGBTI+-motivated assaults or hate crimes are common [52] as well as attending schools without protective policies[53] have all been found to increase LGBTI+ youths' suicidal ideation and suicide attempts compared to youth living in areas where protective policies are commonplace. These findings demonstrate that when institutionalized support is lacking and when LGBTI+ discrimination is prevalent at both a social and cultural level this will have severe repercussions for the well-being and mental health of LGBTI+ youth.

Relatedly, relationships with parents and family are also crucial for the mental health of LGBT youth.[54] Youth who report higher levels of family rejection have been found to be at greater risk for depressive symptoms, anxiety, suicidal

ideation, and suicide attempts. [55,56] Similarly, levels of depression and anxiety are higher in those LGBTI+ youth who fear rejection from family and friends.[56] Additionally, a lack of emotion regulation, maladaptive coping behaviors in response to prejudice or discrimination in LGBTI+ youth has been found to be associated with later symptoms of depression and anxiety and higher levels of psychological distress[57].

LGBTI+ cyberbullying is a unique type of cyberbullying which is targeted at an LGBTI+ individual or community due to their sexual orientation or gender identity. This victimization can involve technologies such as Internet websites, e-mails, chat rooms, text messaging, and instant messaging. There are several examples of cyberbullying instances experienced by LGBTI+ individuals including receiving cruel or intimidating messages, "hate mail" (or "cyberharassment"), posting anonymous derogatory comments about a person, "outing" a person's sexual orientation or gender identity to classmates or parents, as well as sending threatening messages (known as 'cyberstalking').[58] Experiencing LGBTI+ cyberbullying has been linked to lowered mental health including depression, low self- esteem and suicidal ideation and attempts as well as behavioral negative effects such as increased physical aggression and isolation. It has also been found to impact LGBTI+ youths' academic performance and lower their Grade Point Average (GPA) [59].

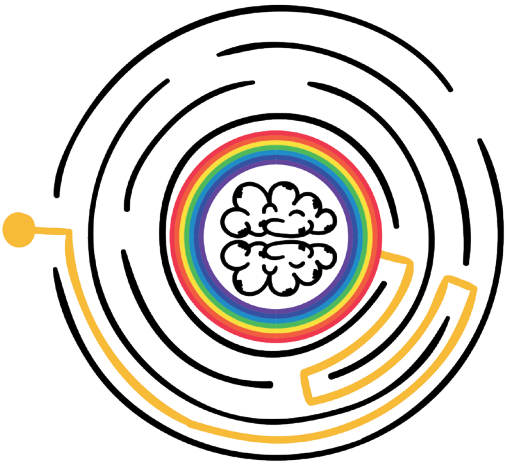
Another sexual minority group that might experience unique mental health issues due to discrimination and unethical medical interventions are intersex individuals- those individuals born with ambiguous genitalia, sex organs, or sex chromosomes might also experience unique mental health issues. [60] The medical community usually encourages families of intersex children to allow them to perform non-life saving, 'correcting' surgery of the genitals.[61] This has however been strongly refuted by intersex organizations and human rights groups which believe such unnecessary and often unethical medical procedures only serve to reinforce the shame and secrecy associated with intersex conditions and are the result of a presumption of 'standards' for the male and female body. Gender 'normalizing' surgery does not guarantee an associated gender identity and might, therefore, result in the individual wanting the bodily tissue that was removed as a result of surgery. It is, therefore, necessary that only medical practices that are vital for the physical health of the individual be

performed (e.g.endocrinological treatments). Any other types of surgery (e.g. gender assignment or vaginoplasty) should only be conducted if it is wanted by the intersex child, who is at a mature enough age to make an informed decision. There is no evidence showing that children who grow up with intersex sex organs have worse mental health, however, there is substantial evidence showing that those intersex children surgically 'treated' suffer both physically as they are often subjected to several operations as well as psychologically in reduced well-being plus lack of trust in the medical community. [62]

A seriously harmful practice for LGBTI+'s mental health is the so-called 'conversion therapy' (also known as 'reparative therapy') which is a range of harmful and discredited practices that lack medical justification, aimed at changing one's sexual orientation, gender identity or gender expression. Research findings show that conversion therapy fails at achieving a sustained change in an individual's sexuality.[63] It instead causes a clear potential risk for mental health of those engaged in these therapies and has been linked to depression, anxiety, and self-destructive behaviors.[20] Furthermore, LGBTI+ youth report perceiving these 'therapies' as further rejection from their families, undermining their self-esteem and mental health.[64] Worldwide, attempts are being made to prevent therapists from conducting conversion therapies with minors.[20]

Little attention has been given to older LGBTI+ people's mental health, which might result in a lack of care from social services to residential care.[65] Specifically, studies conducted with older LGBTI+ people have found higher levels of reported loneliness as well as concerns of being left unsupported and alone in later life.[66] In one study, LG adults reported feeling that they would have no one to receive emotional support from in later life, particularly by gays than lesbians.[67] Similarly, another study with older LGBTI+ adults found that loneliness was associated with lower mental health, higher psychological distress particularly in those LGBTI+ adults not in a romantic relationship and living alone.[68] Despite there being no research conducted with transgender or intersex older people regarding this, it is assumed that loneliness might also be a significant concern for transgender people since they might be more at risk of losing their support system as a result of transitioning. [69]

One last factor that has a negative influence on the mental health of LGBTI+ individuals can occur during public health crises such as the COVID-19 pandemic or the Ebola outbreak. Not only are the unique needs of LGBTI+'s exacerbated during such periods but they can lead to the scapegoating of minority groups, in which they are blamed as the cause of an outbreak or even natural disasters.[70] Experiencing such stigmatization and discrimination can lead to the reduced well-being of LGBTI+ individuals.



THE COMING OUT PROCESS

Heteronormativity is a socially constructed concept which suggests that heterosexuality is the superior, normal and natural sexual identity which at the same time trivializes, undermines, and sees any non-heterosexual behavior, identity, relationship, or community as inferior.[71] As part of a heteronormative culture, every individual is assumed to be heterosexual and cisgender, therefore causing a need for LGBTI+'s to 'come out' - the process of disclosing one's sexual or gender identity as non-heterosexual or gender non-conforming. [12,72]

Coming out in LGs

Sexual orientation identity development has been described in the literature in terms of theoretical stage models of increasing adaptation and identification as gay or lesbian, commonly known as the coming-out process. [12,72-74]

Though the names and number of the stages may vary from theory to theory, they share commonalities in that the process mainly includes identity formation and integration.[75] Characteristically, models commence with a stage in which the individual uses some defence mechanisms to ignore feelings of same-gender attraction. This process of denial is thought to have negative costs in terms of well-being and has been labelled 'internalized homophobia'.[34] However, for many a slow acquisition of same-gender feelings develop as they accept

non- heterosexually oriented feelings. In line with this emergence of same-gender attraction, a period of experimentation with homosexuality occurs. The individual deals with the anxiety evoked from internalized homophobia, either through their own efforts and research or through support provided by health care professionals, in which eventually a sense of identity as gay or lesbian becomes internalized and is viewed as a normal and positive aspect of the self.

Although most researchers have described the coming-out process in clear stages, they do acknowledge that it can also be fluid, without universal linearity or hierarchical progression but include backtracking, halts, and starts.[12,73,74,76] For instance, coming out for lesbians in a patriarchal society can be different from a male coming out in such a community, and similarly, a lesbian of color might experience the coming out process differently to a white middle-class lesbian.[77] Therefore, there is huge diversity within the LGBTI+ community in terms of their experiences of coming out which might be influenced by an intersection of several factors including age, socio-economic status, disability, etc.[78]

Coming Out in Bisexual individuals

The identity process of bisexuals may differ from LGs.[13,79] Some people may first self-label as lesbian or gay, only then coming to a bisexual identity, or, only after having experienced heterosexual relationships. Alternatively, others may have bisexual feelings stemming from childhood. Coming out may especially be challenging for bisexual people as bisexuality has consistently been an 'invisible', 'excluded', or 'silent' sexuality within several fields from popular media and fields of psychology and sex research to LG communities and policy legislators.[80] This is because in many cultures there is a binary understanding of sexuality as either heterosexual or homosexual, therefore bisexuals are often assumed to be going 'through a phase' on the way to either a heterosexual or lesbian/gay identity.[28] Coming out for bisexuals may also be problematic if they feel that they might experience double discrimination from both heterosexual and LGT groups.[71]

Coming out in TGNC

The stages that TGNC people move through might differ. According to one model of transgender emergence, the stages include (1) awareness, (2) seeking information/reaching out, (3) disclosure to significant others, (4) exploration: identity and self-labeling, (5) exploration: transition issues/possible body modification, and (6) acceptance and post-transition issues.[81] The duration of experiencing these stages may differ from one person to the other once again, highlighting the diverse nature in which the coming out process might occur.

Coming Out & Families

Coming out to parents is often most feared by LGBTI+ youth [12,82] as they may be rejected by parents as a result of their identities.[36,56] This is evidenced in the high rates of homeless LGBTI+ youth in comparison to the general population.[83] For parents, it has often been found that they might also experience a 'coming out' process along with their offspring, reporting experiencing parallel emotions to that of their children, in which they may fear their child's safety and future success whether it be academically or personally.[84,85] They may also fear rejection in the form of being cut off from family, friends, or community and also report a sense of loneliness or alienation.[86] Due to such fears, family members may vary in the amount of support they offer their children.[81,85,87,88] However, when parents and family members are able to put aside their own anxieties and provide their LGBTI+ children with the necessary support, this has consistently been found to lead to positive mental health outcomes.[89,90] Denial and rejection from parents and family members do not lead to the removal of the identity but only fuels poorer familial relationships and negative mental health for their offspring.

Although up to now we have covered LGBTI+ youth coming out to peers and parents, it is also possible that the opposite process also occurs in which parents come out to their children. Parents may have several concerns when disclosing their sexual orientation to their children such as wanting to wait for the right age of the child, fear of losing custody to an ex-spouse, or perceived difficulty of being a 'different' type of family.[91,92] Parents have reported receiving several different reactions from their children after coming out to them including anger,

making light of it, indifference, refusal in discussing it, to being thankful for their honesty.[93,94] Despite this process potentially being a stressful one, research findings have shown that disclosure of parental sexual orientation can lead to a deepening of the relationship. [91] It is also worthy to say that a substantial body of research has found that there are no differences in terms of the psychosocial development of children raised by LGBTI+ parents compared to those raised by heterosexual parents.[95-97] Additionally, contrary to popular belief, having LGBTI+ parents has no further impact on the child's own sexual orientation.[95,96]

ROMANTIC RELATIONSHIPS IN LGBTI+ INDIVIDUALS

Romantic relationships are an important and natural part of development for adolescents,[98] however LGBTI+ youth often report fear and lower expectations for romantic satisfaction as well as less control in being able to find suitable romantic partners.[99] This fear may be due to the experience by LGBTI+ youth of certain social barriers including limited access to dating partners, the stress associated with pursuing intimacy with same-sex partners in a heteronormative climate, and the constraints of same-sex romantic behavior in educational settings.[99,100] Not being able to experience romantic relationships may have mental health implications both during adolescence and in future years to come.[100-102] It is therefore not surprising that studies have shown that having same-sex romantic partners is related to better psychological well-being, increased self-esteem, decreased internalized homophobia, and lower substance use for LGB youth. [102-104]

Intimate Partner Violence (IPV) in LGBTI+ Romantic Relationships

There exists limited research on the IPV experienced by LGBTI+'s, however, it has been found to occur as often as, if not more, than that in heterosexual relationships.[105] In a comprehensive review of studies conducted in the USA, it was found that bisexual women were over twice as likely to experience IPV compared to their heterosexual counterparts and that the prevalence of IPV is higher in transgender people.[106] There seems to be some consensus in the literature that one of the most common types of violence in LGBTI+ relationships is verbal abuse followed by physical violence, unwanted sexual activity as well as emotional abuse. [107,108] One reason why LGBTI+'s might experience higher rates of IPV is the unique stressors they experience, such that higher levels of anxiety and depression have been linked to victimization. [109]

Resiliency, social support, and relationship quality are some of the protective factors that have been associated with the reduced risk of IPV. [110,111]

COPING STRATEGIES AND PROTECTIVE FACTORS FOR LGBTI+

Research has mainly focused on risk factors rather than protective factors for LGBTI+ youth. Among the limited studies, the following have been considered as protective factors:

Parental Support

Perhaps one of the most critical protective factors for LGBTI+ youth is the support of parents, which has consistently been found to be related to self-acceptance, positive mental health, higher well-being, and self-esteem.[89,90] Unfortunately, many LGBTI+ youths report receiving lower levels of parental support with regards to their sexuality when compared to other forms of support and this support has been found to be even lower in transgender youth.[112] However, when provided, parental support specific to sexuality and gender expression, has been consistently found to buffer from the risk factors of stigmatization and victimization as well as reduced suicidal ideation and depressive symptomatology.[112,113]

Peer Support

Research has revealed that those LGB youth who retained their friends after coming out reported higher levels of self-esteem, lower levels of depressive symptoms, and less suicidal ideation than those who had lost friends as a result of disclosing their sexual identity. Relatedly, those LGB youth who reported having other LGB friends were found to have fewer feelings of victimization as well as lower levels of depression over time.[114] It has also been found that have having LGBTI+ friends lead to more LGBTI+ supportive behavior such as intervening in response to homophobic remarks.[115]

Coming Out

Revealing one's sexual orientation or gender identity has consistently been found to put LGBTI+ youth at greater risk for verbal and physical harassment [116] and increases the likelihood of losing close friends.[55,99] Despite this, it has also been found that those adults who come out to others and are received by acceptance and affirmation show positive psychosocial adjustment. [116-118] Similarly, in a sample of LGBTI+s who reported being out during high school showed greater overall well-being years later during their young adulthood.[119] These findings suggest that although there are risks associated with coming out during high school, it can have positive buffering effects of psychosocial adjustment.

School Safety

Findings have shown that there is an increased risk for victimization and bullying of LGTBI+ in schools.[120] Therefore, the presence of inclusive policies and programs implemented in the school environment is critical to counteract a negative school environment for LGBTI+ youth. Among the various programs developed in schools worldwide, to name a few: a 'zero tolerance to discrimination and harassment' policy; LGBTI+ inclusive curriculum; Gay-Straight Alliance (GSA's-school-based support groups or clubs) and educational programs for students, teachers, and parents. Some of the most effective have been groups such as GSAs that have been found to improve the social climate in the school[121] and have positive mental health benefits for LGBTI+'s including enhanced feelings

of safety and reduced depressive symptomatology, substance use and suicidal ideation.[122] Additionally, teaching LGBTI+ inclusive curriculum, giving staff training regarding LGBTI+ issues, and also showing support through visual displays of acceptance and affirmation of LGBTI+ students in the form of media such as flyers or posters have all been found to be effective strategies in schools. [123] Also, the presence of 'safe spaces' within schools is critical to inform LGBTI+ youth as to whom it is safe to talk to about their concerns.[124] Further practices, such as 'diversity days' in which diversity of gender and sexual identity are celebrated, historical events or people from the LGBTI+ community are introduced to the educational program, can serve to create an inclusive school environment of safety and acceptance.[125]

Community-Based Organizations (CBOs)

CBOs have been implemented in the well-being and health of LGBTI+ individuals for a long period.[126] The majority of such organizations, such as Queer Cyprus Association, support LGBTI+ youth by peer support groups, educational programs, legal advice, as well as psychological and medical referrals.[127] Other researchers have found that these organizations create a safe space in which LGBTI+ youth can find peers that will support their identities, enhancing feelings of solidarity and alleviating feelings of isolation.[128] There exists a clear link between participation in CBOs and positive mental health in LGBTI+'s, including higher well-being, self-esteem, and lower substance use.[129]

Coping Strategies with Stress

Based on the research and findings covered in this handbook, we provide the following recommendations for empowerment and coping with the unique stressors LGBTI+ individuals may encounter in their daily lives:

- Connect and affiliate with allies such as Gay-Straight Alliances, other LGBTI+ youth, or, LGBTI+ role models.

- Access LGBTI+ focused CBOs for support, advice, and solidarity.

- Refrain from avoidance-based coping strategies such as dismissing or avoiding a stressor.

- Engage in approach–based coping strategies such as learning to take care of oneself and seeking support from others.

- Effectively manage stress by attempting to find meaning to it, by seeing it as an opportunity for growth, increased personal sense of strength, and a change in priorities.

- Practice self-care, both physically and emotionally, by seeking help when needed, experiencing emotions of empathy, and practicing relaxation and mindfulness.

- And don't forget - we are all beautiful exactly the way we are!

REFERENCES:

1. Conger JJ. Proceedings of the American psychological association, incorporated, for the year 1974: Minutes of the annual meeting of the council of representatives. American Psychologist. 1975;30(6):620.
2. Association AP, Nomenclature Co, Statistics. Diagnostic and statistical manual: mental disorders. American Psychiatric Association; 1952.
3. Ford CS, Beach FA. Patterns of sexual behavior. 1951.
4. Kinsey A. Age and sexual outlet. Sexual behavior in the human male. 1948:213-262.
5. Kinsey AC, Pomeroy WB, Martin CE, Gebhard PH. Sexual Behavior in the Human Female. Phila-delphia. B Saunders Co. 1953.
6. Hooker E. The adjustment of the male overt homosexual. Journal of projective techniques. 1957;21(1):18-31.
7. Tuttle GE, Pillard RC. Sexual orientation and cognitive abilities. Archives of sexual behavior. 1991;20(3):307-318.
8. D'Augelli AR, Patterson C, Patterson CJ. Lesbian, gay, and bisexual identities over the lifespan: Psychological perspectives. Oxford University Press on Demand; 1995.
9. Pillard RC. Sexual orientation and mental disorder. Psychiatric Annals. 1988;181):52-56.
10. Coyle A. A study of psychological well-being among gay men using the GHQ-30. British Journal of Clinical Psychology. 1993;32(2):218-220.
11. Herek GM. Gay people and government security clearances: A social science perspective. American Psychologist. 1990;45(9):1035.
12. Savin-Williams RC. Gay and lesbian youth: Expressions of identity. Hemisphere Publishing Corp; 1990.
13. Fox R. Bisexuality in perspective. Education, research, and practice in lesbian, gay, bisexual, and transgendered psychology: A resource manual. 2000:161-206.
14. DiPlacido J. Minority stress among lesbians, gay men, and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. Sage Publications, Inc; 1998.
15. Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, Kessler RC. Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. American journal of public health. 2001;91(6):933.
16. Cochran SD, Sullivan JG, Mays VM. Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay,

and bisexual adults in the United States. Journal of consulting and clinical psychology. 2003;71(1):53.
17. Cochran SD. Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? American psychologist. 2001;56(11):931.
18. Spitzer RL, Md KK, Williams JB. Diagnostic and statistical manual of mental disorders. Paper presented at: American psychiatric association1980.
19. DSM-IV. APATFo. Dsm-iv sourcebook. Vol 1: American Psychiatric Pub; 1994.
20. Association AP. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub; 2013.
21. Zucker KJ, Lawrence AA, Kreukels BP. Gender dysphoria in adults. Annual Review of Clinical Psychology. 2016;12:217-247.
22. Drescher J. Gender identity diagnoses: history and controversies. Gender dysphoria and disorders of sex development: Springer; 2014:137-150.
23. Cohen-Kettenis PT, Pfäfflin F. The DSM diagnostic criteria for gender identity disorder in adolescents and adults. Archives of sexual behavior. 2010;39(2):499-513.
24.https://icd.who.int/browse11/lm/en/http%3a%2f%2fid.who.int%2ficd%2fentity%2f577470983.
25. Kinsey AC, Pomeroy WB, Martin CE, Gebhard PH. Sexual behavior in the human female. Indiana University Press; 1998.
26. Shively MG, De Cecco JP. Components of sexual identity. Journal of homosexuality. 1977;3(1):41-48.
27. Klein F, Sepekoff B, Wolf TJ. Sexual orientation: A multi-variable dynamic process. Journal of homosexuality. 1985;11(1-2):35-49.
28. Diamond LM. A dynamical systems approach to the development and expression of female same-sex sexuality. Perspectives on Psychological Science. 2007;2(2):142-161.
29. Peplau LA, Garnets LD. A new paradigm for understanding women's sexuality and sexual orientation. Journal of Social Issues. 2000;56(2):330-350.
30. Hill DB, Willoughby BL. The development and validation of the genderism and transphobia scale. Sex roles. 2005;53(7-8):531-544.
31. Bennett K. Feminist bisexuality: A both/and option for an either/or world. Closer to home: Bisexuality and feminism. 1992:205-231.
32. Ochs R. Biphobia: It goes more than two ways. 1996.
33. Nagoshi Jl, Terrell Hk, Nagoshi Ct, Brzuzy S. The Complex Negotıatıons Of Gender Roles, Gender Identıty, And Sexual Orıentatıon Among Heterosexual,

Gay/Lesbian, And Transgender Individuals. Journal Of Ethnographic & Qualitative Research. 2014;8(4).
34. Warriner K, Nagoshi CT, Nagoshi JL. Correlates of homophobia, transphobia, and internalized homophobia in gay or lesbian and heterosexual samples. Journal of homosexuality. 2013;60(9):1297-1314.
35. Carroll L, Gilroy PJ, Ryan J. Counseling transgendered, transsexual, and gender-variant clients. Journal of Counseling & Development. 2002;80(2):131-139.
36. D'augelli AR, Hershberger SL, Pilkington NW. Lesbian, gay, and bisexual youth and their families: Disclosure of sexual orientation and its consequences. American journal of orthopsychiatry. 1998;68(3):361-371.
37. Bostwick WB, Boyd CJ, Hughes TL, McCabe SE. Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. American journal of public health. 2010;100(3):468-475.
38. Cochran SD, Mays VM, Alegria M, Ortega AN, Takeuchi D. Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexual adults. Journal of consulting and clinical psychology. 2007;75(5):785.
39. Hatzenbuehler ML. How does sexual minority stigma "get under the skin"? A psychological mediation framework. Psychological bulletin. 2009;135(5):707.
40. Burgard SA, Cochran SD, Mays VM. Alcohol and tobacco use patterns among heterosexually and homosexually experienced California women. Drug and alcohol dependence. 2005;77(1):61-70.
41. Ryan C, Futterman D. Lesbian and gay youth: care and counseling. Adolescent medicine (Philadelphia, Pa). 1997;8(2):207-374.
42. Wharton VW. Gender variance and mental health: A national survey of transgender trauma history, posttraumatic stress, and disclosure in therapy. 2007.
43. Haas AP, Rodgers PL, Herman J. Suicide attempts among transgender and gender non-conforming adults: Findings of the national transgender discrimination survey. American Foundation for Suicide Prevention; 2014.
44. Kenagy GP. Transgender health: Findings from two needs assessment studies in Philadelphia. Health & social work. 2005;30(1):19-26.
45. Cruz TM. Assessing access to care for transgender and gender nonconforming people: a consideration of diversity in combating discrimination. Social science & medicine. 2014;110:65-73.
46. Dewey JM. Knowledge legitimacy: How trans-patient behavior supports and challenges current medical knowledge. Qualitative Health Research.

2008;18(10):1345-1355.
47. Grant JM, Motter LA, Tanis J. Injustice at every turn: A report of the national transgender discrimination survey. 2011.
48. Grossman AH, D'augelli AR. Transgender youth: Invisible and vulnerable. Journal of homosexuality. 2006;51(1):111-128.
49. Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. International journal of transgenderism. 2012;13(4):165-232.
50. Williamson C. Providing care to transgender persons: a clinical approach to primary care, hormones, and HIV management. Journal of the Association of Nurses in AIDS Care. 2010;21(3):221-229.
51. Hatzenbuehler ML, Keyes KM. Inclusive anti-bullying policies and reduced risk of suicide attempts in lesbian and gay youth. Journal of Adolescent Health. 2013;53(1):S21-S26.
52. Duncan DT, Hatzenbuehler ML. Lesbian, gay, bisexual, and transgender hate crimes and suicidality among a population-based sample of sexual-minority adolescents in Boston. American journal of public health. 2014;104(2):272-278.
53. Hatzenbuehler ML. The social environment and suicide attempts in lesbian, gay, and bisexual youth. Pediatrics. 2011;127(5):896-903.
54. Steinberg L, Duncan P. Work group IV: increasing the capacity of parents, families, and adults living with adolescents to improve adolescent health outcomes. Journal of Adolescent Health. 2002;31(6):261-263.
55. D'Augelli AR. Lesbian and bisexual female youths aged 14 to 21: Developmental challenges and victimization experiences. Journal of lesbian studies. 2003;7(4):9-29.
56. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics. 2009;123(1):346-352.
57. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychological bulletin. 2003;129(5):674.
58. Cooper RM, Blumenfeld WJ. Responses to cyberbullying: A descriptive analysis of the frequency of and impact on LGBT and allied youth. Journal of LGBT Youth. 2012;9(2):153-177.
59. Abreu RL, Kenny MC. Cyberbullying and LGBTQ youth: A systematic literature review and recommendations for prevention and intervention. Journal of Child & Adolescent Trauma. 2018;11(1):81-97.

60. Preves SE. Intersex and identity: The contested self. Rutgers University Press; 2003.
61. Carmichael P. Telling children about a physical intersex condition. Dialogues Pediatr Urol. 2002;25:7-8.
62. Reiner WG, Gearhart JP. Discordant sexual identity in some genetic males with cloacal exstrophy assigned to female sex at birth. New England Journal of Medicine. 2004;350(4):333-341.
63. Schidlo A, Schroeder M, Drescher J. Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives. 2001.
64. Adelson SL, of Child TAA. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. Journal of the American academy of child & adolescent psychiatry. 2012;51(9):957-974.
65. Bayliss K. Social work values, anti-discriminatory practice and working with older lesbian service users. Social Work Education. 2000;19(1):45-53.
66. okkema T, Kuyper L. The relation between social embeddedness and loneliness among older lesbian, gay, and bisexual adults in the Netherlands. Archives of Sexual Behavior. 2009;38(2):264-275.
67. Hughes M. Expectations of later life support among lesbian and gay Queenslanders. Australasian Journal on Ageing. 2010;29(4):161-166.
68. Hughes M. Loneliness and social support among lesbian, gay, bisexual, transgender and intersex people aged 50 and over. Ageing & Society. 2016;36(9):1961-1981.
69. Persson DI. Unique challenges of transgender aging: Implications from the literature. Journal of Gerontological Social Work. 2009;52(6):633-646.
70. COVID-19 and the human rıghts of LGBTI people. UNHrC-. https://www.ohchr.org/Documents/Issues/LGBT/LGBTIpeople.pdf.
71. Herek GM. Confronting sexual stigma and prejudice: Theory and practice. Journal of social issues. 2007;63(4):905-925.
72. Fassinger RE. The hidden minority: Issues and challenges in working with lesbian women and gay men. The counseling psychologist. 1991;19(2):157-176.
73. Cass VC. Homosexual identity formation: A theoretical model. Journal of homosexuality. 1979;4(3):219-235.
74. Troiden RR. Becoming homosexual: A model of gay identity acquisition. Psychiatry. 1979;42(4):362-373.
75. Gonsiorek JC. Gay male identities: Concepts and issues. 1995.
76. Kahn MJ. Factors affecting the coming out process for lesbians. Journal of

homosexuality. 1991;21(3):47-70.
77. Mezey NJ. THE PRIVILEGE OF COMING OUT: RACE, CLASS, AND LESBIANS'MOTHERING DECISIONS. International Journal of Sociology of the Family. 2008:257-276.
78. Bilodeau BL, Renn KA. Analysis of LGBT identity development models and implications for practice. New directions for student services. 2005;2005(111):25-39.
79. Klein F. The bisexual option. Routledge; 2014.
80. Barker M. Including the B-word: Reflections on the place of bisexuality within lesbian and gay activism and psychology. Lesbian and Gay Psychology Review. 2004;5(3):118-122.
81. Lev AI. Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families. Routledge; 2013.
82. Potoczniak D, Crosbie-Burnett M, Saltzburg N. Experiences regarding coming out to parents among African American, Hispanic, and White gay, lesbian, bisexual, transgender, and questioning adolescents. Journal of Gay & Lesbian Social Services. 2009;21(2-3):189-205.
83. Durso LE, Gates GJ. Serving our youth: Findings from a national survey of services providers working with lesbian, gay, bisexual and transgender youth who are homeless or at risk of becoming homeless. 2012.
84. Bockting WO, Mcgee D, Goldberg J. Guidelines for transgender care. Informa Health Care; 2007.
85. Brill S, Pepper R. The transgender child: A handbook for families and professionals. Cleis Press; 2008.
86. Hegedus JK. When a daughter becomes a son: Parents' acceptance of their tr nsgender children. Alliant International University, San Francisco Bay; 2009.
87. Ellis KM, Eriksen K. Transsexual and transgenderist experiences and treatment options. The Family Journal. 2002;10(3):289-299.
88. Wren B. 'I can accept my child is transsexual but if I ever see him in a dress I'll hit him': Dilemmas in parenting a transgendered adolescent. Clinical Child Psychology and Psychiatry. 2002;7(3):377-397.
89. Sheets Jr RL, Mohr JJ. Perceived social support from friends and family and psychosocial functioning in bisexual young adult college students. Journal of Counseling Psychology. 2009;56(1):152.
90. Shilo G, Savaya R. Effects of family and friend support on LGB youths' mental health and sexual orientation milestones. Family Relations. 2011;60(3):318-330.
91. Bozett FW. Gay fathers: How and why they disclose their homosexuality to

their children. Family Relations. 1980:173-179.
92. Clay JW. Working with Lesbian and Gay Parents and Their Children. Young Children. 1990;45(3):31-35.
93. Turner PH, Scadden L, Harris MB. Parenting in gay and lesbian families. Journal of Gay & Lesbian Psychotherapy. 1990;1(3):55-66.
94. Weston K. Families we choose: Lesbians, gays, kinship. Columbia University Press; 1997.
95. Patterson CJ. Children of lesbian and gay parents. Child development. 1992;63(5):1025-1042.
96. Bailey JM, Bobrow D, Wolfe M, Mikach S. Sexual orientation of adult sons of gay fathers. Developmental psychology. 1995;31(1):124.
97. Tasker FL, Golombok S. Growing up in a lesbian family: Effects on child development. Guilford Press; 1997.
98. Collins WA, Welsh DP, Furman W. Adolescent romantic relationships. Annual review of psychology. 2009;60:631-652.
99. Diamond LM, Lucas S. Sexual-minority and heterosexual youths' peer relationships: Experiences, expectations, and implications for well-being. Journal of Research on Adolescence. 2004;14(3):313-340.
100. Mustanski B, Birkett M, Greene GJ, Hatzenbuehler ML, Newcomb ME. Envisioning an America without sexual orientation inequities in adolescent health. American Journal of Public Health. 2014;104(2):218-225.
101. Frost DM. Similarities and differences in the pursuit of intimacy among sexual minority and heterosexual individuals: A personal projects analysis. Journal of Social Issues. 2011;67(2):282-301.
102. Russell ST, Driscoll AK, Truong N. Adolescent same-sex romantic attractions and relationships: Implications for substance use and abuse. American journal of public health. 2002;92(2):198-202.
103. Russell ST, Consolacion TB. Adolescent romance and emotional health in the United States: Beyond binaries. Journal of Clinical Child and Adolescent Psychology. 2003;32(4):499-508.
104. Baams L, Bos HM, Jonas KJ. How a romantic relationship can protect same-sex attracted youth and young adults from the impact of expected rejection. Journal of adolescence. 2014;37(8):1293-1302.
105. Black M, Basile K, Breiding M, et al. National intimate partner and sexual violence survey: 2010 summary report. 2011.
106. Brown TN, Herman J. Intimate partner violence and sexual abuse among LGBT people. eScholarship, University of California; 2015.

107. Houston E, McKirnan DJ. Intimate partner abuse among gay and bisexual men: Risk correlates and health outcomes. Journal of Urban Health. 2007;84(5):681-690.
108. Turell SC. A descriptive analysis of same-sex relationship violence for a diverse sample. Journal of Family Violence. 2000;15(3):281-293.
109. Salom CL, Williams GM, Najman JM, Alati R. Substance use and mental health disorders are linked to different forms of intimate partner violence victimisation. Drug and alcohol dependence. 2015;151:121-127.
110. Carlson BE, McNutt L-A, Choi DY, Rose IM. Intimate partner abuse and mental health: The role of social support and other protective factors. Violence against women. 2002;8(6):720-745.
111. Cramer D. Facilitativeness, conflict, demand for approval, self-esteem, and satisfaction with romantic relationships. The Journal of psychology. 2003;137(1):85-98.
112. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. Journal of Child and Adolescent Psychiatric Nursing. 2010;23(4):205-213.
113. Doty ND, Willoughby BL, Lindahl KM, Malik NM. Sexuality related social support among lesbian, gay, and bisexual youth. Journal of Youth and Adolescence. 2010;39(10):1134-1147.
114. Ueno K. Same-sex experience and mental health during the transition between adolescence and young adulthood. The Sociological Quarterly. 2010;51(3):484-510.
115. Poteat VP. Individual psychological factors and complex interpersonal conditions that predict LGBT-affirming behavior. Journal of youth and adolescence. 2015;44(8):1494-1507.
116. D'augelli AR. Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. Clinical child psychology and psychiatry. 2002;7(3):433-456.
117. Luhtanen RK. Identity, stigma management, and well-being: A comparison of lesbians/bisexual women and gay/bisexual men. Journal of Lesbian Studies. 2002;7(1):85-100.
118. Morris JF, Waldo CR, Rothblum ED. A model of predictors and outcomes of outness among lesbian and bisexual women. American Journal of Orthopsychiatry. 2001;71(1):61-71.
119. Russell ST, Toomey RB, Ryan C, Diaz RM. Being out at school: the implications for school victimization and young adult adjustment. American Journal of Orthopsychiatry. 2014;84(6):635.

120. D'Augelli AR, Pilkington NW, Hershberger SL. Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. School Psychology Quarterly. 2002;17(2):148.
121. Graybill EC, Varjas K, Meyers J, Watson LB. Content-specific strategies to advocate for lesbian, gay, bisexual, and transgender youth: An exploratory study. School psychology review. 2009;38(4):570.
122. Goodenow C, Szalacha L, Westheimer K. School support groups, other school factors, and the safety of sexual minority adolescents. Psychology in the Schools. 2006;43(5):573-589.
123. Black WW, Fedewa AL, Gonzalez KA. Effects of "Safe School" programs and policies on the social climate for sexual-minority youth: A review of the literature. Journal of LGBT youth. 2012;9(4):321-339.
124. Finkel MJ, Storaasli RD, Bandele A, Schaefer V. Diversity training in graduate school: An exploratory evaluation of the Safe Zone project. Professional Psychology: Research and Practice. 2003;34(5):555.
125. Toomey RB, McGuire JK, Russell ST. Heteronormativity, school climates, and perceived safety for gender nonconforming peers. Journal of adolescence. 2012;35(1):187-196.
126. Martos AJ, Wilson PA, Meyer IH. Lesbian, gay, bisexual, and transgender (LGBT) health services in the United States: origins, evolution, and contemporary landscape. PloS one. 2017;12(7).
127. Allen KD, Hammack PL, Himes HL. Analysis of GLBTQ youth community-based programs in the United States. Journal of Homosexuality. 2012;59(9):1289-1306.
128. Herdt GH, Boxer A. Children of horizons: How gay and lesbian teens are leading a new way out of the closet. Beacon Press; 1996.
129. Fish JN, Moody RL, Grossman AH, Russell ST. LGBTQ youth-serving community-based organizations: who participates and what difference does it make? Journal of youth and adolescence. 2019;48(12):2418-2431.

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The Diversity of Colours Project is funded by the European Union under the Cypriot Civil Society in Action VI Grant Scheme and implemented by the Queer Cyprus Association. This publication was produced with the financial support of the European Union. Its contents are sole responsibility of the Queer Cyprus Association and do not necessarily reflect the view of the European Union.

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