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PERSPECTIVES

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Ethical Aspects of Mental Health Care for Lesbian, Gay, Bi-, Pan-, Asexual, and Transgender People: A Case-based Approach

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The lives of lesbian, gay, bi-, pan-, asexual, and transgender (LGBTA+/LGBT) people are not considered to be standard in society, unlike those of heterosexual cisgender people. This can lead to prejudices against LGBT people and may negatively influence their access to high-quality health care. Medical and mental health care have been characterized by attitudes (psycho-)pathologizing LGBT lives and therefore supported the stigmatization of LGBT people in the service of heteronormativity. Mental health professionals (MHPs) largely have transferred principles guiding counseling and psychotherapy with heterosexual (straight) cisgender persons to treatment of LGBT individuals without considering the specific features of LGBT lives. This is true even if the treatment is not exclusively LGBT-related, but can address LGBT-unrelated issues. To counteract this, the present paper aims to provide an insight into ethically sound mental health care for LGBT people. By applying the principles of biomedical ethics, we have analyzed how LGBT individuals can be discriminated against in mental health care and what MHPs may need to offer LGBT-sensitive high-quality mental health care. We argue that MHPs need LGBT-related expertise as well as LGBT-related sensitivity. MHPs should acquire specialist knowledge for the diverse lives and the challenges of LGBT people. We encourage MHPs to develop an understanding of how their own implicit attitudes towards LGBT people can affect treatment. However, the demand for special training should not be mistaken as a demand for a specific type of mental health care. The principles of general psychotherapy are equally the basis of psychotherapy with LGBT people.

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Abbreviations: APA, American Psychological Association; DSM, Diagnostic and Statistical Manual of Mental Disorders; ICD, International Statistical Classification of Diseases and Related Health Problems; LGBT, Lesbian, Gay, Bi-, Pan-, Asexual and Transgender; MHP, Mental health professionals; SOCE, Sexual orientation change efforts; SDM, Shared decision making; UN, United Nations; WMA, World Medical Association.

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INTRODUCTION

Gender identity (*e.g.* male, female, diverse, non-binary) and sexual orientation (*e.g.* heterosexual / straight, gay, lesbian, bi- or pansexual) are distinct features of personality but are also considered crucial in association with quality of life and health. However, a normative order of sex (equal to gender: male and female) and sexual orientation (heterosexual), also understood as heteronormativity, is dominant in structuring our society's social life. Heteronormativity is based on both features, the gender binary and the heterosexuality. In general, it leads to the assumption, in individuals and/or in institutions, that everyone is cisgender and straight and that this combination is superior to all other gender identities and sexual orientations. Heteronormativity negates the complexity of gender and sexual orientation and disregards the spectrum character of both concepts. Rather, heteronormativity goes hand in hand with the fact that the gender binary and the heterosexuality constitute and stabilize each other [1]. For example, it also leads people to assume that only masculine men and feminine women are straight. Consequently, diverse lives of people with gender non-conforming identities and non-straight sexual orientations are not considered as normal or usual in society, unlike those of straight people with gender conforming identities. Thus, heteronormativity can lead to prejudices against lesbian, gay, bi-, pan-, and asexual people[1] (LGBPA+) as well as against transgender[2] (T) people [2] and may negatively influence their health care [3].

With regards to mental health care for LGBT individuals, a paradigm shift took place during the recent decade [4-6], which moved mainstream views from a position according to which non-straight sexual orientations and gender non-conforming identities represent disorders, to a position proclaiming that LGBT people have specific features in their development, which should be treated without stigmatization in (mental) health care.[3] Up until 1973, homosexuality was categorized as a disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The International Statistical Classification of Diseases and Related Health Problems (ICD) continued to pathologize homosexuality explicitly until 1991, and implicitly by the category egodystonic sexual orientation, which can still be found in the ICD-10 in form of F66 diagnoses,[4] until today. It will no longer be listed in any form in the ICD-11. Similarly, the diagnosis of transsexualism (F64.0), which is listed in the ICD-10 as a gender identity disorder (F64), will no longer exist in the ICD-11. Instead, the new diagnosis of gender incongruence will be part of a new chapter: Conditions related to Sexual Health.

However, the process of depathologizing LGBT individuals is still incomplete. LGBT individuals worldwide continue to be at the center of political, religious, social, and thus medical discourses with contrary positions: from legal equality and recognition as a healthy norm variant to criminal prosecution and pathologization as a disorder [7,8]. Moreover, discrimination, persecution, and even murder of LGBT people is still commonplace worldwide [9,10]. Therefore, we need comprehensive action to systematically impart knowledge of the specific features of LGBT life realities without explicitly or implicitly (psycho-)pathologizing them.

Individuals on the LGBT spectrum are as heterogeneous as straight and cisgender[5] people, and the lives of LGBT individuals vary greatly depending on intersectional effective factors, such as sex, gender identity, age, culture, religion, education, and social status [11]. However, empirical research is unequally available within the LGBT spectrum, with more research focusing on gays and lesbians than on bi-/pansexual and transgender people. In this field, discrimination refers to unequal (access to) health care of persons or groups on the grounds of sexual orientation and gender identity. In defining discrimination, many scholars distinguish between differential treatment and disparate impact, creating a two-part definition (cf. [12]): Differential treatment occurs when individuals are treated unequally because of their sexual orientation and gender identity. Disparate impact occurs if, for example, persons are treated equally in accordance with a clinical guideline, but the latter is developed in such a way that it favors heterosexual and/or cisgender people over LGBT persons or the LGBT group is even invisible in the guideline. Apart from more conventional forms of individual discrimination, it is also necessary to recognize institutional practices as discriminatory. They may serve in structuring health-related opportunities in relation to sexual orientation and/or gender identity [13]. In the context of LGBT this includes, among others, the possibility of officially marrying a same-sex partner and the opportunity to change one's legal gender.

In the 2011 report on *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* by the *Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities* of the US Institute of Medicine [14] a key finding was on barriers to access quality health care for LGBT adults. The report found a massive shortage of health care professionals (HCP) being aware of the health needs of LGBT and, as a direct consequence, fear of discrimination and malpractice by HCPs, especially among those LGBT people having already experienced discriminatory practices by HCPs [14].

Only recently, in spring 2020, the second EU-LGBTI online survey was published [13]. With almost 140,000 respondents, it is the largest survey of its kind. In com-

parison with the first EU-LGBTI survey conducted in 2012 [15], discrimination continues to exist in daily life, including access to and experience of health care. One in six respondents (16%) felt discriminated against by health or social service employees. In particular, 52% of respondents who rated their general state of health as "very bad" and 36% of respondents who rated it as "bad" felt discriminated against at health care services. Fewer respondents who rated their state of health as "very good" or "good" did so (11% and 14% respectively) [13]. Additionally, two qualitative studies investigated problems in the context of healthcare for and by LGBT people, focusing on six European countries [16] and on healthcare at local level in a German metropolitan area, Hamburg [17], respectively. Both studies show that among HCPs, lack of expertise and pathologizing attitudes towards LGBT individuals are a severe problem.

Evidently, not all LGBT people experience the same in terms of their health care. Factors such as race, ethnicity, socio-economic status, geographical location, and age can have a significant impact on health concerns and needs. However, the impact of sub-population membership on health care, particularly racial and ethnic groups, has been insufficiently studied [14]. Neither have the effects of development; most research has been conducted in adults, less frequently in young and older LGBT people [14].

Nevertheless, the health disparities affecting LGBT people are sufficiently empirically founded. Therefore, the World Health Organization [18], the US Institute of Medicine [14], the American Psychological Association, and the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues [19] recommended, among others, the implementation of strategies for gender-sensitive health care and to routinely ask questions related to sexual orientation and gender identity in clinical settings [20].

Many LGBT individuals face challenges that may or may not be specific to the LGBT spectrum, such as minority stress, coming-out processes, rainbow families, open relationships, and internalized negativity towards being homo-, bi-, pan-, or asexual and/or towards being transgender. Finally, the different dimensions of sexual orientation, sexual behavior (having sex with one or more partners), sexual identity (or self-identifying as gay, straight, bi-, pan-, asexual), and self-identifying sexual attraction (to whom, or if any, one feels sexually attracted to or has sexual fantasies about), alone illustrate the need for specialist knowledge [21].

Mental health care with people from the LGBT spectrum is also as diverse and specific as their lives. However, attitudes towards sexual orientation and gender identities in medical and mental health care have been characterized by (psycho-)pathologizing LGBT lives and thus supporting stigmatization in the service of heteronormativity [14,22,23]. In psychotherapy, the institutionalized and often unreflected consideration of sexual orientations and gender identities from the LGBT spectrum as mentally unhealthy has led to theoretical and clinical approaches to changing deviations from heteronormativity [24], such as reparative therapy (*e.g.* [25]). In a "Report of the Task Force on the Appropriate Therapeutic Response to Sexual Orientation," the American Psychological Association classifies these approaches with the umbrella term "Sexual Orientation Change Efforts" (SOCE; American Psychological Association [26]). Despite a lack of scientific evidence of both a causal relationship between non-straight or asexual orientation and transgender identities and mental illness and its effectiveness, SOCE do not regard LGBT orientations and identities as normal and aim to change them in the direction of heteronormativity (*i.e.* cisgender and heterosexual). Moreover, since medical and MHPs still frequently lack expertise on the specific issues of LGBT individuals [3,13,15,27,28], they often transfer the principles from mental health care treatment with heterosexual cisgender individuals to LGBT individuals, and thereby disregarding the specific features and challenges of LGBT lives [29]. This is exemplified, among other things, by the fact that the diverse lives of LGBT persons are not equally inquired about in the course of medical history as the lives of heterosexual cisgender individuals [14]. While professional associations have pointed to the de-pathologization and anti-discrimination of LGBT people [19,30,31], even in mental health care LGBT people are confronted with ignorance, prejudices, discrimination, and (psycho)pathologization [9,23]. Even though MHPs should be able to use their knowledge and expertise to support LGBT individuals in challenges specific to their lives, it is often the LGBT individuals themselves who are having to inform their MHP about the basic features of their diverse lives, more precisely about their relationships, sexualities, and social contexts [29].

By applying the principles derived from biomedical ethics, this paper aims to provide an ethical framework for working with LGBT individuals in mental health care. In doing so, the paper deals with the following questions: How are LGBT people discriminated against in mental health care? What do MHPs need to provide LGBT persons with high-quality mental health care? To this end, we introduce the principles of biomedical ethics and illustrate them with examples that are experienced by LGBT persons in mental health care. In turn the case presentations aim to illustrate the principles of biomedical ethics. We are aware that we influence the interpretation by selecting, presenting, and focusing on the selected clinical situations [32]. In other words, the cases never speak for themselves. The way we tell them, the perspective we

take and the wording we use influence the outcome. We know that some researchers see this as a methodological problem (cf. [33]). Others, however, argue that accurate and transparent data collection from treatment episodes may influence the provision of high-quality individualized (mental) health care (cf. [34]). The latter is what we intend and why we chose short case presentations. We discuss the importance of ethical principles in mental health care with LGBT individuals and conclude what we believe mental health care should be arrives with LGBT people: LGBT sensitivity and LGBT expertise.

PRINCIPLES OF BIOMEDICAL ETHICS AND THEIR APPLICATION TO MENTAL HEALTH CARE FOR LGBT PEOPLE

How can a complex situation – as in mental health care – be assessed and evaluated with regard to its ethical content? The principles of biomedical ethics offer a pragmatic and widespread approach to this question [35]. It was developed by Beauchamp and Childress [36] as a way to evaluate systematically an ethical dilemma in health care. The main idea of this approach is to discuss an ethical question by using four prima facie principles: (a) respect for autonomy, (b) beneficence, (c) non-maleficence and (d) justice. That means that the four principles claim to be so general and comprehensive that people of different moral convictions can essentially agree on them. In this respect, they are not dependent on an ethical theory. Furthermore, there is no general hierarchy among the principles. For an ethical judgment, all four principles must be applied to a specific topic. In the following, the principles of biomedical ethics will be outlined:

(a): Nowadays the respect for autonomy is of great importance in our understanding of morals and law. Both patient rights and respect for the autonomy of patients are firmly anchored in legal and ethical norms. The focus, however, is on the adult and consentable person. A question that remains controversial among lawyers and ethicists relates to the self-determination of children and adolescents [37]. This is important since sexual orientations and gender identities deviating from heteronormativity often become visible well before reaching adulthood [38,39].

(b): The principle of beneficence refers to the imperative to minimize damage caused by external influences through one's own actions (*e.g.* pain as a result of injury or illness). What is decisive is that the persons concerned determine what is beneficial from their individual attitudes [36,40]. This is important because the change of perspective, which is necessary but rarely carried out, is a moral dilemma. The case examples presented below illustrate this dilemma by referring to different morals on LGBT realities. The dilemma can intensify if the morals remain unreflected upon. Furthermore, this principle is ambiguous, *e.g.* with regard to aspects of time and perspectives: In terms of time, a psychotherapeutic treatment may represent an unreasonable burden for the patient at the moment of a health crisis (current well-being), but after first recovery it can be regarded as tolerable and conducive to the further recovery process and thus the future well-being (prospective well-being). In terms of perspective, the choice of a best practice may differ between those concerned and their relatives or MHPs, even if the different perspectives pursue the well-being of the individual (internal and external well-being [37]). Both in the relationship between parents and children and between MHPs and relatives, it is clear that the parties involved are sometimes divided in their views. Hence, individual well-being is not a universal and objective dimension. The decisive authority in the interpretation of this dimension is rather attributed to those concerned. This also applies regardless of whether the person concerned is willing or able to reflect all aspects of beneficence in the decision-making process.

(c): The principle of non-maleficence is the partner imperative for beneficence. It refers to the moral duty not to harm a person with one's own actions, even if the aim of the action is to increase well-being: the balancing of benefits and risks. Here, too, there are hardly any objective criteria for measuring harm. However, in addition to the individual attitude, it must be considered whether the person themselves or others could be harmed (*e.g.* someone could also want to have changed their sexual orientation and thus harm themselves in this way).

(d): The fourth principle is the imperative of justice. It is a wide-ranging concept. From the perspective of distributive justice, the focus is on the fair distribution of limited resources in the light of individual needs. There are several criteria by which fair distributive justice can be judged, *e.g.* equality, efficiency or solidarity [40]. This makes it difficult to define what can be considered fair in a given situation. Beauchamp and Childress [36] essentially use the term in this sense. Justice understood as a fundamental virtue (virtue ethics) sets a different focus [41]. It refers to the duty to respect everyone's basic needs for their own sake. In particular, it exhorts respect for human dignity [42].

CASE PRESENTATIONS

In light of cases[6] exemplifying LGBT people in mental health care settings, the above-mentioned principles of biomedical ethics will be discussed: MHPs tend to transfer heteronormative attitudes to LGBT people, even if these do not fit [9]. The example of a mother with two children living in a same-sex partnership illustrates this effect and the importance of the principles

of beneficence, non-maleficence, and justice:

A 37-year-old lesbian cis person reports about psychotherapy in which she had the impression that her family situation with her 42-year-old wife, both Caucasian and with an academic background, and two children (5 and 8 years) was not considered to be of equal value to those of heterosexual people. Although the psychotherapist had not openly stated that the male was missing in the upbringing of the children and that the family thus deviated from heteronormativity, she clearly felt that the psychotherapist's objective was to supplement her family with male support. She had the impression that her psychotherapist considered her family unit with two women insufficient. Since she had the feeling that her psychotherapist implicitly regarded only heteronormative families as healthy for the children's upbringing, she felt questioned as to whether her children could develop appropriately in her lesbian family unit. This way, in psychotherapy, too, the lesbian cis mother subtly experienced the discrimination she had experienced in other social contexts. Despite the empathic attitude of the psychotherapist, the patient did not feel that she understood and accepted her life realities. Her wish to be supported and strengthened by psychotherapy in her family world had not been fulfilled.

The transfer of heteronormative attitudes to a lesbian partnership with children not only led to an ineffective psychotherapy, but also to discrimination. The MHP insufficiently questioned her own heteronormative attitudes towards a healthy family, which inevitably includes a male parent next to the female one, and transferred them to a lesbian family with children. Due to this, she was unable to perceive her patient favorably. In doing so, the MHP disregarded the ethical requirement that therapeutic actions should be tailored to the individual needs of the patient. This disregards the principles of beneficence and non-maleficence. The principle of justice is also touched upon here. It requires that each person be recognized as an individual being. In order to work with people on the LGBT spectrum in mental health care, it is necessary to reflect one's own attitudes towards partnership and mental health. Therefore, it is (not only) important for MHPs to recognize the individuality of patients on equal terms and to concede them the right to decide on all facets of their being. Aspects of sexual orientation, gender, and sexuality must also be included, as the following examples illustrate:

A 37-year-old gay cis man, who had been living in an open partnership with his 35-year-old cis male partner for over 5 years, both Caucasian and both employed in a full time job, was looking for psychotherapy due to difficulties in the partnership. Although the open partnership was not a problem for both partners, his psychological problems, including depressive episodes and a lack of self-esteem, were attributed to the open partnership by the psychotherapist. The fact that he lived out his sexuality partly with his partner, partly with other, changing partners, had not been recognized by the therapist as an equivalent form of partnership. Repeatedly, the therapist tried to problematize sexuality. His actual problems, for example, feelings of inferiority or internalized homo-negativity caused by discrimination experienced in his childhood and reactivated by subtle discrimination at his workplace as a social worker, had not been addressed and treated sufficiently by the therapist. The psychotherapist focused and questioned primarily his open partnership as a gay man and did not accept according to his value system this form of relationship as equivalent.

In this example, heteronormative attitudes about a healthy partnership were transferred to an openly gay partnership. As a result, the open gay partnership was recognized as unequal. This is contrary to the imperative of equal treatment and thus violates the principle of justice. This example also shows that an orientation towards the well-being of the patient can only succeed if the patient's individual needs guide the actions (beneficence). Otherwise, even well-meant actions run the risk of becoming to the patient's disadvantage (non-maleficence). Steger [42] argues that in the context of sexual orientation and gender identities, a supportive attitude, an appreciative and unprejudiced approach and the support of a positive self-reference are necessary. But the MHP saw the cause of the patient's problems in his partnership deviating from heteronormativity. As a result, he could neither approach the patient openly without prejudice nor establish a sustainable relationship. However, an affirmative approach can also lead to a patient feeling that their problems are not being taken seriously enough (*e.g.* jealousy in the context of a gay relationship with frequently changing sex partners). Since the main aspects of interpretation in both case presentations relate to questions of sexual orientation, controversies on ethnic aspects are not discussed further here. It remains to be mentioned, however, that the role of ethnic identity in psychotherapy requires similar discussions and must be treated with equal sensitivity.

Another issue of importance is the question of autonomy in children and adolescents. In dealing with adults and people capable of giving consent, it is accepted that subjective experience is the decisive authority for assessing individual well-being. With regard to minors, however, there is no comparable acceptance. The concept of the child's well-being differs from that of the adult's well-being. Thus, the question is whether the assessment of well-being can be made solely on the basis of subjective experience or whether there should be further criteria applied [43]. Children and adolescents of all ages have an idea of what they need for their well-being. But depending on their development and their previous experience

with the respective situation, they are able to assess the consequences of a decision and relate them to alternatives differently. As a result, children and adolescents cannot continuously understand their prospective well-being or the external perspective on their well-being. Hence, they are considered vulnerable, which binds a moral right to protection. If minors are not yet capable of consenting, a legal representative must decide on their behalf, usually the parents or guardians. These have the task of representing the best interests of the child [44]. While the minor only perceives their subjective, internal, and current well-being, the deputy should also capture other dimensions of well-being. In which situations the perspective of the deputy must be included and when it is dispensable, seems to be a critical ethical question. However, by ratifying the Convention on the Rights of the Child [45] the United Nations (UN) state parties agreed to "shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child." In this respect, the UN Convention sets out the right of the child to participate in all child related decisions [46]. It seems advisable to distinguish between spontaneous, possibly thoughtless utterances on the one hand and well-considered expressions deeply felt by the child on the other. The latter could be understood as the child's will, which is considered to be the child's emphatic expression of opinion, repeatedly expressed and of particular emotional importance to the child [47]. To disregard it would undermine the child's self-esteem [47]. Respecting the child's will is also seen as a prerequisite for the self-determination that should be developed in adolescence and adulthood. The will of the child therefore deserves respect in view of this development towards an autonomous personality. In this context, age is not sufficient as the only criterion [47]. If the child or adolescent is able to understand the nature, scope, and significance of a medical treatment and to determine their own will accordingly, they are considered to be capable of self-determination and are entitled to decide on their own [48]. Consequences of an inconsistent view between child, parents, and medical professionals as well as MHPs should be illustrated by the example of a transgender youth:

A Caucasian straight cis mother presents her 13-year-old child in a clinic specializing in child and adolescent psychiatry. She is very concerned about the future of her child as she has observed persistent gender non-conforming behavior in her child since early childhood. The child consistently lives in the desired gender role as a girl, feels comfortable and at home in it, and has completed primary school without any problems, significant conflicts, or minority stress. The child barely deals with her own physical body, avoids both sports activities and sexuality. The latter in particular was hard to explore because the child was very timid, but she mentions an interest in boys. Altogether the child is socially very withdrawn and shows slightly obsessive behavior. The mother asks for a timely treatment with puberty blockers, as she fears that under the influence of testosterone her child will develop clinical relevant distress and gender dysphoria during puberty. Even the 13-year-old child is able to express that she is very afraid of a "false puberty" and wants to avoid it. However, the subsequent diagnostic process takes several years. Three specialists had been asked to carry out mother and child assessments, structured diagnostics, and psychometric questionnaires. All three examinations were state-of-the-art and of high quality. However, the three results contradicted each other and came to different recommendations. In the meantime, the adolescent had progressed to puberty-induced autovirilisation, with a body height of 6.5 ft, a broken voice, and a slight beard growth. The gender incongruence has thus contributed to a pronounced gender dysphoria, which had not been present to the same extent in the prepubertal developmental phase.

Referrals for puberty-blocking hormones involve a heavy burden of decision making. The handling of this decision-making process is currently the subject of controversial discussion [49,50]. This example – securing the diagnosis and assessing the necessity of puberty-blocking hormones by means of a second look procedure in the context of gender incongruence and transgender – shows the risk of overlooking ethical principles in interdisciplinary settings. All specialists involved have provided high-quality work. But they have missed to coordinate and communicate their treatment decision in time; be it for or against starting puberty-blocking hormone therapy. Because of the time-sensitive impact of puberty changes, the factor time plays an important role in the health care of gender incongruent adolescents. Therefore, in case of uncertainties, waiting "does not seem to be a neutral option [51]."

Next to the lack of considering puberty development, none of the involved clinicians took over the treatment lead for the benefit of the young person. The burden to come to a decision was neither clarified nor clearly distributed among the clinicians. The aim of a second look strategy by transgender specialists remains that of quality control [52]. If the system of second looks leads to the diffusion of responsibility and the treatment decision is thus neither made nor communicated in time, this can iatrogenically harm the adolescent's development. However, in order to really achieve high quality care, the treatment lead should be clearly discussed among MHPs involved. If this is not the case, as in the present example, the partner principles of beneficence and non-maleficence could not become effective. By not blocking puberty with hormones, the adolescent's symptoms aggravated to a severe gender

dysphoria. Therefore, referral for puberty blockers should be communicated in the same timely manner (*e.g.* before the voice change) as the cancellation of puberty-blocking hormone treatment (*e.g.* to look for alternative treatment options). In both situations, clear and prompt communication of the result is important in order to give room for initiative and thus promote autonomy in the adolescent. In sum, we argue that compliance with ethical principles must also be embedded in interdisciplinary settings. For people who are unable to speak for themselves due to (young) age or health conditions, there is virtually no evidence of how they perceive their well-being [53]. A "pediatric shared decision-making" [53] could have avoided disregarding the biomedical ethical principles.

While shared decision making (SDM) is a well-established component of patient-centered care in adults [54], its use in pediatrics is poorly understood and rarely applied (*e.g.* it is often overlooked that the main participant in SDM is the patient's caregiver, who has limited decision-making authority, unlike competent adults who make their own decisions [55]). To overcome this, Opel [55] suggested a 4-step framework that aims to provide guidance for the practice of SDM in pediatrics. In step 1, medical professionals or MHPs are asked the following question at each discrete decision: Does the decision include more than one reasonable option? If the answer is no, SDM is not indicated. If the answer is yes, medical or MHPs proceed to step 2 and answer the following question: Does one of the options have a more favorable medical benefit/burden ratio compared to the other option(s)? If yes, it is appropriate that the SDM is led by the medical or MHP. If no, a parent-directed SDM is appropriate. For each SDM approach, the physician continues with step 3 and answers the following question: How sensitive are the options to preference? This helps to determine the specific SDM approach in step 4. Here, SDM is considered a continuum, where an SDM approach led by a medical or MHPs takes up one half and an SDM approach led by caregivers takes up the other half. Within each approach there is a strong and a weak version, where the strong version means that either parents or health professionals noticeably guide the SDM, while the weak version embodies an SDM where decision making is more likely to be mutual. Taking such an approach to health-related decisions in childhood and adolescence can help ensure that biomedical ethical principles are respected for LGBT youth.

DISCUSSION

We argue that MHPs need LGBT-related expertise as well as LGBT-related sensitivity. To this end, they should critically examine and reflect the historical and current norms on sexual orientations and gender identities [24], as well as the influence of these norms on their own values and behaviors, in order to work in a way that promotes development and autonomy without (psycho) pathologization [23,56]. Otherwise, as illustrated by the case examples, MHPs are at risk of controlling norms in the service of heteronormativity. Their inability to look beyond internalized heteronormative attitudes was to the disadvantage of LGBT people seeking treatment and thus prevented psychotherapy from contributing to the improvement of the LGBT individuals' mental health.

An informed therapeutic attitude is required to apply the principles of biomedical ethics outlined above. Guidelines published by the American Psychological Association (APA) recommend an open attitude and a differentiated understanding of LGBT-related lives and their challenges in terms of stigmatization and discrimination [19,57,58]. Statements by the World Medical Association (WMA) accordingly call for a non-pathologizing attitude in medical and mental health care [30,31]. The WMA [30] states that homosexuality is a natural sexual orientation and that mental health care should focus on associated conflicts but not on effort to change sexual orientation. In addition, the right of each individual to self-determine their gender is marked by the WMA [31]. HCPs and MHPs are called upon to set up appropriate treatment offers (justice), which respect the individual's autonomy and beneficence without discrimination (non-maleficence).

Curricula considering this area in the training of MHPs are necessary. MHPs should acquire specialist knowledge for the diverse lives and the challenges of LGBT people. This includes knowledge about the effects of stigmatization and discrimination like minority stress as well as special relationships and sexualities. MHPs are also encouraged to develop an understanding of how their own attitudes towards LGBT people can affect treatment. However, the demand for special training should not be mistaken as a demand for a specific mental health care. The principles of general psychotherapy are equally the basis of psychotherapy with LGBT people.

CONCLUSION

Mental health care for LGBT people should be of equally high quality as mental health care for heterosexual and/or cisgender people. However, equal treatment does not necessarily mean treating LGBT people in the same way [59]. In order to provide mental health care at a comparable, ethically sound, and high-quality level, MHPs must treat LGBT people with the same care (*i.e.* have LGBT-expertise) and respect (*i.e.* be LGBT-sensitive). LGBT-sensitivity initially means forgetting that the person seeking care is LGBT. In order to achieve this, automatic reactions to the person in question must be

reflected (including counter-transference) to ensure that the person can be approached in a value-free, open, and kindly manner. LGBT expertise, by contrast, is about not forgetting that the person is LGBT. The aim here is to identify the biographical significance of growing up as LGBT on the person in care. This means that MHPs should consider the specific physical, psychological, and social conditions of LGBT people and be aware that these conditions are generally overlooked on the grounds of heteronormativity. For the LGBT-inexperienced MHP who wishes to offer mental health care for LGBT people, both to forget and not to forget the person is LGBT, both LGBT-expertise and LGBT-sensitivity, are essential. The outlined principles of biomedical ethics provide orientation for this.

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Footnotes:
[1]Pansexual describes a sexual orientation that includes a choice of partner unrelated to their sex/gender. However, bisexuality is also not limited to males and females. Some bisexual people also understand the "bi" as being attracted to people of the same gender and people of another gender, which can also include transgender and non-binary people. Next to this, asexuality refers to people who do not feel sexually attracted at all. Although neither bi- and pansexuality nor asexuality are at the forefront of this paper, the basic mechanisms of discrimination and pathologization (in the sense of a deviation from heteronormativity) can be transferred to these sexualities and sexual orientations.
[2]The term transgender serves as a generic term for people whose sex does not (or not completely and/or permanently) correspond to their sex characteristics. It refers to people who live in female or male roles and to diverse, non-binary people who identify neither as male nor female, but as, for example, genderqueer or agender.
[3]Note: LGBPA+ people can be both cisgender and transgender.
[4]Psychological and behavioral disorders associated with sexual development and orientation.
[5]People who feel that their gender is congruent with their sex characteristics are described as cisgender.
[6]The case examples are based on the experience of several patients, summarized and thus represent typical constellations. They are generalized in representation and cannot be assigned to individuals. Neither the patient nor anyone else can identify the patient.

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