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GENDER IDENTITY: PROMOTING SEXUAL ORIENTATION and EQUALITY.

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ABSTRACT:

The importance of gender identity in advancing sexual orientation equality is explored in this article. Someone's gender identity is how they personally identify themselves, which may or may not be the same as their biological gender. Despite expanding understanding and acceptance of a wide range of gender expressions, people still face discrimination and exclusion on the basis of their gender or sexual orientation. This article argues that educating people about gender identity and how to respect people of all identities can help advance equality and combat discrimination.

KEYWORDS: gender identity, sexual orientation, equality, marginalization, education, and workplace equality

INTRODUCTION:

An important part of a person's identity that has gained acknowledgment and prominence recently is gender identity. Gender identification refers to a person's personal perception of their gender, which may or may not match the sex they were assigned at birth. Gender identification is a highly personal and inner experience that differs greatly from person to person. While some people may identify as male or female, others may identify as non-binary, genderqueer, or with a distinct gender identity. Despite a rising recognition of other gender identities, those who identify outside of the gender binary still face discrimination and marginalization in many facets of life, including as healthcare, education, and employment.

Theories and ideas When it comes to sexual orientation and gender identity, ideas and meanings are always changing. There are still a lot of old ways to talk about LGBT people, especially in the area of mental health.

CONCEPTS AND DEFINITIONS

Now seen as old-fashioned and even nasty. (2012) The APA is a group of psychologists. Their sexual orientation is the sex of people to whom they are sexually and emotionally attracted. "Lesbian" and "gay" are now used to describe people who like people of the same sex, while "bisexual" is used to describe people who like people of both sexes. Even though these categories are still used a lot, it's important to remember that sexual orientation doesn't always fit into them. Instead, it happens along a continuum (American Psychological Association, 2012), and people can be seen or labeled as LGB in many different ways (D'Augelli, 1994). In the middle of the 1960s, the word "gender identity" was used for the first time to describe a person's ongoing sense of being either male or female (Money, 1994). People who don't identify as male or female are now thought to have a gender identity: "A person's self-concept of their gender, regardless of their biological sex, is called their gender identity" (Lev, 2004, p. 397). It was

defined by the American Psychological Association as "the person's basic sense of being male, female, or of indeterminate sex" (2009a, p. 28). For a long time, only people who had surgery to change their genitalia were allowed to use the word "transsexual." But today, "transsexual" means anyone who has a gender identity that doesn't match the sex they were given at birth and lives as a member of the sex they weren't given at birth or is working towards doing so (e.g., Serrano, 2007; American Psychological Association, 2009a; Coleman et al., 2012). This includes people who have had or want to have medical procedures. In this work, we use the prefix "trans" to talk about transsexuals. Since the 1990s, "transgender" has mostly been used as a catch-all term for people who don't follow gender norms and standards (e.g., Lev, 2004; American Psychological Association, 2009a). It includes people who don't identify as either male or female, as well as transgender and intersex people, and people whose gender presentation and behaviors are different from what society expects. People who are thought of or called transgender, like bisexual men and women, can identify in different ways, just like transgender people. Goals of the study Some possible study goals based on the research article topic "Gender Identity: Promoting Equality for Sexual Orientation" are as follows: To look into the idea of gender identity and how it links to sexual orientation.

Look at how often and why people are treated badly because of their sexual preference or gender identity. to find out what laws and policies are in place that make sure LGBTQ+ people are treated equally. to figure out how well the education and awareness-raising programs that are already in place are helping people understand gender identity and reduce bias.

to make plans for promoting more tolerance and acceptance of people with different gender identities in places like health care, schooling, and work.

IMPACT OF DISCRIMINATION ON MENTAL HEALTH

According to the United Nations (2013), Bostwick et al. (2015), and the European Union Agency for Fundamental Rights (2015), people who are lesbian, gay, bisexual, or transgender often face prejudice, stigma, and social exclusion, such as being cut off from jobs, being abused physically or mentally, and being bullied. Also, discrimination can happen in many places, like the workplace, schools, and healthcare facilities. It can also happen in important relationships, like families (e.g., Milburn et al., 2006; Feinstein et al., 2014; António and Moleiro, 2015). Several studies (Cochran and Mays, 2000; Dean et al., 2000; Cochran et al., 2003; Meyer, 2003; Shilo, 2014) show that LGBT people who have faced stigma and abuse are more likely to have mental distress.

Hershberger and D'Augelli (1995) and Mustanski and Liu (2015) say that LGB people may be more likely to commit suicide, have traumatic stress reactions, have major depressive disorders, have generalized anxiety disorders, have bouts of major depression, or use drugs. Also, transgender people are more likely to have depression, anxiety disorders, social phobia, adjustment disorders, drug abuse, eating disorders, and eating disorders (Hepp et al., 2005; Mustanski et al., 2010; Nemoto et al., 2011). But the fact that this group had thoughts of suicide and tried to do it is worrying: Maguen and Shipherd (2010) found that up to 40% of transgender men and 20% of transgender women have tried to kill themselves. Nuttbrock et al. (2011) took a sample of 500 transgender women and found that about 30% had tried suicide, 35% had planned to do so, and almost half of the participants had suicidal ideas. Dean et al. (2000) found that transgender and transsexual people are more likely to have mental health problems when they are teenagers. In the end, the study shows that stigma and discrimination have a big effect on psychopathology in LGBT communities. But some things, like social and family support, low internalized homophobia, expectations of acceptance versus a rejection, contact with other LGBT people, or religiosity, may help explain the link between sexual orientation or gender identity and stress (Meyer, 2003; Shilo and Savaya, 2013; António and Moleiro, 2015; Snapp et al., 2016). So, it seems important to focus on subjective pain and how each person experiences psychopathology.

CONTROVERSIES ON GENDER DYSPHORIA AND (TRANS) GENDER DIAGNOSES

The exact mental health diagnoses given to transgender and transsexual people are a very controversial topic. Through the Harry Benjamin International Gender Dysphoria Association, which is now known as the World Professional Association for Transgender Health (WPATH), Benjamin made important contributions to this field. Concerned

professionals, trans and LGBT campaigners, and human rights groups have argued strongly in recent years about whether or not the main diagnostic tools should change or get rid of (trans)gender diagnoses. But discussions about this subject have been polarizing, contradictory, and unable to reach a conclusion (Kamens, 2011). Transgender-specific mental health labels have been criticized in general because they add to the stigma that already affects this group (Drescher, 2013). Winter et al. (2009) say that the word "mental disorder" is the reason why trans people are treated badly. The DSM-5 was recently changed (American Psychiatric Association, 2013), and "gender identity disorder" was changed to "gender dysphoria" as part of that process. So, people could only get a psychiatric evaluation if they were upset about being given a gender assignment that they felt didn't fit with who they were at the time (Drescher, 2013). The updated language and criteria are "less pathologizing because they no longer imply that a person's identity is disordered" (DeCuypere et al., 2010, p.119). In reality, gender dysphoria shouldn't be used to make broad statements about transgender people or as a term for transsexuality (Lev, 2004). Gender dysphoria, on the other hand, is "a clinical term used to describe the symptoms of excessive pain, agitation, restlessness, and malaise that gender-variant people who go to therapy often report" (Lev, 2004, p. 910). Even though the changes were well accepted (DeCuypere et al., 2010; Lev, 2013), some people still want gender dysphoria to be "ultimately removed" from the DSM. But the ongoing ICD change is the most important thing right now. Changes to the ICD's (trans)gender categories have been suggested by the World Professional Association for Transgender Health (2013), Global Action for Trans Equality (2011), and various transgender and human rights organizations, as well as members of the health professions. Transsexualism will now be called "gender incongruence," and it will no longer be in the section on "mental and behavioral disorders."

CARE FOR MENTAL HEALTH REFLECTS CONTROVERSIES

Along with changes to diagnostic standards, making sure non-heterosexual and transgender people are healthy has become a bigger focus in the area of mental health. Important counseling and psychotherapy governing bodies around the world have agreed that counselors and therapists need to be able to work well with LGBT minority clients. The American Psychological Association's (APA) guidelines for psychotherapy with lesbian, gay, and bisexual patients are important (American Psychological Association, 2000, 2012). (Bieschke et al., 2001; King et al., 2007) show that LGBT people use psychotherapy more often than the general community. Because they are part of a fragile group and use therapies often, they may be more likely to be given therapies that are harmful or don't work. These ethical standards bring up a number of issues, such as the need for clinicians to recognize that their own views on sexual minorities and familiarity with their experiences are important to the therapy process with these clients. So, people who work in mental health care must look for relevant books, classes, and guidance. Empirical data, on the other hand, shows that some therapists still use clinical techniques that aren't right for LGBT clients. When Bieschke et al. (2006) looked at empirical research on counseling and psychotherapy for LGB clients, they were surprised to find a lot of new studies on "conversion therapy." Even though a recent systematic review of the peer-reviewed journal literature on sexual or gender identity disorders found that conversion therapy is effective and can cause some harm, some mental health professionals still try to help lesbian, gay, and bisexual clients become straight (Bartlett et al., 2009). (American Psychological Association, 2009b, pp. Other, less offensive ways that LGBT clients have been used in professional settings have also been written about (for example, Garnets et al., 1991; Jordan and Deluty, 1995; Liddle, 1996; Hayes and Erkis, 2000). Even therapists who want to be accepting and helpful to LGBT people may accidentally show some heterosexist bias when working with LGBT clients. (2004) Pachanikis and Goldman. Sue (2010) says that these kinds of microaggressions include assuming that a client is always straight, trying to explain why the client is gay, or focusing on an LGB client's sexual orientation when that isn't the main issue (e.g., Shelton and Delgado-Romero, 2011). In counseling and psychotherapy, heterosexual bias can also take the form of "sexual orientation blindness," which Brown (2006) defines as trying to be neutral but leaving out information about the minority position of non-heterosexual clients. (Simoni, 1996; Alderson, 2004) It seems that the basic training of psychotherapists and the historically heterosexist structure of medical and psychological education are not separate from this mostly heterosexual view of human experience in the therapeutic setting. A few decades ago, when mental health workers helped transgender people, they had to tell the difference between "true" transsexuals and other transgender people. By doing this, professionals who were serving as gatekeepers tried to "make sure that the vast

majority of transgender people would not be "gender-ambiguous" in any way" (Serano, 2007, p. 120). The first group would be able to change their bodies, while the second group would not be able to get any medical help other than counseling. Research (Bockting et al., 2004; Bauer et al., 2009) shows that inappropriate gatekeeping is one of the many problems that transgender people still face when they try to get health care. Lev and Serano (2004) and Some mental health professionals still care more about how transgender people show their gender and who they are as a person than how they might feel. Because of this, transgender people might feel like they need to tell their doctors a personal story that fits with what they think the doctors want to hear (Pinto and Moleiro, 2015). This is so they can get hormone or medical treatments. Even though there have been changes to (trans)gender diagnoses in the DSM (Cohen-Kettenis and Pfafflin, 2010), newer diagnoses are still used as if they were the same as the transsexualism diagnosis. This is done in order to find the "true transsexual." It's clear that social and cultural biases have had a big effect on how trans people are diagnosed and how easy it is for them to get hormone and surgery treatments, and that effect is still big today.

CONCLUSION

Mental illness as a whole need to be looked at again because of the problems and conversations about how sexual orientation and gender identity are categorized by doctors. In the 1970s, "homosexuality" was taken out of the DSM because most people agreed that mental illnesses cause pain or are linked to less social functioning (Spitzer, 1981). Also, (trans)gender diagnoses make a big difference in how health workers (e.g., Ehrbar, 2010) and trans-related activists (e.g., Vance et al., 2010) feel about each other. The argument has been between two reasonable points of view: 1) trans(gender) diagnoses should be taken out of health classification systems because they encourage the pathologizing and stigmatizing of gender diversity and increase medical control over trans people's identities and lives; and 2) trans(gender) diagnoses should be kept because health care systems need diagnoses to justify medical treatment, which many trans people need. In fact, transgender people often reject that they have a mental disorder (Global Action for Trans Equality, 2011; TGEU, 2013), while also advocating for the need for treatments and access to healthcare (Pinto and Moleiro, 2015). So, it may be important to know how a past of too much gatekeeping and the stigma against mental illness may affect the (trans)diagnosis argument. In the past, gender identity and sexual preference were seen as falling between two extremes: gender transgression and gender variance or fluidity. On the one hand, people who are now known as LGBT were thought to have mental diseases because they were linked to "transgression" and/or "deviation from norms." Classification systems always show the social attitudes and stereotypes that are still around today (Drescher, 2012; Kirschner, 2013), as well as the historical and cultural contexts in which they were made. Most of the time, they did this wrong because they thought mental illness was the same as gender flexibility or socially inappropriate behavior. Some therapists still use this point of view and its historical roots in their work, such as "conversion" therapies and the small-scale discrimination that LGBT people, including mental health workers, face every day. In contrast, the development of diagnostic methods over the past few decades show a better knowledge of and respect for people's different sexual orientations and gender identities. This point of view recognizes that the way people talk and act in the mental health field (Drescher, 2012) could affect how people think about culture as a whole. So, it acknowledges that clinical practices, health discourses, and medical classifications have an effect on how the duty to fight discrimination and improve the health of LGBT people is communicated. It seems important to stress the value of professional training and supervision if you want to improve your nursing skills when working with sexual minorities. Several authors, such as Pachankis and Goldfried (2004), have written about how important it is for practitioners to keep learning and training in individual and national diversity as part of their professional growth. This is in line with the ethical standards of the APA (American Psychological Association, 2000, 2012), and it becomes even more important when we think about the recent and important changes in this field. Also, the idea of LGBT competence assumes that therapists need to be aware of their own values, attitudes, and views about gender diversity and human sexuality in order to give good care. Even with these moral concerns,

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