

Running head: CLINICIAN PERSPECTIVES ON PANSEXUALITY

EXPLORING CLINICIANS' KNOWLEDGE, BELIEFS AND CLINICAL  
EXPERIENCES RELATED TO PANSEXUAL YOUTH

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## Abstract

Pansexuality is commonly defined as the emotional, romantic, and/or sexual attraction towards people regardless of their biological sex, gender identity, or gender expression. Literature regarding LGBTQ+ populations has more recently been included in the available research. However, specific subgroups receive much less attention. While there is emerging literature on pansexual youth, no study has explored clinicians' knowledge and beliefs about pansexuality, including their training and clinical experience relevant to this population. To address this gap, this mixed-methods study investigated what clinicians know about pansexuality and examined the clinical experiences of those who work directly with them. This study was conducted through an anonymous online survey of mental health professionals in the U.S. A preliminary investigation into this area may highlight both the unique stressors affecting pansexual youth and improve upon the therapeutic services provided to this population. Quantitative methods consisted of univariate, bivariate, and multivariate statistics. Results displayed a positive, statistically significant relationship ( $p = .017$ ) between identified gender and working with pansexual youth. Another linear regression showed that there was a positive, statistically significant relationship ( $p = .000$ ) between receiving relevant/any training/education and working with pansexual youth. In a third regression, a positive, statistically significant relationship ( $p = .001$ ) was found between theoretical orientation and working with pansexual youth. Qualitative methods included thematic analyses to gain a deeper understanding of specific ideologies, biases, and knowledge that these clinicians held. Several pertinent themes emerged from the thematic analysis: unique challenges experienced by pansexual youth, working therapeutically with pansexual youth, and therapists' beliefs and

assumptions. The results showcased the need for clinicians to be more mindful of biases, to further their training on sexual minority populations, and for overall advocacy. Clinical implications called for becoming knowledgeable about nonbinary identities, knowing available resources on pansexuality, seeking consultation, and educating others. Future directions necessitate more empirical studies on pansexual youth as well as clinician training. Future research is encouraged to utilize an intersectional lens to understand this population. This dissertation was conducted with the intent of advocating for this unique population.

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## **Introduction**

The LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and related communities) community is an underrepresented population subject to significant persecution within a single lifetime. In recent decades, there has been a growing social awareness, understanding, and acceptance of LGBTQ+ individuals, resulting in major shifts in our perception of gender and sexuality (Morandini et al., 2017; Russell & Fish, 2016). According to a trend forecasting report in the United States (U.S.), youth were found to be far more open-minded and permissive regarding issues of gender and sexuality (Wunderman Thompson Intelligence Group, 2016). Despite the progressive movement towards nontraditional beliefs, gender and sexual minorities continue to experience alarming rates of mental health concerns, such as depression, anxiety, and suicide (Borgogna et al., 2019; Hobaica et al., 2018; Marshal et al., 2011; Russell & Joyner, 2001). The existing literature also shows that young people are at an elevated risk for adverse mental health outcomes on the basis of their gender and sexual minority identities (Kosciw et al., 2011). An online survey by the Human Rights Campaign (2012) found that LGBT students were more likely to experience harassment, exclusion, discrimination, low social support, and increased substance use when compared to heterosexual students. Moreover, the stigma surrounding more fluid and expansive identities is thought to contribute to emotional distress and negatively impact health (Almeida et al., 2009; Sanders & Chalk, 2016). Together, the current literature underscores the importance of research that seeks to mitigate the social and mental health disparities that continue to be experienced by members of the LGBTQ+ community.



### Comments on Terminology

The following is a breakdown of some of the terminology used throughout this study. More importantly, I want to acknowledge the limitations of terminology in representing individual experiences as the definitions and labels provided here are continuously evolving and a reflection of our ever-changing social, cultural, and political climate.

Broadly speaking, *sexual orientation* is defined as an individual's emotional, romantic and/or sexual attraction to another individual (e.g., gay, lesbian, bisexual, asexual, or pansexual, among others). Sexual orientation is believed to range along a continuum and may change throughout an individual's life. Moreover, an individual's sexual behavior may not always align with an individual's self-identified sexual identity. Historically speaking, *gender* and *sex* have been used interchangeably but today are taken to hold different meanings—although the distinction between the terms is not regularly observed (APA, 2012). *Gender/gender identity* refers to an individual's innate, deeply felt psychological identification as a woman, man, both or neither. Identities such as genderqueer and gender nonconforming are also subsumed under this category. *Sex*, on the other hand, refers to the chromosomal, hormonal and anatomical characteristics that make up an individual's biology (e.g., female, male or intersex). There is also *gender expression*, which describes how an individual chooses to express, or not express, their gender identity. This occurs primarily through choice of clothing, mannerisms, names, and pronouns.

Furthermore, the term *LGBTQ+* is utilized throughout this study as an abbreviation for lesbian, gay, bisexual, transgender, queer, and related communities. It

should be noted that this term does not capture the full spectrum of identities and its usage may mask important differences observed within these groups. Additionally, *nonmonosexuality* is defined as the attraction to more than one gender and often serves as an umbrella term for various sexual identities including bisexuality, pansexuality, omnisexuality, polysexuality, etc. Whether pansexuality is distinct from other nonmonosexualities remains a point of contention and confusion in the field. In particular, one school of thought is that pansexuality is interchangeable with bisexuality as both identities recognize the possibility of attraction to more than one gender (World Public Library, 2017). In fact, some researchers have found that definitions of pansexuality and bisexuality often overlap and are conceptualized in similar ways (Belous & Bauman, 2017; Galupo et al., 2017). Still, others recognize pansexuality as a separate non-monosexual identity that challenges the binary notions of sex and gender (LaPointe, 2017). Nevertheless, researchers are finding that individuals who adopt non-monosexual identities appear to share similar experiences with invisibility, misunderstanding, and prejudice (LaPointe, 2017). All things considered, this study recognizes the ongoing discourse surrounding pansexuality and its place among other non-monosexual identities as well as realizes the fluidity and expansiveness of each of these terms.

### **Pansexuality Overview**

Currently, society is seeing an increase in the open identification and exploration of sexual and gender identities. One newer sexual identity is pansexuality. Pansexuality is commonly defined as the emotional, romantic, and/or sexual attraction towards people regardless of their biological sex, gender identity, or gender expression (Belous &

Bauman, 2017; Morandini et al., 2017). According to this working definition of pansexuality, sex and gender are not determining factors when it comes to an individual's attraction towards others (Gonel, 2013). Based on this notion, pansexual people maintain the ability and willingness to be attracted to all sexes and genders (e.g., male, intersex, transgender, genderqueer, and so forth). However, this does not mean that these individuals are attracted to everyone or that they are attracted to all sexes and genders equally (Savin-Williams, 2017).

The word *pansexual* is derived from the Greek prefix *pan*, meaning all (World Public Library, 2017). The term originates from early 20<sup>th</sup> century psychoanalysis as the psychoanalytic term *pan-sexualism* (Pansexual, n.d.), however, its current meaning developed in light of the growing awareness and recognition of individuals who experience gender outside of the gender binary (e.g., man/woman) (Jakubowski, 2014). In part, the need for a more fluid sexual identity that also captured attraction to transgender and gender nonconforming individuals led to the increasing popularity and adoption of pansexuality (Callis, 2014). In addition, much of what is currently known about pansexuality appears to be influenced by social media and testimonies from celebrities (e.g., Miley Cyrus) to public officials, like Texas legislator Mary Gonzalez—the first openly pansexual elected official in the U.S. (Savin-Williams, 2017; Signorile, 2015).

The emergence of pansexuality as a sexual orientation has led to the onset of psychological research on pansexual individuals. In a cross-sectional study by Morandini and colleagues (2017), individuals who adopted pansexual labels were compared with individuals who adopted more traditional sexual labels. In this study, the sexual and

demographic characteristics of 2,200 LGBTQ+ individuals (ages 18 to 77 years) were analyzed including age, gender, ethnicity, religion, education and income. Participants identified as lesbian/gay ( $n = 1,459$ ), bisexual ( $n = 413$ ), queer ( $n = 168$ ), pansexual ( $n = 146$ ), and other ( $n = 34$ ). The results of the study showed that pansexual respondents were younger and adopted more nonbinary gender identities (e.g., genderqueer) when compared with gay, lesbian and bisexual respondents. Pansexual participants also reported lower levels of educational attainment and income than any other sexual identity. No significant differences were observed with respect to ethnicity and religion. Additionally, the researchers revealed that those adopting the pansexual label were more likely to be cisgender women than men (gender identity matches with sex assigned at birth). The latter finding was anticipated by the researchers as non-monosexual patterns of attraction tend to be more common in women. Notably, pansexual individuals showed similar patterns of attraction and sexual behavior as bisexual individuals, which is consistent with other studies (see Galupo et al., 2017). In sum, this study contributes to the growing literature on pansexuality as it expands on the survey studies that have also documented the increasing prevalence of pansexuality in the U.S. (Galupo et al., 2014; Galupo et al., 2015). However, further data is needed about pansexuality as it remains far from being a commonly understood identity (Savin-Williams, 2017).

### **Pansexuality in Youth**

The ways in which young people are defining their sexual and gender identities is rapidly changing. In a recent study that looked at the identity labels of 17, 112 sexual and gender minorities (ages 13 to 17), as many as 26 distinct sexual orientation and gender identity classifications were described, with a quarter of them being nontraditional labels

such as pansexual (Watson et al., 2020). The increasing number of youth who are claiming a pansexual identity has also been documented in previous research (Belous & Bauman, 2017; Lapointe, 2017). For example, the Human Rights Campaign survey of more than 10,000 LGBTQ+ teenagers (ages 13 to 17) from youth centers across the U.S., showed that the percentage of teenagers who identified as pansexual was approximately 7% (Andre et al., 2014). This national survey also examined various demographic variables of these youth (e.g., gender, ethnicity/race, religious affiliation, school level, living area, and level of happiness). Among the pansexual youth who participated in the study, 69 percent identified as female, 6 percent as male, 7 percent as transgender, and 17 percent as other. The following includes the ethnic/racial breakdown of this sample: White (77%), Hispanic/Latino (8%), Black/African American (3%), Asian/Pacific Islander (3%), American Indian/Native American (2%), and other (6%). Moreover, most pansexual youth identified as atheist/agnostic (40%), while another 26% had a religious affiliation, followed by those who were spiritual but not religious (23%). Most lived in suburban (53%) and urban areas (27%), and the majority were in high school (76%). Additionally, only a small percentage of this group reported feeling very happy (5%). Overall, these results offer preliminary evidence regarding the demographics of pansexual youth.

In general, the experiences of discrimination, harassment, and stigma are common for members of the LGBTQ+ community. Still, pansexual youth are believed to encounter additional stressors related to their sexual identity. Specifically, previous research has indicated that pansexual people experience different types of stigma even within the queer community (Mitchell et al., 2015). Pansexual youth also undergo higher

levels of distress and exclusion compared to their gay, lesbian, and bisexual peers (Gray & Moore, 2018). Additionally, of the pansexual youth surveyed in the Human Rights Campaign study discussed earlier, 32% reported frequently being excluded with a majority of them reporting being called anti-gay slurs (Andre et al., 2014). This survey also documented this group's rates of being out to immediate family (53%), extended family (15%), school (57%), classmates (60%), and teachers (30%)—rates that were lower for pansexual youth compared to other sexual minority groups. The survey also asked this sample of young pansexuals to rate their level of acceptance within their community, family, peer group, and school. A significant portion of them indicated lacking a definite sense of belonging within their social circle and only 4% of them endorsing feeling like they definitely fit in. The above results are surprising provided that youth identifying as pansexual have also been documented to have some of the highest rates of participation in school activities (e.g., band and academic clubs), LGBT organizations, and online communities (Andre et al., 2014; Gonen, 2013).

Other exploratory research has also looked at the experiences of pansexual youth. For example, a qualitative study interviewed Canadian youth in high school belonging to Gay-Straight Alliances on their perspectives, definitions and alignment with pansexuality. The author of this particular study noted that pansexual youth often reported feeling misunderstood, invisible, and discriminated against at school (Lapointe, 2017). The considerable stigma experienced by this young group of people due to their pansexual identity may stem from some common *misconceptions* that society has about more fluid and expansive identities, as demonstrated in the following examples (Andre et al., 2014; Gonen, 2013):

- Pansexuality is not a real sexual orientation.
- Pansexuality is just the latest trend among youth.
- Pansexual people are confused.
- Pansexual people are sexually promiscuous.
- Being pansexual is the same as being bisexual.
- Pansexual people are polyamorous (desire relationships with more than one partner).

Notably, some youth have expressed that they might sometimes refer to themselves as ‘queer’ instead of ‘pansexual’ so as to avoid having to define pansexuality in social situations or to deal with the stigmatization coming from both their heterosexual and non-heterosexual peers (Gonel, 2013).

Furthermore, a mixed-methods study that explored the use of labels in sexual and gender minority youth in British Columbia, Minnesota, and Massachusetts ( $n = 66$ ; mean age of 16.6 years), showed that youth who identified with nontraditional sexual orientations were significantly more likely to use nontraditional gender identities (e.g., gender identities that do not align with sex assigned at birth or do not conform to normative categories of man versus woman) (Porta et al., 2020). In accordance with this finding, similar research has noted that pansexual youth are likely to adopt and even prefer non-cisgender identities more than youth belonging to other sexual identity categories (Andre et al., 2014; Morandini et al., 2017). The adoption of these labels makes sense given the increasing number of people subscribing to nonbinary views of sexuality and gender. Yet, there is minimal understanding regarding the role that gender identity plays in the formation of their sexual orientation. However, one may surmise that

the stigmatization experienced by pansexual youth may be further exacerbated by other intersecting identities, such as gender. Also, sexuality and gender are often conflated aspects of identity and may make the coming out process for some individuals much more difficult (Andre et al., 2014).

Altogether, the existing literature on pansexuality underscores the various issues facing members of this group. From a minority stress perspective, pansexual youth may experience greater stress as a result of holding a minority status within the LGBTQ+ community (Borgona et al., 2019; Gray & Moore, 2018). As previously discussed, feelings of exclusion and bias are also amplified in this population as they struggle to find a community that supports and understands them. The impact of this invisibility and invalidation may contribute to an increased risk of negative mental and physical health problems. Consistent with this, a study conducted by Sanders and Chalk (2016) looking at the predictors of psychological outcomes in non-heterosexual individuals, showed that pansexual individuals experienced significantly higher levels of anxiety and depression across several outcome measures (e.g., Depression Anxiety Stress Scales) when compared with straight, gay, and lesbian individuals. Therefore, it is important for mental health professionals to provide care to pansexual youth that does not further alienate them but provides validation, acceptance and normalization of their sexual orientation instead (Israel et al., 2008). This may help to decrease their avoidance of health services and improve their wellbeing (Porta et al., 2020).

While the literature on pansexuality has elucidated some important findings about this sexual orientation, limitations of the research must also be considered. For example, most of the samples used in these studies were predominately White, which is a



limitation that is often observed in sexual and gender minority health research. Thus, more diverse samples are needed in order to gather further information relevant to our understanding of pansexuality in ethnic-racial minorities and allow for the results of these studies to be more generalizable. Furthermore, some samples appeared to be biased toward those who were younger and more connected to the LGBTQ+ community (Morandini et al., 2017). Therefore, pansexual individuals who are older or less socially connected to the LGBTQ+ community are not as well represented in the research. Most importantly, there was a dearth of analyses examining how social positioning in our current society impacts on the experiences of pansexual youth. Lastly, terms like *sex* and *gender* were defined by researchers across several studies was not always consistent, making it difficult to draw conclusions or compare results.

Generally speaking, research conducted within the mental health field has largely focused on the experiences of gay, lesbian, and bisexual people. While the research on pansexuality as a sexual orientation is expanding, further studies are needed in this area that address the limitations noted above. A more in-depth, nuanced understanding of pansexuality and the experiences of those who adopt this label may undoubtedly offer us important insights regarding how to best conduct clinical work with pansexuals and pave the way for the development of therapeutic interventions that target the distinct social and emotional disparities experienced by this population.

### **LGBTQ+ Mental Health Treatment**

Therapists have a responsibility to equally advocate for all clients including those identifying anywhere along the LGBTQ+ continuum. According to the American Psychological Association Committee on Lesbian, Gay, Bisexual and Transgender

Concerns practice guidelines (2012), clinicians should aim to eliminate the effect of explicit and implicit biases in their assessment and treatment of sexual and gender minorities. Their guidelines for affirmative psychological practice address the following areas: attitudes towards non-heterosexuality, relationships and families, issues of diversity, workplace and economic issues, education and training, and research.

Fortunately, the mental health field has demonstrated improved attitudes toward LGBT clients as well as increased training opportunities and research on LGBT issues (Shelton & Delgado-Romero, 2011). Unfortunately, although there is evidence to show that affirmative psychotherapy can be helpful, some LGBTQ+ people continue to report negative counseling experiences where they have felt judged, invalidated and misunderstood (Buser et al., 2011; Israel et al., 2008; Shelton & Delgado-Romero, 2011). Researchers have also noted the pervasiveness of homophobia in the mental health field including the subtle prejudices and microaggressions that undermine the legitimacy of sexual and gender identities (Shelton & Delgado-Romero, 2011). Moreover, the biased treatment of sexual and gender minorities appears to be due to the lack of training, specialization, and clinical experience with this community (Morrow, 2000). As such, some mental health professionals may remain uninformed about the unique stressors impacting LGBTQ+ people and/or hold pathological views of sexuality and gender that influence how they conduct therapy (World Professional Association for Transgender Health, 2011).

Information on pansexuality is limited in the mental health field. There is also little to no research examining the experiences of pansexual people in therapy. With the rise of pansexuality and the high levels of discrimination and stigmatization reported by

pansexual youth, there is a need for research aimed at understanding the assumptions that clinicians hold about pansexuality. By conducting this type of research, we can identify and address any existing biases that perpetuate the social injustice known to afflict the young people adopting these non-monosexual identities. Also, by analyzing the clinical experiences of those who work directly with them, we may engender the development of helpful therapeutic services that effectively target the minority stress experienced by pansexual youth. Health professionals working in a therapeutic capacity with this population may also have some ideas related to the delivery of more competent, ethical, and sensitive care.

### **Goals of the Current Study**

While there is emerging literature on pansexuality in youth, no study has explored clinicians' knowledge and beliefs about pansexuality, including their training and experience relevant to this population. To address this gap in the literature, a mixed-methods study was conducted in order to investigate what clinicians currently know about pansexuality and examine the clinical experiences of those who work directly with them. This study was conducted through an anonymous online survey of mental health professionals in the U.S. A preliminary investigation into this area may highlight both the unique stressors affecting pansexual youth and improve upon the therapeutic services provided to this population.

Notably, various assumptions underpin the research design and implementation of this study including:

- Sexual orientation is a complex social construct that intersects with other aspects of identity including gender, race, ethnicity, religion, etc.

- Pansexual youth have unique mental health needs that differ from those experienced by other members of the LGBTQ+ community.
- The exploration of pansexuality in this study may not accurately represent the sentiments and unique experiences of every person who identifies with this term.
- Society's concept of sexuality, gender, and sex is ever-changing.

### *Primary Aims and Hypotheses*

**Aim 1.** The importance of knowing how to work therapeutically with pansexual youth has become particularly pertinent given the rise of pansexuality in youth. This study hopes to add to the existing scholarly research by exploring clinicians' knowledge, beliefs, and experiences relevant to this emerging population. A mixed-methods approach was selected in order to collect both descriptive quantitative data and in-depth qualitative data. The results of this study may shed light on what is currently known and believed about pansexuality within the mental health field. It may also have important implications regarding the assessment and treatment of pansexual youth. The following are some of the proposed hypotheses for this aim:

- Clinicians will report varying levels of belief regarding the validity of pansexuality as a sexual orientation.
- Clinicians will report varying levels of knowledge about pansexuality.
- Clinicians will report varying levels of experience working therapeutically with pansexual youth.
- Most clinicians will report having minimal to no knowledge regarding the current literature on pansexuality.
- Most clinicians will conflate pansexuality with other sexual and gender identities.

**Aim 2.** In addition to obtaining descriptive quantitative data, this study will also collect in-depth qualitative data from clinicians who have experience working directly with pansexual youth in therapeutic settings. Anonymous responses to original, open-ended online survey questions will be analyzed for themes to help generate questions and hypotheses for future research. The findings may shed light on some of the current issues impacting pansexual youth as well as the ways in which mental health providers try to address their unique mental health needs. The following questions will be explored for this aim:

- What have you noticed are the struggles and challenges for this population?
- What are your own theoretical assumptions about sexuality and how does this influence your clinical work with pansexual youth?
- Are there any clinical considerations that clinicians should take into account when working with this population?
- What are some effective ways to help clinicians to be more aware of, accepting of, and effective in working with pansexual youth?
- Describe your personal reactions and experiences related to providing services to pansexual youth.

## **Methodology**

### **Participants**

Eighty-four mental health professionals participated in this study about pansexuality in youth. Recruitment for the study utilized email advertisements containing a description of the study, Institutional Review Board (IRB) approval, inclusion criteria, research staff contact information, and a link to a brief and anonymous online survey sent

via an email advertisement (see Appendix A). There were four inclusion criteria for participation in this study. Inclusion criteria specified: 1) participants were either a licensed mental health professional or a current psychology student in an APA accredited psychology program, 2) participants had experience working with children/adolescents, 3) participants resided and practiced in the U.S., and 4) participants spoke English. These criteria increased the likelihood that subjects would be engaged in the delivery of direct therapeutic services to pansexual youth. Participants were excluded from the present study if they did not meet inclusion criteria or did not complete sufficient questions on the online survey. To be considered sufficiently completed at least 72% of the survey must have been answered. As this convenience sample was not selected at random, the findings may not be representative of the knowledge, beliefs, and experiences of clinicians in the mental health field.

### ***Demographics***

Of the 107 individuals who initiated the online survey platform, 87 consented and met criteria to participate, and 84 (78.5%) of those response sets were sufficient for use in the data analysis (i.e., completed at least 72% of the survey). Comprehensive demographic information is provided below.

**Sociocultural identities.** Participants included individuals of all ages: 52.4% were in their twenties, 31% were in their thirties, 10.7% were in their forties, 4.8% were in their fifties, and 1.2% were in their sixties. Most participants identified as female (81%), 13.1% identified as male, 4.8% identified as genderqueer, and 1.2% identified as transgender. Additionally, the majority of the sample identified as European origin/White (74.7%), 7.2% as Asian-American/Asian origin/Pacific Islander, 6% as African-

American/Black/African origin, 4.8% Latino-a/Hispanic, and 4.8% as bi-racial or multiracial. Other racial/ethnic backgrounds identified by participants included Middle Eastern (2.4%). One (1.2%) participant did not respond to this question. In terms of sexual identity, about half of the sample primarily identified as straight/heterosexual (52.4%), 11.9% of participants identified as bisexual, 9.5% identified as lesbian, 7.1% identified as gay, 7.1% identified as queer, 6% identified as pansexual, 3.6% identified as other (i.e., “fluid;” “gray asexual”), 1.2% identified as asexual, and 1.2% did not know/preferred not to say.

**Professional discipline and theoretical orientation.** Thirty-seven participants (44%) identified as current psychology doctoral students, 26 participants (31%) identified as clinical psychologists (PhD/PsyD), 10 participants (11.9%) identified as school psychologists (PhD/PsyD), eight participants (9.5%) identified as licensed clinical social workers (LCSW), one participant (1.2%) identified as a psychiatrist (MD), one participant (1.2%) identified as a licensed social worker (LSW), and one participant (1.2%) identified as a licensed professional counselor (LPC) (refer to Table 1). Theoretical orientation also varied across subjects (refer to Table 2). The majority identified as primarily behavioral/cognitive behavioral (CBT) (51.2%), while 21.4% of participants identified as integrative/eclectic and 11.9% identified as psychodynamic/psychoanalytic. Additional theoretical orientations represented in the sample included dialectical behavior therapy (DBT) (7.1%), existential/humanistic (3.6%), family/systems (1.2%), acceptance and commitment therapy (ACT) (1.2%), and other (1.2%). One (1.2%) participant did not provide a response to this question.

**Clinical experience, settings and expertise.** Among participants, 90.5% *currently* worked with adolescents (13 to 17 years), 57.1% with children (12 years or under), 51.2% with adults/older adults, 27.4% with families, 14.3% with groups, and 6% with couples. Participants also worked in various treatment settings (refer to Table 3), such as outpatient clinics (40.5%), private practices (29.8%), department/school clinics (23.8%), public school systems (K-12) (23.5%), hospitals (17.9%), community mental health centers (14.3%), inpatient psychiatric hospitals (9.5%), partial hospitalization/intensive outpatient clinics (4.8%), the foster care system (3.6%), and college counseling centers (3.6%). Other practice settings included community center (1.2%), juvenile justice system (1.2%), LGBTQ center (1.2%), private school (1.2%), and university (1.2%).

Moreover, participants varied across specialties/areas of expertise (refer to Table 4). The most common specialties/areas of expertise included child and adolescent internalizing disorders (65.5%), child and adolescent externalizing disorders (50%), LGBTQ+ issues (42.9%), trauma/PTSD (36.9%), ASD/developmental disorders/learning disabilities (27.4%), family/systems (16.7%), personality disorders (11.9%), eating disorders (9.5%), pediatrics (9.5%), grief/loss/bereavement (8.3%), serious mental illness (8.3%), substance and alcohol-related disorders (7.1%), and other (6%). Additional responses for specialties/areas of expertise included sleep/insomnia (2.4%), relationships (1.2%), transgender and gender nonbinary (1.2%), and young adult developmental issues (1.2%).

## **Materials**



For the purposes of this study, the researcher created a 31-item survey (see Appendix B for the written format) using Qualtrics survey software provided by Rutgers University. The survey is composed of three sections:

- Demographic information (11 items).
- Knowledge, understanding and beliefs about pansexuality (13 items).
- Clinician experiences related to working with pansexual youth in therapeutic settings (7 items).

Of the total items, 25 are closed-ended questions and statements (81%) and six are open-ended questions (19%). Some of the closed-ended questions provide the option to elaborate upon responses. The responses collected from open-ended questions were used for the qualitative analysis, while responses to closed-ended questions were used for quantitative analysis. Furthermore, information regarding the reliability and validity of the survey are unavailable as this survey was developed solely for the purposes of this study.

### *Questionnaire*

The demographic section of the survey inquired about U.S. residency, age, biological sex, gender identity, race/ethnicity, sexual orientation, profession, primary practice setting, theoretical orientation, primary client populations, and clinical specialty/area of expertise. Participants were asked to select one or more responses from the list provided for each demographic question. For example, to assess for primary client populations, participants were asked, “What client groups do you mostly work with?” Many of the questions also included an “Other” response so as to provide the option of writing a different answer.

Clinicians' knowledge, understanding, and beliefs about pansexuality were assessed through twelve closed-ended questions as well as one open-ended question, which asked participants to elaborate on any of their responses in this section. Eight of the closed-ended items were rated on 5-point typical Likert scales from 1 (*Strongly disagree; Not at all familiar; Not at all aware*) to 5 (*Strongly agree; Very familiar; Very aware*), respectively. Sample items of closed-ended questions include: "How aware do you think the mental health field is about pansexuality?" and "Please rate the extent to which you agree with the following statement: Pansexuality is a valid sexual orientation." Additionally, three of the closed-ended questions included "Yes" and "No" response choices, with some offering the option of elaborating upon the selected response. Sample items included questions such as: "Did you know about the term pansexuality prior to this study?" and "Have you received any training or education relevant to working with pansexual youth?" The final closed-ended item in this section asked participants to select a statement that most reflected their beliefs about sexuality and gender.

Finally, the last section of the survey inquired about the experiences of clinicians who have worked therapeutically with pansexual youth. Of the two closed-ended items in this section, one question asked participants to indicate whether they have worked with pansexual youth including how many they have worked with and how many they are currently treating. Another closed-ended question asked them to select all the issues that have come up in their work with pansexual youth. Five open-ended questions were also used for this section. Some examples of these items include: "How can we help clinicians to be more aware of, accepting of, and effective in working with pansexual youth?" and

“Please briefly describe your own reactions and experiences related to providing services for pansexual youth.”

**Missing Data.** Missing data is prevalent in most analyses as surveys often allow for a participant to skip questions that they may not know the answer to or are uncomfortable with answering. Missing data has the potential to negatively impact statistical power and may damage the validity of the analysis as well as potentially allow for a research bias (Acock, 2005). Fortunately, this study had very few questions with missing data (most had only one missing) and when the researcher found a missing answer from a participant, the answer was simply counted as missing. No other methods for missing data such as maximum likelihood estimation, were utilized in this study.

### **Design and Procedure**

The study design used a convergent mixed methods approach, which “merges quantitative and qualitative data, which provides a comprehensive analysis of the research problem. In this design, the investigator typically collects both forms of data... and then integrates the information in the interpretation of the overall results” (Creswell & Creswell, 2018, p.15). The mixed methods approach also helps maximize the diversity and depth of responses obtained by participants.

The Rutgers University IRB approved all study procedures before the survey was distributed to participants. The survey was adapted to an online format using Qualtrics software provided by Rutgers University. The researcher input survey questions, responses, and instructions into the Qualtrics software to create the survey. Before sending the survey to prospective participants, the study was piloted to assess for clarity of instructions and content, to ensure comprehensibility and functionality, and to gain an

estimate of the expected completion time. Once reviewed, the online survey was made accessible to participants via a website link. Participants were informed at the time of recruitment that participation could take up to 10 to 30 minutes. This time frame was anticipated to allow for sufficient time to complete informed consent procedures and the online survey.

All participants were provided with an online informed consent form that outlined the study procedures, confidentiality, risks, and benefits (see Appendix C). It also informed participants about the anonymity and voluntary nature of the research. Additionally, participants were notified that they could skip any questions they did not wish to answer or withdraw their participation without penalty at any time simply by exiting the survey. Participants were also informed that their participation would contribute to the emerging knowledge and understanding of pansexuality in the mental health field, inform about some of the unique needs and challenges faced by pansexual youth, and benefit future practitioners in developing better supports for pansexual individuals. Because written consent could not be obtained, participants were asked to click an on-screen button to indicate if they consented to participate, this served as participant consent to continue. Individuals who declined to provide consent were immediately exited from the online survey platform. Participants who consented were instructed to print a copy of the consent form for their records. By clicking on the survey link at the end of the consent form, participants proceeded to the online survey, which included demographic and background questions as well as questions assessing for their beliefs, knowledge, and experience related to pansexuality. If participants did not submit their responses at the end of the survey, their responses were not included as a part of the

study. The principal investigator also carefully examined participant responses from the demographic section of the survey to manually confirm that participants met inclusion criteria.

All efforts were made to keep participant responses confidential by implementing a data security plan that minimized the risk of a breach in confidentiality. Since the survey was anonymous, there was no link between participant responses and identifying information. Once approved by the Rutgers IRB, participants were recruited through purposive sampling. Email advertisements that included information about the study as well as the link to the online survey was distributed to mental health professionals, APA organizations, student listservs of accredited doctoral clinical and counseling programs, and campus organizations such as LGBTQ+ groups. Additionally, network recruitment using a snowball sampling technique was used. For example, participants were asked to pass on information about the study to others in their social networks who might meet inclusion criteria. Participants who had subsequent questions or concerns about their participation were free to contact either the principal investigator, the faculty sponsors or the university personnel affiliated with the Human Subjects Research Protection Program, whose contact information was also listed on the consent form. No adverse events occurred at any point during the research protocol.

### **Data Collection and Analysis**

Qualtrics were used to collect and forward responses to the research team. A combination of quantitative and qualitative data was obtained. Data was collected on a rolling basis. The number of responses obtained was not limited in advance due to an inability to predict how many participants would provide answers that would be complete

enough for inclusion in the data set. After an extended period of time during which no additional responses were obtained, data collection was closed, and all data were exported from Qualtrics into Microsoft Excel for analysis. The investigator then manually transferred the data from Microsoft Excel into IBM SPSS Statistics (Version 26) and created variables for each item and response set. After both data sets were analyzed, the findings were integrated using a side-by-side comparison approach that involved presenting one set of findings and then the other (Creswell & Creswell, 2018). All data is expected to be deleted three years after study findings are professionally presented or published. No information that can identify subjects will appear in any professional presentation or publication.

### *Quantitative Analysis*

Since this study used an original survey in lieu of a pre-validated measure, the data analysis was primarily descriptive in nature. Descriptive statistics were obtained by analyzing the frequency percentages of responses to closed-ended survey questions. Data cleaning and screening procedures consisted of checking for errors, assessing for data normality, and running descriptives. Thirty-eight participants (45.2%) checked yes to question 25 (have you worked with pansexual youth?); however, one participant (participant 10) data was not used as answers did not indicate work with pansexual youth but answers pertaining to a colleague who identified as pansexual; another participant (participant 37) indicated working with “0” pansexual youth so the yes response for this question is invalid. After correcting for this error and manually checking who correctly checked yes to this question, 36 participants (42.9%) indicated having worked with pansexual youth; six of these participants (participant 1, 4, 9, 34, 39, and 49) did not

answer the open-ended survey items related to their experience and so the resulting data from 30 participants were used for the qualitative analysis.

Due to the limited amount of participants in this study, analyses conducted quantitatively are considered insufficient as a standalone method. A power analysis would reveal that there are not enough participants as 80% power is needed for a medium effect (almost double this study's participants) (Cohen, 1992). Further, the quantitative analyses conducted are utilized to inform and contextualize the data rather than make determinate statements or rationalizations. Descriptives and frequencies were ran in addition to correlational analyses. Regressions were utilized to evaluate the accuracy of predictions (Salkind, 2014). A regression or prediction line is used to analyze the data through a series of points (Mertler & Vannatta, 2017). Hierarchical multiple regressions were also ran to determine impacts of specific variables and their ability to predict relationships.

### *Qualitative Analysis*

A qualitative approach was used to analyze participant responses to open-ended survey questions as a way to supplement the quantitative data. It should be noted that the qualitative responses provided by participants are not meant to represent the clinical experiences of all mental health professionals who have worked or are currently working with pansexual youth.

Braun and Clarke's (2006) guidelines for conducting a thematic analysis was used to examine all qualitative data in this study. Generally speaking, this method involves a series of coding procedures that systematically identifies, analyzes, and reports patterns or themes across a dataset in relation to a research question. Moreover, it emphasizes the

identification and organization of novel themes not captured by the existing literature. Braun and Clarke (2006) describe thematic analysis as “relatively unique among qualitative analytic methods in that it only provides a method for data analysis; it does not prescribe methods of data collection, theoretical positions, epistemological or ontological frameworks” (p. 178). Thematic analysis also “rests on the presumption that ideas which recur across a dataset capture something psychologically or socially meaningful” (Braun & Clarke, 2006, p. 223). This particular approach is thought to be flexible and accessible to researchers as it can be used to answer almost any type of research question (Craver, 2014).

According to Willig (2013), “thematic analysis has only relatively recently been recognized as a qualitative research method in its own right, and there are now a number of clear and comprehensive accounts of how to carry out high quality thematic analysis” (p. 179). Braun and Clarke’s (2006) guidelines are often cited as the best available systematic approach to thematic analysis and believed to underpin most other methods of qualitative data analysis (Willig, 2013). It was also selected as the most appropriate data analytic method for this study as other methods (e.g., grounded theory) require continually adapting and changing the study questions in response to new information, which was not feasible (Willig, 2013).

Braun and Clarke (2006) provide a rigorous, step-by-step guide for conducting a thematic analysis. It includes a thorough description of the data analysis process that involves the following six discrete stages: a) data familiarization, b) initial code generation with a focus on line-by-line coding, c) looking for themes based on initial coding, d) reviewing themes, e) defining and labeling themes, and f) report writing.



Additionally, this process calls for a constant moving back and forth between the entire data set, the coded extracts of data, and the analysis of the data—a process that allows the researcher to form a sense of what information might be pertinent and relevant for answering the research questions (Craver, 2014).

## **Results**

The following section provides an in-depth analysis of the results of the current study. This study sought to answer research questions regarding clinicians' knowledge, beliefs, and clinical experiences working with pansexual clients. Results from both qualitative and quantitative analyses are presented. Univariate, bivariate, and multivariate analyses of the study's results are provided in narrative form and APA statistical tables. Univariate and bivariate statistics were run to contextualize and better understand the sample's participants and their demographic information. The research questions have also been answered by conducting preliminary bivariate statistics such as correlations, t-tests, and ANOVAs that informed a hierarchical multiple regression.

### **Quantitative Findings**

IBM SPSS Statistics version 26 was used to complete the statistical analysis conducted for this study. Data cleaning and screening procedures discussed in the methodology section have been completed before computing statistical analyses. The information on the table displays that the data were normally distributed, thus, there were no issues of multicollinearity found as the variables have a correlation of less than .80. Descriptive statistics and frequencies of the sample have been included to better understand the study's participants. The total participants in the study was 84. Univariate statistics will be reported in conjunction with qualitative results.

*Univariate Analyses*

The running of descriptive statistics displayed that 75 participants (89.3%) of the sample believe pansexuality is a valid sexual orientation. Eight individuals neither agree or disagree. Only one participant (1.2%) selected 'disagree' to this question, therefore, the vast majority of the sample does believe that pansexuality is a valid orientation. Sixty-five participants (78.3%) selected either disagree or strongly disagree to the statement that pansexual youth are promiscuous. Therefore, 18 participants (21.7%) did have this common misconception about pansexual individuals being promiscuous. Nine participants (10.8%) responded either strongly agree or agree to the question about pansexuality being the latest trend among youth. Moreover, 6 participants (7.1%) reported they agree with this statement, "pansexual youth are just confused." Thus, the majority of participants did not agree with this statement.

Zero participants agreed with the statement, "pansexuality is the same as polyamory," showcasing that clinicians in this study understand that pansexuality and polyamory are two distinct orientations. In reference to the statement about sexuality and gender fluidity, one participant (1.2%) answered, "sexuality and gender are both fixed," five participants (6%) answered, "sexuality is fluid and gender is fixed," five individuals (6%) selected "other," but the majority of the sample, 72 participants (85.7%), answered, "sexuality and gender are both fluid." For the question, "did you know about the term pansexuality prior to this study? (yes/no)," 79 participants (94%) answered yes, but 4 participants (4.8%) said no. For the question, "how familiar are you with the literature on pansexual youth," the vast majority of the sample answered with "not familiar at all," "slightly familiar," and "somewhat familiar" with a total of 73 participants (88%)

answering in one of those categories. Therefore, only 10 participants (12%) answered “moderately familiar” or “very familiar.”

The results for the question, “have you received any training or education relevant to working with pansexual youth? (yes/no),” displayed that 20 participants (23.8%) reported they have received training or education relevant to working with pansexual youth while 64 individuals (76.2%) reported they have not. In reference to the question, “have you consulted with others or the literature on issues relevant to pansexuality in youth? (yes/no),” 26 participants (31%) selected yes to having consulted with others or the literature while most participants (69%) said no they have not.

Nine participants (10.7%) reported that they strongly agree with the statement, “pansexuality and bisexuality are similar sexual orientations” and 24 (28.6%) participants reported they agree with this statement. Thus, 39.8% of the clinicians believe pansexuality and bisexuality are similar. In regard to the question, “how aware do you think the mental health field is about pansexuality,” 91.7% of the participants reported that they believe the profession is “somewhat aware” to “not aware at all.” Overall, univariate statistics aligned with qualitative results reported below.

### ***Bivariate Analyses***

Various Pearson correlations were conducted to explore potential correlations within the data. However, many of the correlations conducted were not found to bring upon meaningful, statistically significant correlations. Interestingly, the researcher found there were differences in responses between those clinicians who reported experience working with pansexual youth and those without any experience. Participants that reported clinical experience working with pansexual youth only made up 45.2% of the

sample ( $n = 36.2$ ) (42.9%). Interestingly, when specifically looking at individuals who have worked with pansexual youth and clinician age, it was found that there was a statistically significant negative correlation ( $p < .01$ ). Thus, the older in age the clinician reported, the less likely they were to have experience working with pansexual youth. Additionally, Pearson correlation analyses revealed there was a statistically significant negative correlation ( $p < .05$ ) between working with pansexual youth and gender identity. Additionally, there was not a statistically significant correlation between working with pansexual youth and race.

### ***Multivariate Analyses***

Various linear regressions were conducted. One linear regression was conducted to determine if there is an impact between identified gender and working with pansexual youth. The regression revealed that there was a positive, statistically significant relationship ( $F = 5.91, p = .017$ ). Another linear regression showed that there was a statistically significant relationship between receiving any training or education relevant to working with pansexual youth and working with pansexual youth ( $F = 32.46, p = .000$ ). In a third linear regression, the relationship between theoretical orientation and working with pansexual youth was also examined. The results displayed a positive, statistically significant relationship ( $F = 12.29, p = .001$ ). A fourth linear regression was ran to determine if there is a relationship between race and working with pansexual youth. There was not a statistically significant relationship. The three statistically significant regressions results can be found on Tables 5, 6, and 7. Lastly, hierarchical multiple regressions were ran to analyze the association between various independent variables and dependent variables while controlling for demographic variables as well.

Unfortunately, there were not statistically significant results. This may be due to low power or the amount of participants in the study.

### **Qualitative Findings**

A thematic analysis was conducted using responses to the open-ended survey questions related to working therapeutically with pansexual youth—27, 28, 29, 30, and 31 (see Appendix B for specific prompts). Additionally, a separate qualitative analysis was conducted for an *optional* open-ended survey question (question 24) that asked participants to elaborate on their responses to closed-ended survey questions, which also included participants without any prior clinical experience with pansexual youth. In order to identify themes across responses to different questions, the data was collated by participants rather than by questions. Although this approach to collating the data is not standard, it helps researchers in seeing patterns across the dataset rather than around specific questions, which is especially useful for analyzing qualitative survey data (Braun and Clarke, 2006). Braun and Clarke’s (2006) guidelines for conducting a thematic analysis was used to examine all qualitative data in this study. Specifically, the qualitative analysis was conducted in the following six phases:

1. Participant responses were reviewed several times and transferred to an excel document for examination. Detailed notes that consisted of an initial list of potential themes based on concepts and phrases in the data were recorded. Themes are believed to “[capture] something important about the data in relation to the research question, and [represent] some level of patterned response or meaning within the data set” (Braun and Clarke, 2006, p. 82).

2. The second phase of analysis involved working methodically through the entire data set and coding line-by-line for as many potential themes as possible.
3. In the third phase of analysis, different codes were organized into potential themes. Subsequently, the relevant coded data extracts within the identified themes were collated (see Appendix D for an example of data extracts with focused codes). Moreover, visual representations of themes were created to assist this phase of analysis.
4. Initial themes were also reviewed and refined in the fourth phase of analysis until they appeared to form a coherent pattern in relation to the data set. This stage involved several iterations of refinement.
5. The next phase of analysis consisted of naming, defining, and further refining the themes by going back and forth between the themes and the data set (see Appendices E, F, G, and H for the developed visual representations of themes).
6. The sixth phase of the analysis involved identifying extracts from participant responses that illustrated aspects of each theme and provided evidence of the themes. These extracts were modified for minor spelling and grammatical errors to enhance readability. The frequencies at which each of these themes/sub-themes appeared in the data were also calculated.

Importantly, participant responses to specific questions occasionally included elements of more than one theme. As such, overlap in themes was inevitable. The excerpts were also further examined by the researcher and connected back to the research questions and the relevant research literature in the discussion section.

Of the 84 participants in this study, 36 participants (42.9% of total sample) indicated having prior or current experience working with pansexual youth. Of these 36 participants, 30 of them (83.3% of respondents; 35.7% of total sample) responded to the open-ended survey questions related to their clinical experience. Participants who denied having clinical experience with pansexual youth were exempt from answering the *qualitative* questions of the survey pertaining to clinical work with pansexual youth. After discarding non-applicable responses (e.g., n/a), the total number of responses were recorded for each of the following items:

- Question 27. What have you noticed are some of the unique stressors experienced by this population? (29 participants; 96.7% of respondents; 34.5% of total sample).
- Question 28. How have your personal beliefs about sexuality and gender influenced your clinical work with pansexual youth? (27 participants; 90% of respondents; 32.1% of total sample).
- Question 29. What should clinicians take into account when working with this population? (27 participants; 90% of respondents; 32.1% of total sample).
- Question 30. How can we help clinicians to be more aware of, accepting of, and effective in working with pansexual youth? (27 participants; 90% of respondents; 32.1% of total sample).
- Question 31. Please briefly describe your own reactions and experiences related to providing services for pansexual youth (22 participants; 73.3% of respondents; 26.2% of total sample).

### ***The Unique Challenges Experienced by Pansexual Youth***

Participants were asked to describe some of the unique stressors experienced by pansexual youth based on their clinical work with this population. Responses across different questions were analyzed for common themes in order to better understand these challenges. In the final analysis, two themes containing two or three sub-themes were identified (see Appendix E for a visual representation of themes).

**1. The Black Sheep Effect.** Twenty-two participants (73.3% of respondents; 26.2% of total sample) mentioned that pansexual youth often feel excluded and are treated differently by other members of society including, but not limited to, family, school, and peers. Subthemes identified for this category were: (a) misunderstood and ostracized, and (b) stigma and discrimination.

*1a. Misunderstood and Ostracized.* Nineteen participants (63.3% of respondents; 22.6% of total sample) talked about the misunderstanding and rejection experienced by pansexual youth. In particular, participants frequently expressed that pansexual youth often feel misunderstood by others with regards to their sexual identity, making it the most frequently cited subtheme for this category. According to one participant, pansexual youth struggle with “having an identity that is not well understood and not in common vernacular, especially among older generations” [Participant 40]. Others expressed that these youth are “misunderstood by family” [Participant 26] and that “even peers don’t always understand it” [Participant 76]. Additionally, some participants shared that due to the lack of understanding in others about their pansexual orientation, “these youth are often expected to teach others about their identity” [Participant 63] and “explain about it all the time” [Participant 70]. Another participant also observed that pansexual youth seem to find it “difficult to find others who understand” [Participant 13].



Other participants detailed the lack of support experienced by pansexual youth for their non-monosexual identity. For instance, one participant shared that pansexual youth are “not being respected or recognized for their identities” [Participant 55], while others stressed that there is a “lack of visible role models in mainstream culture” [Participant 61], including an “absence of queer support” [Participant 68]. Moreover, two participants highlighted that these youth “struggle to find a community” [Participant 14] as well as “difficulties with finding their voice/place within the LGBTQ community” [Participant 35]. Others similarly stressed the “lack of acceptance” [Participant 23] that pansexual youth experience “even by those within the LG community” [Participant 73]. There were also a handful of participants who emphasized the rejection of pansexual individuals by people in their lives (e.g., “rejection from family” [Participant 71]; “more peer rejection” [Participant 67]).

***Ib. Stigma and Discrimination.*** Twelve participants (40% of respondents; 14.3% of total sample) described the types of stigma and discrimination experienced by pansexual youth. More specifically, many participants reported that pansexual youth often deal with discrimination by others due to their identities. According to one participant, the discrimination these youth encounter occurs “both outside the queer community and within it” [Participant 61] and may be “due to confusion or outright bigotry” [Participant 63]. Another wrote, people “[make] erroneous assumptions and [treat] them poorly because they are seen as different and not fitting in” [Participant 5]. According to other participants, pansexual youth often come across invalidation, including “dismissal of their identity as being valid” [Participant 73]. Two other examples of this includes, “‘just a phase’ response from others” [Participant 13] and the

belief that “it’s ‘trendy’ to be pansexual” [Participant 76]. Another participant said, “it brings an additional challenge to be seen by some as having an illegitimate or ‘trendy’ identity within the LGBTQ community” [Participant 80].

Relatedly, one participant detailed her perspective on pansexuality and how it compares to the experience of others in the queer community:

Because of the overlap between different identity labels, the fluidity of these terms and the experience of them, and the newness of the term, I can't say that I can distinguish unique stressors for pansexual use outside of those for LGBTQ youth in general and particularly for bisexual youth. I can say I think some pansexual people experience a kind of courtesy stigma in that their affirmation and sometimes attraction to/openness to relationships with trans and gender diverse people can lead to stigma. This would be something bisexuals may not as readily experience. [Participant 40]

The stigma and discrimination experienced by pansexual youth for their orientation also appears occur in other social contexts. For instance, several participants noted that pansexual youth have had “previous negative experiences with mental health professionals” [Participant 68] and experience with “microaggressions from school staff” [Participant 78].

**2. On Being Pansexual: Personal Narratives.** Twenty-Five participants (83.3% of respondents; 29.8% of total sample) touched on aspects of identity development, family relationships, and the impact of sexual identity on the well-being of pansexual youth. Subthemes for this category were: (a) identity development, (b) navigating familial relationships, and (c) impact of identity on self and well-being.

**2a. Identity Development.** Fourteen participants (46.7% of respondents, 16.7% of total sample) referenced some of the unique challenges that pansexual youth face in relation to the development of their sexual identity. For example, two participants shared that pansexual youth struggle with “being able to be themselves” [Participant 12] and having to deal with the pressure of “finding an identity while being pushed by others to make identity mean fixed identity” [Participant 47]. Another also commented on the “lack of available resources surrounding pansexuality” [Participant 61].

Moreover, several participants emphasized that the coming out process for pansexual youth tends to be more challenging for this population. According to one participant, pansexual youth are needing to navigate “the erasure they can feel when their identity is rejected” [Participant 73], while another participant highlighted the difficulties stemming from the “erasure of non-monosexual identities” [Participant 70]. On a similar note, a few participants expressed that pansexual youth are challenged with knowing “how to cope if they identify as pansexual but are dating a heterosexual partner” [Participant 82] and “with sometimes being straight passing depending on who they are dating” [Participant 32].

Many other participants also noted the difficulties with navigating multiple cultural identities. For example, two participants discussed the invalidation that pansexual youth feel when “disclosing [their] identity to family” [Participant 53] due to the “conflicting values/beliefs/attitudes from parents/family members” [Participant 33] about sexuality and gender. Likewise, another participant wrote, “My client has trouble justifying her orientation to her mother, who is strongly catholic” [Participant 17].

**2b. Navigating Familial Relationships.** Fourteen participants (46.7% of

respondents; 16.7% of total sample) expanded on some of the issues that pansexual youth face within the family system. Often, participants discussed that coming out to family was a significant stressor for these teens because of the “family distress” [Participant 68] it caused, including navigating the challenging “process of family acceptance and understanding” [Participant 67]. Several other participants also discussed the invalidation that pansexual youth encounter from family, such as misunderstanding about their sexual orientation and the conflation of sexuality and gender. For example, one participant stated, “All my client's parents were unaware of this term prior to hearing it from their child. Parents think defining sexual orientation and gender are trendy now” [Participant 76]. Another participant also observed “family invalidation related to cultural and religious beliefs about acceptable gender and sexual norms” [Participant 33]. Similar concerns were noted by other participants. Examples of this included: “lack of support from family” [Participant 61]; “feeling alienated from family members” [Participant 78]; and “rejection by family” [Participant 71].

***2c. Impact of Identity on Self and Well-Being.*** Ten participants (33.3% of respondents; 11.9% of total sample) commented on the impact that these stressors have on the well-being of pansexual youth. For example, two participants noticed that in their clinical work with this population, pansexual youth often have “difficulty feeling that they ‘fit’ in any one peer group” [Participant 67] and struggle with “imposter syndrome in the queer community” [Participant 82]. Moreover, one participant wrote that pansexual youth also have “strong needs for acceptance, validation, and understanding” [Participant 23], while another mentioned the frustration these youth experience as a result of “the gendered nature of sexual orientation descriptions and categories” [Participant 35].

Relatedly, a few others described some of the emotional disturbances they have observed in pansexual youth such as, “suicidal ideation” [Participant 68], and “anxiety and anger” [Participant 13]. Another participant also expanded on their experience with pansexual youth:

In my practice, these youth often struggle with disorganized thoughts and communication. They also often have experienced complex trauma in childhood, sometimes directly related to (i.e. stemming from) their identity as an SGM youth, though not always. [Participant 62]

### ***Therapists’ Beliefs and Theoretical Assumptions About Sexuality and Gender***

Participants were asked to expand on their personal beliefs and theoretical assumptions about sexuality and gender including how these perspectives impact on their clinical work with pansexual youth. Responses across different questions were analyzed for common themes so as to explore the viewpoints that clinicians have related to pansexuality. In the final analysis, one theme containing three sub-themes was identified (see Appendix F for a visual representation of this theme).

**1. Therapists’ Beliefs and Theoretical Assumptions.** Twenty participants (66.7% of respondents; 23.8% of total sample) detailed their beliefs and assumptions about pansexuality and related topics (e.g., sexuality and gender). Subthemes identified for this category were: (a) bisexuality versus pansexuality, (b) attitudes toward pansexuality, and (c) the sex and gender revolution.

***1a. Bisexuality Versus Pansexuality.*** Four participants (13.3% of respondents; 4.8% of total sample) discussed their perspectives on pansexuality and bisexuality. For example, one participant claimed that pansexuality is “essentially bisexuality but also

includes folks who don't identify in the female and male genders" [Participant 14].

Another participant recommended that clinicians learn to "understand how [pansexuality] is different from bisexuality and how conflating the two concepts is hurtful toward building trust and a strong therapeutic relationship with such clients" [Participant 62].

Not surprisingly, several participants talked about the ongoing "hostility between bisexual and pansexual communities" [Participant 35]. One participant also elaborated on the misunderstanding between both communities:

I also personally understand the tension between the bisexual community, many of whom view bisexuality as synonymous with pansexuality, and pansexuals who use the term in order to be more inclusive. Personally, in order to honor both the history of the 'B' in LGBTQ but also be inclusive I use both terms, and truly feel a kinship with both [Participant 40].

***Ib. Attitudes Toward Pansexuality.*** Twelve participants (40% of respondents; 14.3% of total sample) touched on the attitudes and beliefs they have around pansexuality. Many of them shared their thoughts regarding the validity of pansexuality like the right that these individuals have to love whomever they want. For instance, one participant stated, "I believe all identifications are valid" [Participant 33], while another wrote, "I believe that each person has the right to figure out for themselves who they are in terms of gender and sexuality, and to figure out who they want to be with or are attracted to" [Participant 5]. Others echoed similar views including one participant who shared the following: "I am open and believe that all people should be able to express their gender and sexuality in therapy and feel accepted. I have been very explicit about this belief to my client" [Participant 17].

Others also opened about their attitudes on sexuality and its corresponding labels. In particular, one participant said, “My personal beliefs lead me to encourage youth to not feel wedded to a label or that there is a right or wrong label, but to identify in the way that feels best to them, and use terms in the way that is meaningful to them” [Participant 40]. A different participant also shared the following:

I believe that there is no fixed truth to how humans should relate to each other. Values, which need to constantly evolve within a society, should inform our behaviors. When we value peace, acceptance, love, community, and respect, we should act in ways that validate and support healthy relationships. If someone who is pansexual is enjoying a healthy romantic or sexual relationship, or exploring what matters to them in their relationships, then I am happy for them. At my core, I believe that people have the right to engage in consensual, healthy relationships. [Participant 42]

Moreover, some participants acknowledged the influence that their personal beliefs and theoretical assumptions have on their clinical practice with pansexual youth. For example, one participant mentioned it having a “positive” impact on their work as they are “able to educate other professionals and colleagues about pansexuality and bisexuality to promote equal treatment and compassion for these youth” [Participant 73], while another noted, “I also specialize in treating transgender and gender diverse people, so my strong trans-affirmative beliefs lead me to a strong belief in the importance of gender inclusivity” [Participant 40].

***1c. The Sex and Gender Revolution.*** Eleven participants (36.7% of respondents; 13.1% of total sample) expanded on their views on sexuality and gender. Most

participants expressed having open beliefs about the nature of sexuality and gender. One participant said, “I am open and flexible in my views of sexuality and gender [Participant 47], while another similarly expressed, “As a LGBTQ clinician I am inherently open-minded to gender and sexual minorities” [Participant 68]. Others also commented on the fluid nature of sexuality and gender including the belief that clinicians “need to be open to the fluid nature of gender and sexual orientation” [Participant 35]. Additionally, a handful of participants also highlighted the evolving and ever-changing nature of sexuality and gender. For example, one participant wrote that “our understanding of sexuality and gender is always evolving” [Participant 55]. Others specified that sexuality and gender “might change across time (both with youth and with adults)” [Participant 5], and that the terms used for them “constantly evolve” [Participant 42]. Relatedly, another participant shared that we “should see it as social progress that people are being more open to all folks particularly trans folks” [Participant 12].

### *Working Therapeutically with Pansexual Youth*

Participants were asked to describe their experiences and reactions to working with pansexual youth. Participants were also asked to expand on the ways mental health professionals can be more aware, accepting, and effective when working with this population. Responses across different questions were analyzed for common themes. In the final analysis, three themes containing three sub-themes each were identified (see Appendix G for a visual representation of themes).

**1. Supporting Pansexual Youth in the Therapy Room.** Twenty-six participants (86.7% of respondents; 30.1% of total sample) discussed practice considerations for the therapist, including what has prepared them for work with pansexual youth. This category



was the most commonly observed in the sample. Subthemes for this category included: (a) personal qualities, (b) therapeutic interventions, and (c) combating microaggressions.

*1a. Personal Qualities.* Fifteen participants (50% of respondents; 17.9% of total sample) identified personal factors that they believe impact on their clinical work with pansexual youth. In particular, most participants described the benefits of maintaining openness, respect, curiosity, and a non-judgmental stance when working with this population. For example, one participant indicated, “I consider myself to be very open and non-judgmental and I think it allows clients to open up more” [Participant 15], while others similarly emphasized that it helps to “be open and non-judgmental” [Participant 71]. Other excerpts from participants also illustrated this point: “At baseline, being open to learning and supporting all forms of sexuality and gender diversity have been very helpful for me” [Participant 67]; and “Even if a clinician is unfamiliar with this population, they could approach the topic with a genuine curiosity that will communicate a sense of wanting to understand their client” [Participant 26].

Several participants also emphasized other practice considerations. Specifically, one participant said, “I practice a gender-affirmative, sex-positive approach to therapy. This helps me create a safe space for clients exploring their identities” [Participant 35]. Others claimed that they “want to provide affirmative care” [Participant 78], while some believe they are “more open, accepting and affirming” [Participant 23]. Another participant described what has been helpful to them with respect to the care they provide for non-monosexual youth:

I try to be critically reflective of how my own biases influence my clinical practice. I always strive to be gender and sexually affirming and provide explicit

support as an ally of pansexual youth (or youth of any sexual minority identity).

[Participant 62]

Relatedly, when discussing what has helped them in their clinical work with pansexual youth, one participant wrote, “I very much appreciate my fluent awareness of the differences between gender and sexuality” [Participant 80].

***Ib. Therapeutic Interventions.*** Sixteen participants (53.3% of respondents; 19% of total sample) described the therapeutic interventions clinicians should take into consideration when working with pansexual youth based off of their own clinical experiences with this population. Most participants reiterated the importance of asking pansexual youth to define what pansexuality means to them. The following excerpt provides evidence for this:

Clinicians should realize that just because you can find a definition of ‘pansexual’ online doesn't mean that is not necessarily the definition that fits for the young person they are working with. It's important to know the general definition, and then ask the client what it means to them to be pansexual. If done in the spirit of wanting to know the client fully, rather than asking the client to educate the clinician, it can be therapeutic for the client. [Participant 63]

Others also considered it a necessary component of the treatment process. For instance, one participant wrote, “I strongly recommend clinicians allow the client to define the terms they are using to describe their identities” so as to better “understand their perspective on the topic” [Participant 35]. Several participants reiterated this opinion stating, “It helps me to remember clients are the experts on their own experience” [Participant 55] and that “regardless of label definition each person defines parameters of

their orientation” [Participant 71]. This personalized approach to treatment was also referenced by another participant: “Being sensitive to ask the youth or individual how they define the term. Pansexual, or gender non-binary, or gay often have unique significance for the patient themselves. General definitions may or may not adequately encompass the patient's experience” [Participant 13].

Notably, several participants highlighted the importance of interventions such as listening, asking questions, and providing validation. The following are some examples illustrating this point: “Align with the client and believe them when they discuss their experiences of their own sexual orientation” [Participant 62]; “Listen to [your] clients experiences and accept their experiences as valid” [Participant 73]; and “[ask] respectful clarifying questions” as it is “much better than pretending you know or understand what a teen is saying to you!” [Participant 67]. Another participant also opened up about how the “Lack of societal support for their identity makes support from their therapist much more critical” [Participant 61].

Furthermore, other participants listed the ways in which clinicians can be more effective in their clinical work with pansexual youth. For example, two participants made reference to pronouns. One participant specifically wrote, “ask about preferred pronouns and share yours” [Participant 33], while the other commented, “I respected their choice of pronouns and partners the same way I would any other youth who did not identify in this way” [Participant 26]. Another participant also emphasized the following with regards to working therapeutically with pansexual youth:

The importance of listening, being respectful and non-judgmental, knowing about helpful resources, considering the impact of their friends, family and school

environment on them, as well as any possible impact of religion for them, helping them develop a support system that works well for them and finding others who also identify as pansexual so that they do not feel alone, complications that might arise with coming out and dating. [Participant 5]

Finally, some participants stressed the importance of a strong social support system for these youth. One participant wrote, “A strong connection to a queer community via personal relationships or online groups is crucial” [Participant 68], while another suggested that clinicians “Include parents and siblings (if helpful)...as there is typically a divide between a teens understanding and a parent's understanding” [Participant 76].

***Ic. Combating Microaggressions.*** Twelve participants (40% of respondents; 14.3% of total sample) discussed microaggressions and how to avoid them. In particular, participants frequently mentioned the negative impact of making assumptions about pansexuality. According to one participant, clinicians “should watch their assumptions about this population” [Participant 12]. Others also emphasized a similar point of view: “Don't make assumptions and don't allow yourself to fall prey to the discriminatory messages out there about pansexuality” [Participant 81]; and “Don't make assumptions about gender/sexual orientation...or assume it will be the focus of treatment” [Participant 33]. Another participant asserted:

Assumptions can create problems. I recommend asking a client ‘What does that term mean to you?’ to understand their perspective on the topic....Questioning identity does not make this a phase/trend, rather a topic of ongoing exploration and identity development. Questioning identity does not make this a phase or

trend, rather a topic of ongoing exploration and identity development. [Participant 35]

Interestingly, others stressed that “sexuality is only one part of identity” [Participant 12] and that for some, “the majority of [the] work does not revolve around their sexual or gender orientation” [Participant 42].

Several participants also mentioned that clinicians should “Try to learn as much as [they] can so [they] do not appear ignorant or dismissive” [Participant 15], while others expressed, “I can't even imagine how frustrating it must be to go into a therapy room and have to explain something about themselves that in their mind is common knowledge” [Participant 17]. Others also offered their perspective on how to educate about pansexuality and its common misconceptions. For example:

Helping [clinicians] understand what pansexuality is and what it is NOT, just as importantly, e.g., not having anything to do with ‘promiscuity’ or polyamory necessarily, and that just like any other aspect of identity and identity formation, all youth will have their own path to this identity and understanding of what pansexuality means for them. [Participant 67]

Another participant similarly wrote, “It is also important to realize that someone who is attracted to more than one gender is not more promiscuous than someone who is heterosexual or only attracted to the ‘opposite’ sex” [Participant 63].

**2. Therapists’ Reactions and Subjective Experiences.** Twenty-one participants (70% of respondents; 25% of total sample) detailed their personal reactions and subjective experiences related to their clinical work with pansexual youth. Subthemes for this category included: (a) professional experiences, (b) kinship with pansexual youth,

and (c) qualities in pansexual youth.

**2a. Professional Experiences.** Sixteen participants (53.3% of respondents; 19% of total sample) spoke about their clinical experiences with pansexual youth. In particular, many participants emphasized the positive experiences they have working with this population. For example, a few wrote that their work with pansexual youth “has been extremely rewarding” [Participant 63] and “meaningful” [Participant 40]. Others also described a sense of fulfillment, gratitude, and enjoyment. Examples of this included the following: “Working with students and clients who are pansexual is very fulfilling for me in regards to my personal research and clinical interests and advocacy” [Participant 73]; “I am grateful for the opportunities to work with pansexual youth and look forward to continuing to assist them in their journeys of self-exploration” [Participant 35]; and “I enjoy it very much! I love that young people are exploring different aspects of their gender and sexual identities and/or know who they are!” [Participant 76]. Another participant reported both positive and negative reactions: “I have felt empowered at times working with these clients and angry at society for invalidating these individuals” [Participant 68]. Additionally, two participants referenced their growth as a clinician as a result of their work with pansexual clients. One of them shared:

I worked with a youth who identified both as transgender and pansexual.

Although I could not relate on a personal level to what this youth might have experienced, my work with them provided me with a humbling learning experience and reminded me to stay open and curious with all clients at all times.

[Participant 26]

Two participants also discussed some of the challenges they have encountered in

their work with his population. One of them expressed that working with pansexual youth is “Challenging in terms of family work” [Participant 33]. On a different note, two participants shared that working with pansexual youth is not any different than working with other youth. For example, one participant wrote, “It is similar to working with youth who identify as LGBT, queer, or asexual, etc., and that if I am open and accepting of who they are, the therapy tends to go well” [Participant 5].

**2b. Kinship with Pansexual Youth.** Nine participants (30% of respondents; 10.7% of total sample) described their sense of kinship with pansexual youth. In particular, several participants detailed their personal experiences with invalidation. For example, one participant stated, “I am sensitive to and understand the incredibly negative impact of invalidation and non-acceptance of identity” [Participant 26], while another expressed, “I feel a kinship with pansexual youth, in some ways, as I understand the discrimination they face” [Participant 81]. Likewise, one participant also wrote, “I feel very protective of these kids. I wish I had had an LGBTQ identified school staff or clinician to work with me when I was a child” [Participant 78].

Many participants also identified as LGBTQ+ themselves and discussed aspects of their own identity including the positive role it plays in their work with pansexual youth. For instance, one participant said, “As a queer-identified therapist, I find my clients are more willing to self-identify to me, and more willing to discuss the ways their orientation affects their lived experience” [Participant 61], while another claimed, “It's not possible for me to set my own LGBTQ identity aside. I believe that it's an advantage, however, as it has allowed me to remain very open-minded in working with youth of any gender identity/expression and any sexuality” [Participant 80]. Others also expressed

similar sentiments such as, “I relate to it as someone who had a lot of vacillating experiences of their own sexuality in my teens. I think it allows me to be open and nonreactive to shifting experiences of sexuality and create an open space” [Participant 17].

**2c. Qualities in Pansexual Youth.** Five participants (16.7% of respondents; 6% of total sample) mentioned qualities they have observed in pansexual youth stemming from their work with this population. One participant wrote, “I am always amazed at these youths' strength in being who they are despite the mental health and structural challenges they often face” [Participant 62]. Another shared being “impressed at their ability to be so flexible and open-minded” [Participant 63]. Others also described pansexual youth as “awesome” and “a hope to our world [as] they show that the world is growing [and] evolving” [Participant 12], and “Pansexual youth tend to have a sophisticated and thoughtful understanding of both sexuality and gender that is rare in older generations, [which] leads to in-depth and complex discussions of various aspects of sexuality that may not always align. For example, emotional attraction, physical attraction and desire, intellectual compatibility, political or social connection, etc.” [Participant 40].

**3. Transforming the Mental Health Field.** Twenty-five participants (83.3% of respondents; 29.8% of total sample) discussed the various action items that need to take place within mental health in order to increase awareness about pansexuality and improve upon the clinical services provided to this population. Subthemes for this category included: (a) individual action, (b) systemic changes, and (c) barriers and biases.

**3a. Individual Action.** Sixteen participants (53.3% of respondents; 19% of total sample) described the actions that clinicians can take themselves to become more aware,



accepting, and effective in their clinical work with pansexual youth. For example, one participant wrote, “Clinicians should be knowledgeable about various sexual identities” [Participant 2], while another stated that “Clinicians should gain knowledge about the different types of sexual and romantic attraction,” including putting pansexuality “on forms as an option to allow your mind to understand that many youth identify this way” [Participant 12]. Others also recommended that clinicians educate themselves on the following: “literature on sexual fluidity” and the “extensive research on outcomes for bisexuals, many of which likely extend to pansexuals” [Participant 40]; “Protective and risk factors specific to this population” [Participant 68]; and “helpful resources” [Participant 5]. Another participant exclaimed, “Information! Honestly, even just watching the youtube channels or reading the tumblr posts that so many of these youths find comfort in would help clinicians understand the experiential phenomenology here” [Participant 17]. Relatedly, one participant shared the following based off of their own experience:

Their gender and sexual identity did not change how I provided treatment for them, but it led me to do some reading [and] training to increase my knowledge and competency in understanding their identities. [Participant 26]

In addition to the action items above, some participants wrote, “Clinicians should consult with other professionals and seek ongoing education” [Participant 42], while others said, “Read, take CE courses or found consultation groups” [Participant 76]. On a similar note, two participants recommended that clinicians seek “exposure to [pansexual] clients” [Participant 14]. A couple of participants also stressed the need for clinicians to explore “their own identities and how conscious of them they are” [Participant 47].

**3b. Systemic Changes.** Twenty participants (66.7% of respondents; 23.4% of total sample) described some of the systemic changes that need to occur within mental health in order to effectively change the ways clinical services are provided to pansexual youth. Often, participants emphasized the need for more training and resources on pansexuality. This also included the need to make them more accessible to clinicians (e.g., free). For example, one participant stated, “Better training and more widely-available resources for clinicians looking to educate themselves” [Participant 61]. Other participants were also specific about the type of training needed: “Training that is about inter-subjectivity” [Participant 47]; “Provide training on-site and call out microaggressions when we see them” [Participant 78]; and training on “how to address conflicting values, beliefs, [and] attitudes from parents/family members in a way that encourages acceptance and support of their children’s identity without being invalidating, and thus risk turning them off, of their perspectives” [Participant 33]. Other participants similarly asserted the need for “free online resources for education” [Participant 71] and “more resources for clinicians to help pansexual youth” [Participant 2].

Other types of support most commonly discussed by participants were education, consultation, coursework, and research. Specifically, one participant said, “Help to educate, educate, educate” and “Include the term pansexual in broader discussions of LGBTQ+ populations” [Participant 26], while another wrote, “Education, consultation, and training” [Participant 70]. Another participant shared:

Educating [clinicians] about pansexuality and resources for people who are pansexual; having them hear directly from pansexual youth and adults about their experiences both positive and negative in the world and with mental health

treaters, doctors, teachers, etc. [Participant 5]

Regarding coursework, one participant emphasized the following:

Pansexuality needs to be included in multicultural counseling classes, as well as any discussion around LGBTQ+ communities. Overall, the LGBTQ+ education needs to be included across ALL curriculum rather than limited to diversity or human sexuality classes. [Participant 35]

Another participant shared, “I would like to see all training programs have a mandatory LGBTQ class. My program had a general diversity course as well as other electives, but I don't believe there was anything specific to pansexual youth” [Participant 63]. Relatedly, a few participants referenced the need for “more literature” [53] and “more research” [Participant 81] from “pansexual researchers and clinicians” [Participant 68].

**3c. Barriers and Biases.** Six participants (20% of respondents; 7.1% of total sample) noted their observations on the present barriers and biases in the mental health field. For example, in discussing their clinical experience with a youth who identified as pansexual, one participant mentioned that their supervision on the case was “unfortunately unhelpful” [Participant 13], while others wrote, “I wish I had more opportunities to learn how to do this though, since I’m certainly no expert and often worry that I may be inadvertently invalidating to my clients due to lack of knowledge” [Participant 33]. Another participant shared, “Most clinicians not in the LGBTQ community, despite being open, are lacking a lot of really basic knowledge. I wish clinicians would make more of an effort to do their own research. I also wish people didn’t consider LGBTQ issues inappropriate for school” [Participant 78].

Relatedly, two participants also noticed the presence of biases from their

colleagues regarding sexuality. For instance, one participant expressed, “I tend to believe youth are who they say they are more than some of my colleagues do” [Participant 63].

Another participant shared a similar experience: “The most negative reactions I experience is when my colleagues are not as accepting or unwilling to engage in conversations about youth sexuality. They have dismissed it as a ‘trend’ or state that sexuality in adolescents shouldn’t be discussed as they are ‘too young’ to really know their identity” [Participant 73].

### ***Expanding on Clinician Responses to Quantitative Items***

Of the 84 participants in this study, 23 participants (27.4% of total sample) answered the *optional* question that asked participants to elaborate on any of their responses to the closed-ended questions in the survey (questions 1 through 23).

Responses were recorded from participants with and without any experience working with pansexual youth. Responses were analyzed for common themes so as to explore clinicians’ knowledge and beliefs about pansexuality. In the final analysis, two themes containing three sub-themes each were identified (see Appendix H for a visual representation of themes, sub-themes and associated focused codes).

**1. The Gray Area: Pansexuality and Bisexuality.** Thirteen participants (56.5% of respondents; 15.5% of total sample) discussed their views on both pansexuality and bisexuality. Subthemes for this category included: (a) is pansexuality needed? (b) similarities between labels, and (c) differences between labels.

***1a. Is ‘Pansexuality’ Needed?*** Four participants (17.4% of respondents; 4.8% of total sample) detailed their personal views on pansexuality and its validity as a sexual

orientation. For example, two participants commented on the negative impact of the term *pansexuality* on the bisexual community. One participant wrote:

I think ‘pansexuality’ is actually a term that harms the established community of those who are attracted to people of genders both the same and different from one's own, fka/aka bisexuality. It creates all these false divisions within the community, making it difficult for me to find the right term to name my own identity. [Participant 4]

Another participant reiterated similar views about the pansexual label:

I feel like bisexuality covers the same thing as pan and I feel like there are so many sexuality labels it lacks parsimony and makes it harder for people to take seriously the idea that there is more than heterosexuality. I realize pan is supposed to include non-binary/trans people, but I think bisexual, while it technically only refers to 2 sexes/genders, is encompassing enough. [Participant 10]

Others also discussed their uncertainty regarding pansexuality and how it compares with other non-monosexual orientations (e.g., “It's hard to say whether bi and pan are similar or not. It just depends on the person you ask, as I have heard different people describe these identities in different ways” [Participant 63]).

***Ib. Similarities Between Labels.*** Six participants (26.1% of respondents; 7.1% of total sample) touched on the similarities between pansexuality and bisexuality. For example, one participant stated, “I have clients who use pansexuality and bisexuality interchangeably” [Participant 47], while another shared, “anecdotally many bisexual people I know could be qualified as pan if they wanted to take on that label” [Participant 17]. Moreover, some participants expressed that both labels “are similar in orientation

(aka who they are attracted to)” [Participant 70], and both signify “a person attracted to people of a variety of genders” [Participant 75]. Another participant explained that while pansexuality is independent from bisexuality, “certain aspects of [it] are similar to bisexuality, particularly in the sense that they are not attracted to only one gender” [Participant 64].

Interestingly, one participant asserted that both pansexual and bisexual communities both have to deal with the erasure of their non-monosexual identities; they stated, “I think that there can be some confusion that occurs simply because there isn't mirroring or twinship that can be achieved easily by non-monosexual youth due to erasure of non-monosexual identities” [Participant 70].

***1c. Differences Between Labels.*** Eight participants (34.8% of respondents; 9.5% of total sample) elaborated on their beliefs about pansexuality and how it is different than bisexuality. More specifically, one participant spoke hesitantly about the differences between pansexuality and bisexuality: “As far as I’m aware, bisexual means only attracted to male/female (binary), whereas pansexual means attracted to anyone regardless of how they identify. Again, as far as I’m aware, though I may be wrong!” [Participant 33]. Another participant wrote, “I see bisexuality as an umbrella term (attraction to more than one sex and/or gender) and pansexuality [as] more specific (attraction to all sexes or genders as opposed to only some)” [Participant 78]. Others also commented on the belief that pansexuality “is less binary than bisexuality” [Participant 55] and “encompasses more genders” [Participant 63]. On a related note, one participant wrote, “I feel that pansexuality is a way to express openness/attraction to gender

expression that isn't necessarily encompassed by identifying as bisexual” [Participant 17].

Additionally, another participant detailed their personal experience with both terms:

I identified as bisexual and realized that the ‘pansexual’ label fit my identity much better, as I had been attracted to and involved with individuals who did not identify as fully male or fully female. To me, the term pansexuality did a better job of honoring their identities. [Participant 80]

Further, one participant explained that pansexuality and bisexuality are similar in orientation but “not similar in identity, which is socially constructed and bound by culture, age, race, and other contexts” [Participant 70].

**2. *Understanding Perspectives on Pansexuality.*** Eighteen participants (78.3% of respondents; 21.4% of total sample) shared their personal perspectives on pansexuality including reactions to the study. Subthemes for this category included: (a) addressing misconceptions, (b) more than just another trend, and (c) reactions to the study.

**2a. *Addressing Misconceptions.*** Eight participants (34.8% of respondents; 9.5% of total sample) addressed misconceptions about pansexuality. Some of the common misconceptions described by participants are best illustrated in the following excerpts: “Pansexual youth are no more likely to be ‘promiscuous’ than youth who do not identify as pansexual” [Participant 61]; “The stereotype of pansexual youth being promiscuous is ‘strongly disagree,’ however, some of my pansexual youth clients are promiscuous for reasons outside of identity/orientation” [Participant 35]; and “I say neither agree nor disagree that pansexual people are promiscuous because I don’t think pansexuality has anything to do with promiscuity, not that I am undecided” [Participant 78]. Others also

claimed, “I know that pansexual youth as promiscuous is a dangerous stereotype, but it's possible that some are, just as some heterosexual youth are promiscuous” [Participant 4].

Many participants also discussed the common misconception regarding pansexuality and polyamory. For instance, one participant wrote, “People can be both pansexual and polyamorous, but they do not necessarily go together” [Participant 5]. Another participant shared, “many of my polyamorous clients identify as pansexual or bisexual, but I also have many gay/lesbian/straight polyamorous clients” [Participant 70]. Relatedly, one participant challenged another common misconception of pansexual youth: “as is a natural stage of being a youth exploring sexuality, many may be confused. However, I do not agree with the phrasing of ‘pansexual youth are \*just\* confused’” [Participant 30].

**2b. More than just Another Trend.** Six participants (26.1% of respondents; 7.1% of total sample) discussed their perspectives with regards to the rise of pansexuality in youth including the implication of it being a *trend*. Specifically, one participant shared, “It does seem that pansexuality is a ‘recent trend,’ but I believe that that's because a) the terminology was not in use in years prior, and b) it has become more acceptable to be open about such things, which of course brings up the rates of identification with bisexuality, pansexuality, etc.” [Participant 80]. Another participant wrote:

I would never refer to pansexuality as [a] ‘trend,’ i.e. to imply that it is not valid or genuine, but I do think that as we develop new concepts and language for sexuality and gender, people (especially youth) have more ways to identify and explore their identities, in a very healthy way. [Participant 67]



Additionally, one participant mentioned that the increase of pansexuality is due to society “becoming more accepting and validating” [Participant 68], while others indicated that youth have become “more open to fluid sexuality and gender” [Participant 55]. Others echoed similar sentiments about the rise of pansexuality in youth. For example, one participant said, “I feel that this sexual identity is currently ‘trending’ in that it is becoming more known and, thus, more explored. But, for many who identify in this way, I do not think that it is a socio-cultural trend that will simply pass or be grown out of” [Pansexuality 30]. Another participant emphasized the following perspective:

I think you could say that ‘pansexuality is the latest trend,’ because the term is newer, so people could not identify as such until it became a more widely recognized concept. I do think that pansexual is a valid way to identify, and I think that phrasing was meant to imply that because it is a ‘trend’ it is not valid, but I chose to ‘disagree’ rather than ‘strongly disagree,’ because factually, it does represent a trend (if you think of a trend as a general pattern of increase in popularity, without the trivializing connotations. [Participant 75]

**2c. Reactions to the Study.** Eight participants (34.8% of respondents; 9.5% of total sample) shared their personal reactions to the study on pansexuality. In particular, one participant shared, “These questions make me sad because folks should know this stuff” [Participant 12]. Another participant said, “I do not feel like I know enough about pansexuality to offer strong opinions” [Participant 46], while another wrote, “I am fairly confident about my responses, but I believe it is important to note that my area of research with my advisor and my dissertation topic are specifically about sexual and

gender minority youth” [Participant 62]. One participant also indicated taking “issue with the wording of these attitude questions” [Participant 4].

Several participants also opened up about their lack of knowledge and clinical training on pansexuality. One participant wrote, “I have not received any training on working with individuals in the LGBTQ+ community” [Participant 19]. Another detailed the following:

It does not bother me that I have not received specific training on pansexual youth in my program, because I understand that we live in an evolving world, and that I as a practitioner can seek to educate myself outside of specific training for clinicians (through lived experience, talking with people in a variety of communities, etc.). I like to think I would have some understanding of what it is to identify as pansexual, but in the context of this survey, I am actually a little confused about what you are referring to as bisexual and pansexual....I feel like we occasionally talk about ‘sexual minority’ youth and ‘queer-identified youth’ in my program, which ostensibly includes pansexual youth, but not specific discussion of pansexuality. [Participant 75]

This same participant subsequently mentioned, “No one in my program has ever talked about pansexual youth, and I am not aware of really any literature on pansexual youth. I suspect that research on pansexual youth is fairly limited, which is probably why I have not heard much about it before in the context of my clinical practice” [Participant 75].

Lastly, two participants from the study also described other specific reflections that the study provoked for them. Regarding the definition of pansexuality, one participant declared that “the academic definition for purposes of research and how a

client may use the term are not the same” [Participant 47]. Another participant also expanded on their views around sexuality and gender.

### **Discussion**

The purpose of this study was to provide a preliminary exploration of clinicians’ beliefs, knowledge, and therapeutic experiences regarding pansexuality in youth so as to better understand what practitioners know about this emerging population. In the following discussion, we examine both the quantitative and qualitative analyses of the study. Interpretations of all the study’s hypotheses will be discussed including clinical implications for mental health professionals working with this population. Lastly, this section outlines limitations and future directions for research on this understudied topic and population.

### **Interpretation of Findings**

#### ***Summary of Participants***

A total of 84 participants completed the online survey. Most participants were White (74.7%), female (81%) psychology doctoral students (44%) and clinical psychologists (31%) currently working with adolescents (90.5%) in outpatient clinics (40.5%). About half of the sample identified as straight/heterosexual (52.4%). Most participants described their theoretical orientation as primarily behavioral/cognitive-behavioral (51.2%) or integrative/eclectic (21.4%). Additionally, the most common area of expertise among participants was child/adolescent internalizing disorders (65.5%) and externalizing disorders (50%). The third most common area of expertise was LGBTQ+ issues, reported by 42.9% of the sample. Lastly, participants were recruited from a diverse group of professional organizations and listservs.

***Finding 1: Most Clinicians Believed that Pansexuality is a Valid Orientation.***

Quantitative results displayed that 75 participants (89.3%) of the sample believe pansexuality is a valid sexual orientation. Eight individuals neither agree or disagree. Only one participant (1.2%) selected 'disagree' to this question, therefore, the vast majority of the sample does believe that pansexuality is a valid orientation. This finding supports the hypothesis that clinicians would endorse varying levels of beliefs regarding the validity of pansexuality as a sexual orientation. Fortunately, more clinicians than not appeared to believe pansexuality is valid. Still, this result is concerning as one person who is providing mental health care does not believe 'pansexual' is a valid sexual orientation. Thus, it is wondered how this clinician is providing proper care.

A thematic analysis of qualitative data can help expand on this main finding. Regarding clinical work with pansexual youth, clinicians were asked to describe their attitudes and beliefs around pansexuality. Indeed, many clinicians believe that pansexuality, as well as other non-monosexual orientations, is a valid way to identify and that individuals have the right to love whomever they want. In particular, one participant wrote that they are explicit in sharing their beliefs about the right to sexual and gender expression to their clients. Another participant stated, "If someone who is pansexual is enjoying a healthy romantic or sexual relationship, or exploring what matters to them in their relationships, then I am happy for them. At my core, I believe that people have the right to engage in consensual, healthy relationships" [Participant 42]. Others also noted that pansexuality better accommodates the openness and attraction to non-binary people and represents a new way of socially constructing sexuality in contrast to what previously had seemed given objectively by nature. Further, some participants also acknowledged

the positive impact that these beliefs have on their ability to be more affirming and effective in their clinical practice with pansexual youth.

No other study to this researcher's knowledge has empirically investigated clinicians' beliefs about pansexuality, specifically its validity as a sexual orientation in youth.

***Finding 2: Misconceptions About Pansexuality Persists Among Some Clinicians.***

There is a considerable amount of stigma experienced by pansexual youth related to their pansexual identity, some of which may stem from common *misconceptions* that society has about more fluid and expansive identities such as pansexuality (Andre et al., 2014; Gonel, 2013). This study further explored whether similar misconceptions about this unique identity are held by clinicians in mental health.

In particular, participants were asked to rate the extent to which they agree with the following statement: '*Pansexual youth are promiscuous.*' Sixty-five participants (78.3%) selected either disagree or strongly disagree for this question. Therefore, 18 participants (21.7%) endorsed this common misconception about pansexual individuals being promiscuous and showcases the importance of needing to understand what is contributing to these biases held by this subset of the sample.

Participants were also asked to rate the extent to which they agree with the statement that '*pansexuality is the latest trend among youth.*' Nine participants (10.8%) responded either strongly agree or agree to this statement. One possible interpretation is that there is a clear bias present for these participants. Thus, the stigma attached to identifying as pansexual may even be prevalent among mental health professionals as evidenced by these results. Other possible interpretations are offered through the thematic

analysis conducted in this study. That is, for some of the participants, pansexuality is seen as a ‘trend’ among young people, not because it is an invalid orientation, but because it is becoming more well-known and increasing in popularity. One participant explained that while they agreed with the belief that pansexuality is the latest trend, they do not think “it is a socio-cultural trend that will simply pass or be grown out of” [Participant 30]. Others emphasized that the increased rates of identification with pansexuality is solely a result of society becoming more accepting of these nonbinary identities. A few participants also noted that with the development of new concepts and terminology for sexuality, many youth have taken on the label of pansexuality to better communicate what they already know to be true about themselves.

Other misconceptions about pansexuality were also found among practitioners. For instance, although the majority of participants did not agree with the statement that *‘pansexual youth are just confused,’* six mental health professionals (7.1%) did agree with this sentiment. This finding is concerning as it indicates that some clinicians may maintain that a pansexual person is ‘just confused’ rather than accepting the individual for how they choose to identify.

Fortunately, zero participants agreed with the following statement that *‘pansexuality is the same as polyamory.’* This showcases that clinicians in this study understand that pansexuality and polyamory are two distinct orientations. The qualitative data also show evidence in support of this finding. For example, when expanding on their response to the above misconception, one participant wrote, “People can be both pansexual and polyamorous, but they do not necessarily go together” [Participant 5],

while another stated, “many of my polyamorous clients identify as pansexual or bisexual, but I also have many gay/lesbian/straight polyamorous clients” [Participant 70].

Furthermore, several participants reported difficulties related to encountering bias from others in the mental health field. Examples of this taken directly from the qualitative data included the following: “I tend to believe youth are who they say they are more than some of my colleagues do” [Participant 63]; and “The most negative reactions I experience is when my colleagues are not as accepting or unwilling to engage in conversations about youth sexuality. They have dismissed it as a ‘trend’ or state that sexuality in adolescents shouldn’t be discussed as they are ‘too young’ to really know their identity” [Participant 73]. Pansexual youth have also reported “previous negative experiences with mental health professionals” [Participant 68]. Additionally, many participants often mentioned that clinicians should avoid making erroneous assumptions or generalizations about pansexual youth, a suggestion that cut across responses to open-ended questions, indicating the need to further demystify assumptions about this group.

While most clinicians did not endorse these misconceptions about pansexuality, stigma continues to exist among some clinicians. Similar research has also noted the pervasiveness of homophobia in the mental health field including subtle prejudices and microaggressions that undermine the legitimacy of sexual and gender identities (Shelton & Delgado-Romero, 2011). Unfortunately, the stigma surrounding more nonbinary identities is thought to contribute to emotional distress and negatively impact health (Almeida et al., 2009; Sanders & Chalk, 2016). Therefore, clinicians holding these ideologies may exacerbate these negative outcomes.

***Finding 3: Most Clinicians Believed Sexuality and Gender are Fluid.***

Participants were also asked to indicate the statement that was most reflective of their beliefs regarding sexuality and gender. One participant (1.2%) answered, “sexuality and gender are both fixed,” five participants (6%) answered, “sexuality is fluid and gender is fixed,” and five individuals (6%) selected “other,” but the majority of the sample, 72 participants (85.7%), answered, “sexuality and gender are both fluid.” Thematic analysis also revealed similar patterns. For example, participants in this study almost universally endorsed that sexuality and gender are fluid, may change over time, and are “always evolving” [Participant 55]. Many participants also recommended that clinicians be more open to the fluid nature of gender and sexuality and “see it as social progress that people are being more open to all folks, particularly Trans folks” [Participant 12]. Additionally, there was no evidence supporting the hypothesis that most clinicians will conflate pansexuality with other gender identities.

The current literature also supports this main finding and further highlights the growing social awareness, understanding, and acceptance of LGBTQ+ individuals that have resulted in major shifts to our perception of sexuality and gender (Morandini et al., 2017; Russell & Fish, 2016). While this prior research matches this study’s results, it is still concerning that about 15% of the sample does not operate under the assumption that sexuality and gender are fluid.

***Finding 4: Clinicians Varied in Awareness, Knowledge, and Clinical Experience with Pansexual Youth.***

In this study, many participants lacked awareness of the literature on pansexuality, suggesting that this is another common area of misinformation among clinicians. The researcher hypothesized: clinicians will report varying levels of



knowledge about pansexuality, most clinicians will report having minimal to no knowledge regarding the current literature on pansexuality, and clinicians will report varying levels of experience working therapeutically with pansexual youth. Question 12 asked, ‘*Did you know about the term pansexuality prior to this study?*’ Fortunately, 79 participants (94%) answered yes, but 4 participants (4.8%) said no. One participant said, “I think the academic definition for purposes of research and how a client may use the term are not the same” [Participant 47].

Question 15 asked, ‘*How familiar are you with the literature on pansexual youth?*’ The vast majority of the sample answered with “not familiar at all,” “slightly familiar,” and “somewhat familiar” with a total of 73 (88%) participants answering in one of those categories. Therefore, only 10 participants (12%) answered “moderately familiar” or “very familiar.” One participant said, “I do not feel like I know enough about pansexuality to offer strong opinions” [Participant 46]. Another said, “These questions make me sad because folks should know this stuff” [Participant 12]. These findings speak to the need for not only more research to be produced on pansexual youth, but also on the dissemination of this literature. Further, it must be explored why clinicians are not well versed on this population’s literature. Are such readings not required in graduate programs? Are clinics, hospitals, practices, etc. not providing resources for their clinicians? Other questions such as these arise when the vast majority of the sample are reporting their lack of familiarity on such vital literature. Further, a linear regression was ran to determine if there is a relationship between race and working with pansexual youth. There was not a statistically significant relationship, thus, race is not a predictor of working with pansexual youth.

Interestingly, another linear regression was conducted to determine if there is an impact between identified gender and working with pansexual youth. The regression revealed that there was a positive, statistically significant relationship meaning that the gender the clinician identified with is a possible predictor for the clinician working with pansexual youth. Thus, clinicians should be mindful of how their own gender identity may be impacting whether or not they are working with pansexual youth and why or why not.

Question 16 asked, *‘Have you received any training or education relevant to working with pansexual youth?’* Twenty participants (23.8%) reported they have received training or education relevant to working with pansexual youth while 64 individuals (76.2%) reported they have not. A linear regression showed that there was a positive, statistically significant relationship between receiving any training or education relevant to working with pansexual youth and working with pansexual youth. Thus, training and education are predictors of working with pansexual youth. Qualitative analysis yielded similar results, “I have not received any training on working with individuals in the LGBTQ+ community” [Participant 19]. Another said, “No one in my program has ever talked about pansexual youth, and I am not aware of really any literature on pansexual youth. I suspect that research on pansexual youth is fairly limited, which is probably why I have not heard much about it before in the context of my clinical practice” [Participant 75].

These result displays the dire need for specific training and education relevant to working with pansexual youth. Clinicians are urged to continuously be checking their assumptions, especially when selecting words like bisexual or pansexual to describe

sexual orientation (Sprott & Hadcock, 2018). Their incorrect usages of words may be highlighting to clients their lack of knowledge and training on sexual orientation. In fact, it was found that LGBTQ+ youth typically reported that the main reason they chose their provider was due to being LGBTQ+ affirming (Goldbach et al., 2018). Training clinicians to be LGBTQ+ affirmative in their graduate programs are vital in becoming effective providers (Sprott & Hadcock, 2018). It is suggested to begin this training while clinicians are in their graduate programs before they begin working with clients in the community.

Question 17 asked, *‘Have you consulted with others or the literature on issues relevant to pansexuality in youth?’* Twenty-six (31%) participants selected yes to having consulted with others or the literature while most participants (69%) said no they have not. This statistic is concerning as in an earlier question (15) 88% of participants reported they are not very familiar with pansexual youth literature. Clinicians are told when they have a lack of knowledge on a particular topic or population to seek consultation. Thus, it is important to encourage consultation, supervision, and other methods to close this gap of knowledge. Coinciding with these quantitative results, qualitative results showed that clinicians are lacking in their perceived knowledge surrounding pansexuality. “Most clinicians not in the LGBTQ community, despite being open, are lacking a lot of really basic knowledge. I wish clinicians would make more of an effort to do their own research” [Participant 78].

Of interest, bivariate correlations found that, the older in age the clinician reported, the less likely they were to have experience working with pansexual youth. Additionally, a linear regression examined the relationship between theoretical

orientation and working with pansexual youth. The results displayed a positive, statistically significant relationship ( $F= 12.29.$ ,  $p = .001$ ). Therefore, the theoretical orientation of the clinician is statistically significant.

***Finding 5: Clinicians Endorsed Varied Beliefs Regarding Pansexuality and Bisexuality.***

The data showed that clinicians endorsed varied beliefs about pansexuality and bisexuality. In a previous study, researchers examined how youth defined bisexual and pansexual identities and found that young bisexual people often viewed sex and gender as nonbinary, which was consistent with the views of their pansexual peers (Flanders et al., 2017). One school of thought is that pansexuality is interchangeable with bisexuality as both identities recognize the possibility of attraction to more than one gender (World Public Library, 2017). In fact, some researchers have found that definitions of pansexuality and bisexuality often overlap and are conceptualized in similar ways (Belous & Bauman, 2017; Galupo et al., 2017).

Results from the current study matched results from prior works. Question 15 read, “Please rate the extent to which you agree with the following statement: *Pansexuality and bisexuality are similar sexual orientations.*” Nine participants (10.7%) reported that they strongly agree with this statement and 24 (28.6%) participants reported they agree with this statement. Thus, 39.8% of the clinicians believe pansexuality and bisexuality are similar. These results showcase the need for a further understanding of these different orientations. The qualitative findings coincide with this assertion as well. One participant said, “I think ‘pansexuality’ is actually a term that harms the established community of those who are attracted to people of genders both the same and different

from one's own, fka/aka bisexuality. It creates all these false divisions within the community, making it difficult for me to find the right term to name my own identity” [Participant 4]. Similarly, someone said, “I feel like bisexuality covers the same thing as pan and I feel like there are so many sexuality labels it lacks parsimony and makes it harder for people to take seriously the idea that there is more than heterosexuality. I realize pan is supposed to include non-binary/trans people, but I think bisexual (while it technically only refers to 2 sexes/genders) is encompassing enough” [Participant 10].

Another participant said, “It's hard to say whether bi and pan are similar or not. It just depends on the person you ask, as I have heard different people describe these identities in different ways” [Participant 63]. Interestingly, a participant brought up a great point, “I have clients who use pansexuality and bisexuality interchangeably” [Participant 47]. Thus, it is understandable why some clinicians are unclear on differences. Clinicians may be running under the assumption of these terms being interchangeable due to lack of training as well as their client’s using both. For instance, pansexual people are generally grouped under the bisexual umbrella but have been found to report different experiences of stigma within queer community than those reported by bisexual people (Mitchell et al., 2014). Another participant explained, “I see bisexuality as an umbrella term (attraction to more than one sex and/or gender) and pansexuality is more specific (attraction to all sexes or genders as opposed to only some)” [Participant 78]. Some clinicians had insightful perspectives regarding this question, such as, “I feel pansexuality is a way to express openness/attraction to gender expression that isn't necessarily encompassed by identifying as bisexual, although anecdotally many bisexual

people I know could be qualified as pan if they wanted to take on that label” [Participant 17].

It is important to highlight varied beliefs among clinicians. Implications of this include asking youth to define their pansexual or bisexual orientation given that each individual might define it differently. Moreover, the understanding of pansexuality and how it differs from other sexual identities such as bisexuality are a frequent point of contention and confusion. All things considered, this study recognizes the ongoing discourse surrounding pansexuality and its place among other non-monosexual identities as well as realizes the fluidity and expansiveness of each of these terms. It is urged to increase awareness, acceptance, and understanding of nonbinary identities among youth (Flanders et al., 2017).

***Finding 6: Increased Awareness, Education, and Training About Pansexuality is Needed in Mental Health.***

Quantitative and qualitative findings showcased the dire need for more awareness, education, and training about pansexuality. Qualitative results allowed for obtaining rich results in terms of ideas on what clinicians need to know and how and when best to provide this training. Question 14 asked, “*How aware do you think the mental health field is about pansexuality?*” Most participants (91.7%) reported that they believe the profession is “somewhat aware” to “not aware at all.” Therefore, participants in this study believe their peers are not knowledgeable enough to work with this population. This furthers the argument made prior about necessary training and how much is still not known about this population. Consistent with these findings, a participant reported, “We need more resources for clinicians to help pansexual youth” [Participant 2].

Unfortunately, one participant reported, “My supervision at the time was unfortunately unhelpful” [Participant 13]. The lack of therapist knowledge and training, as well as the lack of available resources regarding pansexual individuals, is evidence that training for mental health professionals is needed.

Question 29 asked, “*Are there any clinical considerations that clinicians should take into account when working with this population?*” One participant said, “Although I am proud to support pansexual and gender diverse youth, my views may sometimes prevent me from asking more in-depth questions that others might think of” [Participant 63]. Another participant shared a familial experience to provide further clarification, “When talking with my cousin, who is 16 and identifies as pan/ace depending on the period in their life, they describe struggling to justify their experience to adults who are not familiar with the meanings of these terms, which are normal in their cohort. I can't even imagine how frustrating it must be to go into a therapy room and having to explain something about their self that in their mind is common knowledge” [Participant 17]. Thus, it appears this participant was empathizing with the potential negative emotions that may be experienced by this population when working with a clinician who is not knowledgeable on their experiences.

Question 30 asked, “*What are some effective ways to help clinicians to be more aware of, accepting of, and effective in working with pansexual youth?*” Participants gave great insight into what is needed. A participant said, “Better training, more widely-available resources for clinicians looking to educate themselves” [Participant 61]. Another said, “I would like to see all training programs have a mandatory LGBTQ class. My program had a general diversity course as well as other electives, but I don't believe

there was anything specific to pansexual youth” [Participant 63]. One participant said, “Pansexuality needs to be included in multicultural counseling classes, as well as any discussion around LGBTQ+ communities. Overall, the LGBTQ+ education needs to be included across ALL curriculum rather than limited to diversity or human sexuality classes” [Participant 35]. Of critical importance, the findings indicated that clinicians must seek out training and education related to pansexuality. In support of this, participants discussed needing to seek additional support, education, and training surrounding pansexuality in describing their experiences and reactions to the work.

***Finding 7: Pansexual Youth Experience Unique Challenges Related to their Sexual Identity.***

The qualitative results indicate that pansexual youth experience unique challenges related to their pansexual identity. Regarding their clinical experiences with pansexual youth, many participants reported that these youth often experience misunderstanding about their identity as well as ostracization from people in their lives. Because pansexual youth have an identity that is not well understood, they “are often expected to teach others about their identity, which is an unfair burden on top of the discrimination they often face whether it be due to confusion or outright bigotry” [Participant 63]. This main finding builds on a prior study conducted by Gonel (2013) which found that pansexual youth sometimes refer to themselves as ‘queer’ instead of ‘pansexual’ so as to avoid having to define pansexuality in social situations or to deal with the stigmatization coming from both their heterosexual and non-heterosexual peers. Additionally, other participants detailed the lack of support experienced by pansexual youth in the queer community including “difficulties with finding their voice/place within the LGBTQ



community” [Participant 35]. Furthermore, participants frequently emphasized the pervasiveness of family invalidation and rejection in the experiences of pansexual youth. Although this family rejection is not specific to pansexual youth, feelings of exclusion and bias may be further amplified in them due to their common struggles to find a community that supports and understands them.

This main finding is also consistent with findings from prior studies. One study found that pansexual youth typically undergo higher levels of distress and exclusion compared to gay, lesbian, and bisexual peers (Gray & Moore). A different qualitative study that interviewed adolescents in Gay-Straight Alliances also showed that pansexual youth often report feeling misunderstood and discriminated against (Lapointe, 2017). Additionally, of the pansexual youth surveyed in a Human Rights Campaign study, 32% of pansexual youth often reported feeling excluded for being different (Andre et al., 2014). Other literature on pansexual youth also indicates that this group experiences greater stress and stigma due to holding a minority status within the LGBTQ+ community (Borgona et al., 2019; Gray & Moore, 2018; Mitchell et al., 2014). Collectively, these findings further underscore the social and emotional disparities experienced by this unique community.

***Finding 8: Most Clinicians Reported Positive and Meaningful Clinical Experiences with Pansexual Youth.***

Participants reported positive, meaningful experiences when reflecting on their clinical work with pansexual youth. Question 31 asked, ‘*Describe your personal reactions and experiences related to providing services to pansexual youth.*’ Qualitative results showed a variety of positive, beautifully stated replies. One participant shared,

“Pansexual youth tend to have a sophisticated and thoughtful understanding of both sexuality and gender that is rare in older generations and leads to in-depth and complex discussions of various aspects of sexuality that may not always align, for example, emotional attraction, physical attraction and desire, intellectual compatibility, political or social connection, etc.” [Participant 40].

In reference to the clinician’s feelings about learning from their client(s), a participant stated, “I worked with a youth who identified both as transgender and pansexual. Although I could not relate on a personal level to what this youth might have experienced, my work with them provided me with a humbling learning experience and reminded me to stay open and curious with all clients at all times” [Participant 26]. Multiple participants expressed gratitude from their pansexual clients for helping them grow as a clinician.

One positive and hopeful outcome of this study is that many participants expressed, “I am impressed at their ability to be so flexible and open-minded” [Participant 63]. Another said, “they are awesome - just a hope to our world - they show that the world is growing, evolving” [Participant 12]. Another encouraging finding was that many participants found meaning and satisfaction in their work with this population. As one participant put it, “I relate to it as someone who had a lot of vacillating experiences of their own sexuality in my teens. I think it allows me to be open and nonreactive to shifting experiences of sexuality and create an open space”. [Participant 17]. Another said, “I am LGBTQ myself and very interested in these issues. Therefore, I seek out youth clients who identify as LGBTQ” [Participant 78]. These statements show solidarity as well as the importance of a great therapeutic alliance. Further, this displays

the impact of identity of their clinical work with pansexual youth and their increased likelihood to seek this work out.

In addition to emphasizing the positive feelings they experienced in the work, participants were also frank about the difficulties and complexities they had encountered in their work with pansexual youth. A few participants emphasized challenges and concerns they believe are encountered by their clients, “I am always amazed at these youths' strength in being who they are despite the mental health and structural challenges they often face” [Participant 62]. This statement showcases that clinicians are aware of additional challenges endured by this population.

Moreover, clinicians reported their own challenges in working with this population while also empathizing with their client’s struggles, one participant said, “I have felt empowered at times working with these clients and angry at society for invalidating these individuals” [Participant 68]. Another said their experience was “challenging, in terms of family work” [Participant 33]. This coincides with previous literature showcasing the consequences of expressing one’s sexuality to loved ones in terms of family dynamics. Lastly, a participant shared, “Probably in the positive direction. I feel a kinship with pansexual youth, in some ways, as I understand the discrimination they face” [Participant 81]. Thus, many participants connected with the hardships experienced by their clients. Overall, participants expressed appreciation for their client’s strength and resiliency as well as their willingness to serve this population.

### **Clinical Implications**

The study’s findings have a number of implications regarding clinical training and practice with pansexual youth including concrete steps that the mental health field can

take to best address the needs of this population. As discussed previously, therapists have a responsibility to equally advocate for all clients including those identifying as LGBTQ+. According to the American Psychological Association Committee on Lesbian, Gay, Bisexual and Transgender Concerns practice guidelines (2012), clinicians should aim to eliminate the effect of explicit and implicit biases in their assessment and treatment of sexual and gender minorities. Because pansexual youth experience ongoing stigma and are at higher risk for mental health issues (Sanders & Chalk, 2016) related to their sexual identity, it is strongly recommended that clinicians provide care that does not further alienate them but instead provides validation, acceptance, and normalization of their sexual orientation and lived experiences (Israel et al., 2008). By being a skilled and affirming therapist, clinicians may help pansexual youth decrease their avoidance of health services and improve their wellbeing (Porta et al., 2020). Furthermore, findings from this study suggest that sexuality and gender are ever-changing and constantly evolving, and that collectively, we are empowered to continue to challenge assumptions about sex and gender, and make way for much needed social progress in these areas.

Overall, the findings in this study suggest that clinicians maintain an open, accepting, and non-judgmental stance when working therapeutically with pansexual youth in order to create a more validating and safe space. Participants also strongly recommended that clinicians take the time to ask sensitive and clarifying questions with regards to how these youth define their pansexual identity, which can promote a positive and supportive tone for therapy. It is important for clinicians to realize that the term ‘pansexuality’ has a unique significance for every individual. Additionally, a more

personalized approach also helps clinicians avoid making unfounded assumptions or generalizations about pansexuality.

Regarding therapeutic interventions, participants emphasized helping pansexual youth develop connections with an affirming community and like-minded peers due to the high levels of rejection and lack of social support often encountered by this population. Helping them navigate relationships with family (if appropriate), and explore issues such as dating, coming out, self-exploration, and pan erasure, is also of importance. Further, the study's findings suggest that clinicians take the time to examine aspects of their own identity, including attitudes and beliefs about sexuality and gender, as it may impact how they conduct work with pansexual youth and related communities. Participants also recommended other meaningful action items for clinicians intending to work with pansexual youth (e.g., learn as much as possible about sexual and gender minorities; become familiar with available resources on pansexuality; become a role-model and ally; do your own research; seek consultation; and educate others).

While more youth are coming out as pansexual than ever before, the education and training provided to mental health professionals regarding this population is tremendously lacking. The findings of the current study suggest that training and education on pansexuality is needed, including more research, resources, and coursework on this topic. This is important as the biased treatment of sexual and gender minorities is often due to the lack of training, specialization, and clinical experience with these communities (Morrow, 2000). Although the majority of participants in this study believed that pansexuality is a valid orientation, there was variation in terms of their knowledge about pansexuality and experience working with this population, which

further underscores the importance of increasing awareness of pansexuality, disseminating accurate knowledge about this and other non-monosexual orientations, and addressing microaggressions that may result in invalidating experiences for pansexual youth. By integrating the suggestions indicated above, mental health professionals can provide the compassionate and affirming services that these individuals deserve as well as alleviate the stress associated with having a unique sexual identity.

Finally, clinicians are urged to understand the risk factors for this population. Mental health professionals are suggested to be mindful of risks that are specifically heightened for this population. For example, identities were used as a way to frame risks (Graham et al., 2015). A study showed that individuals who disclosed their sexual orientation identity increased odds of smoking (Gamarel et al., 2020). These risk factors may include a lack of support from family and rejection as well as poorer health outcomes which include depression, heavy drinking, and recreational drug use (Gamarel et al., 2020; Newcomb et al., 2012; Ryan et al., 2010). Unfortunately, individuals who identified as pansexual, asexual, and other reported higher scores of family rejection than those who identified as gay/lesbian, queer, or questioning (Gamarel et al., 2020). In addition to family rejection, it was also found that for pansexual individuals family violence was increased (Gamarel et al., 2020). Family violence has been shown to be associated with negative mental health outcomes and relational consequences. Therefore, this is vital for clinicians to assess for not only sexual preferences and gender identity, but also for how mental health is being impacted due to lack of family support. Due to the recent research on family violence and rejection being particularly present for pansexual

individuals, it is of the upmost importance to make sure clinicians are first assessing and then if present, monitoring responses to such experiences.

As previously discussed, family rejection and family violence is pertinent within LGBTQ+ populations (Gamarel et al., 2020). Family rejection of LGBTQ+ youth is typical, especially with families with more difficult dynamics such as instability and strain (Cox et al., 2010; Rhoades et al., 2018; Robinson, 2018). Thus, clinicians should be aware of family expectations and how those expectations may change upon disclosure (Goodrich et al., 2019). Clinicians working with such populations should screen for dysfunctional family dynamics that may exacerbate rejection and violence. Clinicians are also urged to hold difficult conversations surrounding ideas and expectations, especially when family members are processing the news that may be shocking about their loved one (Goodrich et al., 2019). Mental health professionals are positioned well to mitigate these risks.

### **Limitations**

A major strength of the current study is its topic. The topic of pansexuality is extremely understudied and thus, this study sought to understand a population that is largely ignored in society as well as the available research. Additionally, another strength is the variety of treatment settings that the clinicians studied were employed in: outpatient clinics (40.5%), private practices (29.8%), department/school clinics (23.8%), public school systems (K-12) (23.5%), hospitals (17.9%), community mental health centers (14.3%), inpatient psychiatric hospitals (9.5%), partial hospitalization/intensive outpatient clinics (4.8%), the foster care system (3.6%), and college counseling centers (3.6%). An additional strength was the participant's sexual identity, almost half of the

sample was non-heterosexual (11.9% of participants identified as bisexual, 9.5% identified as lesbian, 7.1% identified as gay, 7.1% identified as queer, 6% identified as pansexual, 3.6% identified as other (i.e., “fluid;” “gray asexual”), 1.2% identified as asexual, and 1.2% did not know/preferred not to say).

The current study had a variety of different strengths; however, the study is not without its limitations. Survey research is one of the most popular research designs utilized within social science (Heppner et al., 2015). A typical limitation is those of survey research, for example, an individual can report whatever they wish and they may falsely report beliefs. These inaccuracies reported, as surveys are typically self-reported, may skew the data and overall results of the study. Survey responses were limited to those who have internet access to be able to participate, meaning participants who do not have access to the internet based on potentially several factors, thus they may have been excluded from participation. This may be a limitation because there may be individuals of a lower socioeconomic status that do not have the ability to afford internet access that are not represented. In regard to access, people must be able to read the survey questions written in English. Reading in the English language was implicitly required for participation in the study. Therefore, the perspectives of individuals who live in the U.S., but do not speak English were unintentionally excluded. This may be a limitation by not having those perspectives reflected in the current study.

The survey has a clinician population, who are known to be busy seeing clients, thus, responses may not have been as thorough. Additionally, the racial/ethnic background breakdown of the participants is a limitation as the vast majority of the sample identified as White (74.7%). Another limitation of the study’s demographics was



in terms of gender identity, the demographic breakdown of participants seemed to be skewed towards identifying as a woman (81%). As such, the exploration of pansexuality in this study may not accurately represent the sentiments and unique experiences of every person who identifies with this term. Thus, more diverse samples are needed in order to gather further information relevant to our understanding of pansexuality in diverse ethnic-racial minorities and allow for the results to be more generalizable.

Lastly, there are several limitations regarding the thematic analysis conducted in this study. For example, “while thematic analysis is flexible, this flexibility can lead to inconsistency and a lack of coherence when developing themes derived from the research data” (Holloway & Todres, 2003, p. 2). To mitigate this, this study closely followed Braun and Clarke’s (2006) exhaustive guidelines for thematic analysis and provided as much transparency about the process as possible. The various assumptions that underpin the research design were also made explicit. Additionally, survey data typically involves short responses to questions, which poses particular challenges for identifying thematic patterns across the dataset (Braun and Clarke, 2006). In order to compensate for this specific limitation, a mixed-methods approach was taken so that the qualitative analysis primarily served to build on the quantitative results. In spite of the limitations discussed above, the findings of the current study contribute to a growing understanding regarding what is currently known about pansexuality in the mental health field.

### **Future Research**

Earlier sections have illustrated the dearth in literature regarding pansexuality, which makes sense as research conducted within the mental health field has largely focused on the experiences of gay, lesbian, and bisexual people. Therefore, it is no

surprise that much future research is needed to better understand not only what mental health professionals know about this topic, but how the various divisions of clinicians can provide better services to this population. This section will outline steps and directions of future research to be conducted.

The limitations section explained that the sample of mental health professionals was not diverse in terms of gender and race/ethnicity. Therefore, future research should incorporate more individuals from marginalized backgrounds to account for such experiences. Future research should explore *how* mental health professionals from different disciplines need to integrate working with sexual minorities within their theoretical schools of thought. This study's sample consisted of the following theoretical orientations: CBT (51.2%), integrative/eclectic (21.4%), psychodynamic/psychoanalytic (11.9%), dialectical behavior therapy (DBT) (7.1%), existential/humanistic (3.6%), family/systems (1.2%), acceptance and commitment therapy (ACT) (1.2%), and other (1.2%). Therefore, this calls for future studies to explore some of the less prevalent orientations in this study such as existential/humanistic, family/systems, and ACT. Perhaps there would be different results based on other theoretical orientations not explored in this study. For example, a feminist approach may be more cognizant within its ideologies than other theories. Additionally, more postmodern theories may take into account the ability to identify as one wishes which coincides with the 'many truths' versus 'one universal truth' of modern theories. Thus, postmodern theories such as narrative or solution-focused orientations may have yielded different results in terms of familiarity with pansexuality.

The need for advocacy for this population is extremely evident. Along with all of

these risks discussed earlier, those within the LGBTQ+ community have been disproportionately incarcerated (Meyer et al., 2017; Tadros et al., 2020). Further, there are risks for substance use and maladaptive behaviors within this group (McCann & Brown, 2018). LGBTQ+ individuals also have higher rates of suicidal ideation and attempts (Haas et al., 2011; Marshal et al., 2011) than their non-LGBTQ+ counterparts. It is well known that LGBTQ+ individuals experience mental health issues at much higher rates than the general population (Becerra-Culqui et al., 2018; Cammett, 2009). These individuals are faced with minority stressors such as discrimination, internalized heterosexism, abuse, and rejection which tends to result in a variety of negative mental health consequences (Meyer, 1995, 2003; Meyer et al. 2008). Therefore, clinicians should motivate help seeking behaviors from LGBTQ+ individuals experiencing mental symptoms or suicidal ideation (Haas et al., 2011). Regardless of theoretical orientation, it is recommended to include outcome evaluations into all interventions with the goal of reducing suicidal ideation risk among the LGBTQ+ population. (Haas et al., 2011).

Advocacy within the community is particularly important due to the risks associated with being a member of the LGBTQ+ population. Community resources can be beneficial to the clinician as well as the client (Nichols, 2014; Sprott & Hadcock, 2018; Waldura et al., 2016). Community connections allow for socialization around consent practices, safety issues related to higher risk practices, and social support for coping with stigma and minority stress (Sprott & Hadcock, 2018). Vocational, educational, financial, clinical, and housing services are necessary community services for LGBTQ+ individuals (Tadros et al., 2020). Advocacy is needed at the policy-level in reference to nondiscrimination and equality in health care coverage (Haas et al., 2011).

Research is also needed to examine implications and consequences of not having such in place. Future research conducted through an intersectional lens would provide us with additional data regarding the intersectionality of pansexuality with other pertinent identities (e.g., race, gender, ethnicity, sex, disability, etc.). Intersectionality is a word that describes overlapping or intersecting social identities and related systems of oppression, domination, or discrimination (The Combachee River Collective, 1977; Crenshaw, 1989). Intersecting social identities can be used to understand how systemic oppression and social inequality occur (The Combachee River Collective, 1977; Crenshaw, 1989). This theory acknowledges the complex existence of those who are considered minorities on multiple levels. Matsuda (1993) explains that identity-based politics have been a source of empowerment, but it is also vital to not to ignore intragroup differences. In other words, each individual's experience is unique. Clinicians are urged to use an intersectional approach specifically to explore the role of power and privilege within intersecting identities (Lefevor et al., 2018). Therefore, how the vectors of race, class, ability, education, and gender identity impact the individual's pansexual identity is vital to explore therapeutically.

Other ideas for future research involve replicating the current findings with reliable and valid instruments. Due to the lack of such measures existing in the current literature, the researcher encourages the creation of these. Additionally, conducting a more comprehensive qualitative investigation (e.g., clinician interviews) to expand on this study's findings may be helpful in gaining a deeper understanding. For example, it may be useful to know the specific knowledge gaps as well as the barriers in place to treating this population. Investigation into the experiences of pansexual youth and their

experience in therapy may be helpful in conducting a needs-assessment for pansexual youth. A needs-assessment could uncover additional risks not yet explored in the literature as well as give insight into interventions that have better outcomes therapeutically. Lastly, given the mixed views clinicians endorse about pansexuality and bisexuality, future research could consider comparing the experiences of individuals from both communities and exploring similarities and differences to aid in better treatment outcomes.

All in all, a more in-depth, nuanced understanding of pansexuality and the experiences of those who adopt this label may undoubtedly offer us important insights regarding how to best conduct clinical work with pansexual youth and pave the way for the development of therapeutic interventions that target the distinct social and emotional disparities experienced by this population. The researcher also calls upon other LGBTQ+ allies to support and affirm these identities via research advocacy.

### References

- Acock, A. C. (2005). Working with missing values. *Journal of Marriage and Family*, 67(4), 1012–1028. <https://doi.org/10.1111/j.1741-3737.2005.00191.x>
- Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among lgbt youth: The influence of perceived discrimination based on sexual orientation. *Journal of Youth and Adolescence*, 38(7), 1001–1014. <https://doi.org/10.1007/s10964-009-9397-9>
- American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist*, 67(1), 10–42. <https://doi.org/10.1037/a0024659>
- Andre, A., Brown, J., Delpercio, A., Kahn, E., Nicoll, A., Sherouse, B. (2014). *Supporting and caring for our bisexual youth*. The Human Rights Campaign Foundation. <https://www.hrc.org/supporting-and-caring-for-our-bisexual-youth>
- Becerra-Culqui, T. A., Liu, Y., Nash, R., Cromwell, L., Flanders, W. D., Getahun, D., Giammattei, S. V., Hunkeler, E. M., Lash, T. L., Millman, A., Quinn, V. P., Robinson, B., Roblin, D., Sandberg, D. E., Silverberg, M. J., Tangpricha, V., & Goodman, M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Pediatrics*, 141(5), e20173845. <https://doi.org/10.1542/peds.2017-3845>
- Belous, C. K., & Bauman, M. L. (2017). What's in a name? Exploring pansexuality online. *Journal of Bisexuality*, 17(1), 58–72. <https://doi.org/10.1080/15299716.2016.1224212>
- Borgogna, N. C., McDermott, R. C., Aita, S. L., & Kridel, M. M. (2019). Anxiety and

depression across gender and sexual minorities: Implications for transgender, gender nonconforming, pansexual, demisexual, asexual, queer, and questioning individuals. *Psychology of Sexual Orientation and Gender Diversity*, 6(1), 54–63. <https://doi.org/10.1037/sgd0000306>

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>

Buser, J. K., Goodrich, K. M., Luke, M., & Buser, T. J. (2011). A narratology of lesbian, gay, bisexual, and transgender clients' experiences addressing religious and spiritual issues in counseling. *Journal of LGBT Issues in Counseling*, 5(3–4), 282–303. <https://doi.org/10.1080/15538605.2011.632395>

Callis, A. S. (2014). Bisexual, pansexual, queer: Non-binary identities and the sexual borderlands. *Sexualities*, 17(1–2), 63–80. <https://doi.org/10.1177/1363460713511094>

Cammett, A. (2009). Queer lockdown: Coming to terms with the ongoing criminalization of lgbtq communities. *Scholarly Works*. <https://scholars.law.unlv.edu/facpub/613>

Cohen, J. (1992). Statistical power analysis. *Current Directions in Psychological Science*, 1(3), 98–101. <https://doi.org/10.1111/1467-8721.ep10768783>

Cox, N., Dewaele, A., van Houtte, M., & Vincke, J. (2010). Stress-related growth, coming out, and internalized homonegativity in lesbian, gay, and bisexual youth. An examination of stress-related growth within the minority stress model. *Journal of Homosexuality*, 58(1), 117–137. <https://doi.org/10.1080/00918369.2011.533631>

- Craver, G. (2014, December 1). *Not just for beginners - a review of successful qualitative research: A practical guide for beginners*. The Qualitative Report.  
<https://nsuworks.nova.edu/tqr/vol19/iss48/3>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics [1989]. In K. T. Bartlett & R. Kennedy (Eds.), *Feminist Legal Theory* (1st ed., pp. 57–80). Routledge. <https://doi.org/10.4324/9780429500480-5>
- Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (Fifth edition). SAGE.
- Flanders, C. E., LeBreton, M. E., Robinson, M., Bian, J., & Caravaca-Morera, J. A. (2017). Defining bisexuality: Young bisexual and pansexual people’s voices. *Journal of Bisexuality, 17*(1), 39–57.  
<https://doi.org/10.1080/15299716.2016.1227016>
- Galupo, M. P., Davis, K. S., Gryniewicz, A. L., & Mitchell, R. C. (2014). Conceptualization of sexual orientation identity among sexual minorities: Patterns across sexual and gender identity. *Journal of Bisexuality, 14*(3–4), 433–456.  
<https://doi.org/10.1080/15299716.2014.933466a>
- Galupo, M. P., Mitchell, R. C., & Davis, K. S. (2015). Sexual minority self-identification: Multiple identities and complexity. *Psychology of Sexual Orientation and Gender Diversity, 2*(4), 355–364. <https://doi.org/10.1037/sgd0000131>
- Galupo, M. P., Ramirez, J. L., & Pulice-Farrow, L. (2017). “Regardless of their gender”:



Descriptions of sexual identity among bisexual, pansexual, and queer identified individuals. *Journal of Bisexuality*, 17(1), 108–124.

<https://doi.org/10.1080/15299716.2016.1228491>

Gamarel, K. E., Watson, R. J., Mouzoon, R., Wheldon, C. W., Fish, J. N., & Fleischer, N.

L. (2020). Family rejection and cigarette smoking among sexual and gender minority adolescents in the usa. *International Journal of Behavioral Medicine*, 27(2), 179–187. <https://doi.org/10.1007/s12529-019-09846-8>

Gen Z goes beyond gender binaries in new Innovation Group data. (2016, March 11).

*Wunderman Thompson Intelligence Group*.

<https://intelligence.wundermanthompson.com/2016/03/gen-z-goes-beyond-gender-binaries-in-new-innovation-group-data/>

Goldbach, J. T., Rhoades, H., Green, D., Fulginiti, A., & Marshal, M. P. (2018). Is there a need for lgbt-specific suicide crisis services? *Crisis*, 40(3), 203–208.

<https://doi.org/10.1027/0227-5910/a000542>

Gonel, A. H. (2013). Pansexual Identification in Online Communities: Employing a

Collaborative Queer Method to Study Pansexuality. *Graduate Journal of Social Science*, 10(1).

<http://www.gjss.org/sites/default/files/issues/chapters/papers/Journal-10-01--02-HaleGonel.pdf>

Goodrich, K. M., Trahan, D. P., & Brammer, M. K. (2019). Family dynamics following disclosure as lgb: A narratology. *The Family Journal*, 27(2), 122–132.

<https://doi.org/10.1177/1066480719832516>

Graham, K., Treharne, G. J., Ruzibiza, C., & Nicolson, M. (2015). The importance of

health(Ism): A focus group study of lesbian, gay, bisexual, pansexual, queer and transgender individuals' understandings of health: *Journal of Health Psychology*.

<https://doi.org/10.1177/1359105315600236>

Gray, A., & Moore, E. (2018). Understanding the relationship between sexual identity, life satisfaction, psychological well-being, and online community use. *Modern Psychological Studies*, 23(2). <https://scholar.utc.edu/mps/vol23/iss2/4>

Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., Silverman, M. M., Fisher, P. W., Hughes, T., Rosario, M., Russell, S. T., Malley, E., Reed, J., Litts, D. A., Haller, E., Sell, R. L., Remafedi, G., Bradford, J., Beautrais, A. L., ... Clayton, P. J. (2010). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, 58(1), 10–51. <https://doi.org/10.1080/00918369.2011.534038>

Heppner, P. P., Wampold, B. E., Owen, J., Wang, K. T., & Thompson, M. N. (2015). *Research design in counseling* (Fourth Edition). Cengage Learning.

Hobaica, S., Alman, A., Jackowich, S., & Kwon, P. (2018). Empirically based psychological interventions with sexual minority youth: A systematic review. *Psychology of Sexual Orientation and Gender Diversity*, 5(3), 313–323.

<https://doi.org/10.1037/sgd0000275>

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, 3(3), 345–357.

<https://doi.org/10.1177/1468794103033004>

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapists'

helpful and unhelpful situations with LGBT clients: An exploratory study.

*Professional Psychology: Research and Practice*, 39(3), 361–368.

<https://doi.org/10.1037/0735-7028.39.3.361>

Jakubowski, K. (2014, November 12). *Pansexuality 101: It's more than 'just another letter.'* Everyday Feminism. <https://everydayfeminism.com/2014/11/pansexuality-101/>

Kosciw, J. G., Palmer, N. A., Boesen, M. J., Bartkiewicz, M. J., Greytak, E. A., & Gay, L. and S. E. N. (Glsen). (2012). *The 2011 national school climate survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools.* Gay, Lesbian and Straight Education Network.

Lapointe, A. A. (2017). "It's not pans, it's people": Student and teacher perspectives on bisexuality and pansexuality. *Journal of Bisexuality*, 17(1), 88–107.

<https://doi.org/10.1080/15299716.2016.1196157>

Lefevor, G. T., Park, S. Y., & Pedersen, T. R. (2018). Psychological distress among sexual and religious minorities: An examination of power and privilege. *Journal of Gay & Lesbian Mental Health*, 22(2), 90–104.

<https://doi.org/10.1080/19359705.2017.1418696>

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., Thoma, B. C., Murray, P. J., D'Augelli, A. R., & Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 49(2), 115–123.

<https://doi.org/10.1016/j.jadohealth.2011.02.005>

- Matsuda, M. J., Lawrence, C., Delgado, R., & Crenshaw, K. (1993). *Words that wound: Critical race theory, assaultive speech, and the First Amendment*. Westview Press.
- McCann, E., & Brown, M. (2018). Vulnerability and psychosocial risk factors regarding people who identify as transgender. A systematic review of the research evidence. *Issues in Mental Health Nursing, 39*(1), 3–15.  
<https://doi.org/10.1080/01612840.2017.1382623>
- Mertler, C. A., & Vannatta, R. A. (2017). *Advanced and multivariate statistical methods: Practical application and interpretation* (Sixth edition). Routledge, Taylor & Francis Group.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38–56.
- Meyer, Ilan H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Meyer, Ilan H., Dietrich, J., & Schwartz, S. (2008). Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay, and bisexual populations. *American Journal of Public Health, 98*(6), 1004–1006.  
<https://doi.org/10.2105/AJPH.2006.096826>
- Meyer, Ilan H., Flores, A. R., Stemple, L., Romero, A. P., Wilson, B. D. M., & Herman, J. L. (2017). Incarceration rates and traits of sexual minorities in the united states: National inmate survey, 2011-2012. *American Journal of Public Health, 107*(2), 267–273. <https://doi.org/10.2105/AJPH.2016.303576>

Mitchell, R. C., Davis, K. S., & Galupo, M. P. (2015). Comparing perceived experiences of prejudice among self-identified plurisexual individuals. *Psychology & Sexuality, 6*(3), 245–257. <https://doi.org/10.1080/19419899.2014.940372>

Morandini, J. S., Blaszczynski, A., & Dar-Nimrod, I. (2017). Who adopts queer and pansexual sexual identities? *The Journal of Sex Research, 54*(7), 911–922. <https://doi.org/10.1080/00224499.2016.1249332>

Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay, and bisexual clients. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients*. (pp. 137–156). American Psychological Association. <https://doi.org/10.1037/10339-006>

Nadal, K. L. (2013). *That's so gay! Microaggressions and the lesbian, gay, bisexual, and transgender community* (1st ed). American Psychological Association.

Newcomb, M. E., Heinz, A. J., & Mustanski, B. (2012). Examining risk and protective factors for alcohol use in lesbian, gay, bisexual, and transgender youth: A longitudinal multilevel analysis. *Journal of Studies on Alcohol and Drugs, 73*(5), 783–793. <https://doi.org/10.15288/jsad.2012.73.783>

Nichols, M. (2014). Therapy with LGBTQ clients: Working with sex and gender variance from a queer theory model. In *Principles and practice of sex therapy, 5th ed* (pp. 309–333). The Guilford Press.

*Pansexual* / origin and meaning of pansexual by online etymology dictionary. (n.d.).

Retrieved August 23, 2016, from <https://www.etymonline.com/word/pansexual>

*Pansexuality*. (n.d.). World Public Library. <http://netlibrary.net/articles/Pansexuality>

- Porta, C. M., Gower, A. L., Brown, C., Wood, B., & Eisenberg, M. E. (2020). Perceptions of sexual orientation and gender identity minority adolescents about labels. *Western Journal of Nursing Research*, *42*(2), 81–89. <https://doi.org/10.1177/0193945919838618>
- Rhoades, H., Rusow, J. A., Bond, D., Lanteigne, A., Fulginiti, A., & Goldbach, J. T. (2018). Homelessness, mental health and suicidality among lgbtq youth accessing crisis services. *Child Psychiatry & Human Development*, *49*(4), 643–651. <https://doi.org/10.1007/s10578-018-0780-1>
- Robinson, B. A. (2018). Conditional families and lesbian, gay, bisexual, transgender, and queer youth homelessness: Gender, sexuality, family instability, and rejection: conditional families and lgbtq youth homelessness. *Journal of Marriage and Family*, *80*(2), 383–396. <https://doi.org/10.1111/jomf.12466>
- Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, *91*(8), 1276–1281. <https://doi.org/10.2105/ajph.91.8.1276>
- Russell, Stephen T., & Fish, J. N. (2016). Mental health in lesbian, gay, bisexual, and transgender (Lgbt) youth. *Annual Review of Clinical Psychology*, *12*(1), 465–487. <https://doi.org/10.1146/annurev-clinpsy-021815-093153>
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of lgbt young adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205–213. <https://doi.org/10.1111/j.1744-6171.2010.00246.x>
- Salkind, N. J. (2014). *Statistics for people who (Think they) hate statistics* (Fifth edition).

SAGE Publications, Inc.

- Sanders, E. K., & McCartney Chalk, H. (2016). Predictors of psychological outcomes in nonheterosexual individuals. *Psi Chi Journal of Psychological Research*, *21*(2), 100–110. <https://doi.org/10.24839/2164-8204.JN21.2.100>
- Savin-Williams, R. C. (2011). Identity development among sexual-minority youth. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of Identity Theory and Research* (pp. 671–689). Springer. [https://doi.org/10.1007/978-1-4419-7988-9\\_28](https://doi.org/10.1007/978-1-4419-7988-9_28)
- Scott, V. C., Kenworthy, T., Godly-Reynolds, E., Bastien, G., Scaccia, J., McMickens, C., Rachel, S., Cooper, S., Wrenn, G., & Wandersman, A. (2017). The Readiness for Integrated Care Questionnaire (RICQ): An instrument to assess readiness to integrate behavioral health and primary care. *American Journal of Orthopsychiatry*, *87*(5), 520–530. <https://doi.org/10.1037/ort0000270>
- Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology*, *58*(2), 210–221. <https://doi.org/10.1037/a0022251>
- Signorile, M. (2015, May 29). *Mary Gonzalez, First Openly Pansexual Legislator, Explains How She Is Changing Minds In Texas*. HuffPost. [https://www.huffpost.com/entry/mary-gonzalez-pansexual\\_n\\_7433432](https://www.huffpost.com/entry/mary-gonzalez-pansexual_n_7433432)
- Sprott, R. A., & Hadcock, B. B. (2018). Bisexuality, pansexuality, queer identity, and kink identity. *Sexual and Relationship Therapy*, *33*(1–2), 214–232. <https://doi.org/10.1080/14681994.2017.1347616>
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling.

American Psychologist, 53(4), 440–448. <https://doi.org/10.1037/0003-066X.53.4.440>

Tadros, E., Ribera, E., Campbell, O., Kish, H., & Ogden, T. (2020). A call for mental health treatment in incarcerated settings with transgender individuals. *The American Journal of Family Therapy*, 1–14.  
<https://doi.org/10.1080/01926187.2020.1761273>

*The combahee river collective statement*. (n.d.). COMBAHEE RIVER COLLECTIVE.  
Retrieved August 23, 2016, from <http://combaheerivercollective.weebly.com/the-combahee-river-collective-statement.html>

The Human Rights Campaign Foundation. (2012). *Growing up lgbt in america: Hrc youth survey report key findings*. <https://www.hrc.org/resources/youth-report>

Waldura, J. F., Arora, I., Randall, A. M., Farala, J. P., & Sprott, R. A. (2016). Fifty shades of stigma: Exploring the health care experiences of kink-oriented patients. *The Journal of Sexual Medicine*, 13(12), 1918–1929.  
<https://doi.org/10.1016/j.jsxm.2016.09.019>

Watson, R. J., Wheldon, C. W., & Puhl, R. M. (2020). Evidence of diverse identities in a large national sample of sexual and gender minority adolescents. *Journal of Research on Adolescence*, 30(S2), 431–442. <https://doi.org/10.1111/jora.12488>

Willig, C. (2013). *Introducing qualitative research in psychology* (3. ed). Open Univ. Press.

World Professional Association for Transgender Health. (2011). *Standards of care*. <https://www.wpath.org/publications/soc>



Table 1

*Frequency Percentages of Professional Discipline*

Discipline	(n = 84) f%
Current Psychology Doctoral Students	44
Clinical Psychologists (PhD/PsyD)	31
School Psychologists (PhD/PsyD)	11.9
Licensed Clinical Social Workers (LCSW)	9.5
Psychiatrist	1.2
Licensed Social Worker (LSW)	1.2
Licensed Professional Counselor (LPC)	1.2

*Note.* f% = frequency percentage

Table 2

*Frequency Percentages of Theoretical Orientation*

Orientation	(n = 84) f%
Behavioral / Cognitive Behavioral (CBT)	51.2
Integrative / Eclectic	21.4
Psychodynamic / Psychoanalytic	11.9
Dialectical Behavior Therapy (DBT)	7.1
Existential / Humanistic	3.6
Family / Systems	1.2
Acceptance and Commitment Therapy (ACT)	1.2
Other	1.2
No Response	1.2

*Note.* f% = frequency percentage

Table 3

*Frequency Percentages of Treatment Settings*

Setting	( <i>n</i> = 84) <i>f</i> %
Outpatient Clinics	40.5
Private Practices	29.8
Department / School Clinics	23.8
Public School Systems (K-12)	23.5
Hospitals	17.9
Community Mental Health Centers	14.3
Inpatient Psychiatric Hospitals	9.5
Partial Hospitalization / Intensive Outpatient Clinics	4.8
Foster Care System	3.6
College Counseling Centers	3.6
Community Center	1.2
Juvenile Justice System	1.2
LGBTQ Center	1.2
Private School	1.2
University	1.2

*Note.* *f*% = frequency percentage

Table 4

*Frequency Percentages of Specialties / Areas of Expertise*

Specialty	( <i>n</i> = 84) <i>f</i> %
Adolescent Externalizing Disorders	65.5
Child and Adolescent Externalizing Disorders	50
LGBTQ+ Issues	42.9
Trauma / PTSD	36.9
ASD / Developmental Disorders / Learning Disabilities	27.4
Family / Systems	16.7
Personality Disorders	11.9
Eating Disorders	9.5
Pediatrics	9.5
Grief / Loss / Bereavement	8.3
Serious Mental Illness	8.3
Substance and Alcohol-related Disorders	7.1
Other	6
Sleep / Insomnia	2.4
Relationships	1.2
Transgender and Gender Nonbinary	1.2
Young Adult Developmental Issues	1.2

*Note.* *f*% = frequency percentage

Table 5

*Linear Regression: Gender Identity and Working with Pansexual Youth*

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Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.646	.268		9.862	.000
	Have you worked therapeutically with pansexual youth?	-.396	.163	-.259	-2.431	.017

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*a. Dependent Variable: What is your gender identity? - Selected Choice*

Table 6

*Linear Regression: Relevant Training/Education and Working with Pansexual Youth*

Model		Unstandardized		Standardized	t	Sig.
		Coefficients		Coefficients		
		B	Std. Error	Beta		
1	(Constant)	1.042	.133		7.860	.000
	Have you worked therapeutically with pansexual youth?	.458	.080	.533	5.697	.000

*a. Dependent Variable: Have you received any training or education relevant to working with pansexual youth? - Selected Choice*

Table 7

*Linear Regression: Theoretical Orientation and Working with Pansexual Youth*

Model		Unstandardized		Standardized	t	Sig.
		Coefficients		Coefficients		
		B	Std. Error	Beta		
1	(Constant)	5.642	.809		6.977	.000
	Have you worked therapeutically with pansexual youth?	-1.725	.492	-.363	-3.505	.001

*a. Dependent Variable: What theoretical orientation do you most identify with?  
- Selected Choice*

## Appendix A

### Recruitment Materials

Email Advertisement

From: bap182@gsapp.rutgers.edu

Subject: Youth and Sexuality Dissertation Study

Many clinicians are seeing an increase in youth exploring or identifying their gender and sexual identity. One 'newer' identity is pansexuality. We are interested in learning what our colleagues know about this emerging population. Please consider taking part in this research study, whether you have or have not had experience with this population.

Participants will be asked to complete a *brief, anonymous online survey*. The survey is primarily comprised of multiple-choice questions and some open-ended questions. Your participation is completely voluntary and you are free to withdraw at any time.

*To be eligible to participate, you must:*

1. Be a mental health professional or psychology doctoral student in an APA accredited program.
2. Work with children and/or adolescents.
3. Reside and practice in the United States.
4. Speak English.

**To begin the survey, please click on the following link:**

([https://rutgers.ca1.qualtrics.com/jfe/form/SV\\_6rRjbzzNTYw8BjD](https://rutgers.ca1.qualtrics.com/jfe/form/SV_6rRjbzzNTYw8BjD))

We would greatly appreciate your participation in this effort to bring more awareness to the issues impacting this population. Please also consider forwarding this study to interested parties.

Thank you for your time and consideration,  
Principal Investigator: Brisa Pena, Psy.M.  
Dissertation Chair: Karen Skean, Psy.D.  
Dissertation Co-Chair: Patrick Connelly, Psy.D.

*If you have any questions about this study, please contact me at*  
[bap182@gsapp.rutgers.edu](mailto:bap182@gsapp.rutgers.edu)

This recruitment email was approved by the Rutgers University Institutional Review Board for the Protection of Human Subjects on 5/14/19; approval of this email expires on 12/31/2019.

This study has been approved by the Rutgers University Institutional Review Board for the Protection of Human Subjects.



**Appendix B****Survey Questions**

Date \_\_\_\_\_  
Time \_\_\_\_\_  
Participant Code \_\_\_\_\_

**INTRODUCTION:**

For my doctoral dissertation, we want to explore clinician's knowledge and understanding of pansexuality. We also want to explore the clinical experiences of clinicians who provide mental health services for pansexual youth. In order to do this, we have asked you to participate in a brief, online anonymous survey. We hope to use the information you provide to better understand the issues that this population faces as well as to improve upon the services provided to pansexual youth in therapeutic settings.

**INSTRUCTIONS:**

The following is a brief, anonymous online survey that consists of both closed-ended and open-ended questions. You do not have to answer any question that you do not want to answer. Remember, there are no right or wrong answers. Your participation is voluntary, and you are free to withdraw from the study at any time by simply leaving the website. Please click "submit" at the end of the survey to submit your responses.

## QUESTIONS:

Section I: Demographic Information

1. Do you live and work (or go to school) in the United States?
  - a. Yes
  - b. No
2. How old are you?
  - a. 20-29 years old
  - b. 30-39 years old
  - c. 40-49 years old
  - d. 50-59 years old
  - e. 60-69 years old
  - f. 70-79 years old
  - g. 80-89 years old
  - h. 90+ years old
3. What is your biological sex?
  - a. Male
  - b. Female
  - c. Intersex
  - d. Other: \_\_\_\_\_
  - e. I do not know / prefer not to say
4. What is your gender identity?
  - a. Man
  - b. Woman
  - c. Transgender Man
  - d. Transgender Woman
  - e. Genderqueer
  - f. Non-Binary
  - g. Agender
  - h. Two-Spirit
  - i. Other: \_\_\_\_\_
  - j. I do not know / prefer not to say
5. What is your racial/ethnic background?
  - a. African-American / Black / African Origin
  - b. Asian-American / Asian Origin / Pacific Islander
  - c. Latino-a / Hispanic
  - d. American Indian / Alaska Native / Aboriginal Canadian
  - e. European Origin / White
  - f. Bi-racial / Multi-racial
  - g. Other: \_\_\_\_\_

6. What is your sexual orientation?
  - a. Straight / Heterosexual
  - b. Gay
  - c. Lesbian
  - d. Bisexual
  - e. Pansexual
  - f. Asexual
  - g. Queer
  - h. Other: \_\_\_\_\_
  - i. I do not know / prefer not to say
7. What is your profession?
  - a. Clinical psychologist (PhD / PsyD)
  - b. School psychologist (PhD / PsyD)
  - c. Licensed clinical social worker (LCSW)
  - d. Psychology doctoral student
  - e. Other: \_\_\_\_\_
8. In what treatment setting do you primarily see clients? (*Select all that apply*)
  - a. Community mental health center
  - b. Public school system (K-12)
  - c. Outpatient clinic
  - d. Hospital
  - e. Partial hospital / Intensive outpatient
  - f. Inpatient psychiatric hospital
  - g. Private practice
  - h. Foster care system
  - i. Department/school clinic
  - j. Other: \_\_\_\_\_
9. What is your main theoretical orientation? (*Select only one*).
  - a. Behavioral / Cognitive-behavioral
  - b. Dialectical behavior therapy (DBT)
  - c. Existential/humanistic
  - d. Family / Systems
  - e. Integrative / Eclectic
  - f. Interpersonal psychotherapy (IPT)
  - g. Psychodynamic/psychoanalytic
  - h. Other (specify): \_\_\_\_\_
10. Which client groups do you mostly work with? (*Select all that apply*).
  - a. Children (12 years or under)
  - b. Adolescents (13-17 years old)
  - c. Adults / Older Adults

- d. Families
  - e. Couples
  - f. Groups
11. What specialties/areas of expertise do you have? (*Select all that apply*).
- a. Child and adolescent internalizing disorders
  - b. Child and adolescent externalizing disorders
  - c. ASD, developmental disorders, and learning disabilities
  - d. Family / Systems
  - e. LGBTQ+ issues
  - f. Pediatrics
  - g. Trauma and PTSD
  - h. Substance and alcohol-related disorders
  - i. Eating disorders
  - j. Personality disorders
  - k. Grief/loss/bereavement
  - l. Severe mental illness
  - m. Other (specify): \_\_\_\_\_

Section II: Knowledge, Understanding and Beliefs about Pansexuality

**Pansexuality is defined as the emotional, romantic and/or sexual attraction to any sex, gender or gender identity.**

12. Did you know about the term *pansexuality* prior to this study?
- a. Yes
    - i. If yes, how did you learn about it? \_\_\_\_\_
  - b. No
13. Please rate the extent to which you agree with the following statement: ***Pansexuality is a valid sexual orientation.***
- a. Strongly disagree
  - b. Disagree
  - c. Neither agree nor disagree
  - d. Agree
  - e. Strongly agree
14. How aware do you think the mental health field is about pansexuality?
- a. Not at all aware
  - b. Slightly aware
  - c. Somewhat aware
  - d. Moderately aware
  - e. Very aware
15. How familiar are you with the literature on pansexual youth?
- a. Not at all familiar
  - b. Slightly familiar
  - c. Somewhat familiar

- d. Moderately familiar
  - e. Very familiar
16. Have you received any training or education relevant to working with pansexual youth?
- a. Yes
    - i. If yes, please describe: \_\_\_\_\_
  - b. No
17. Have you consulted with others or the literature on issues relevant to pansexuality in youth?
- a. Yes
  - b. No
18. Which of the following statements is **most reflective** of your beliefs about sexuality and gender:
- a. Sexuality and gender are both *fixed*.
  - b. Sexuality and gender are both *fluid*.
  - c. Sexuality is *fixed* and gender is *fluid*.
  - d. Sexuality is *fluid* and gender is *fixed*.
  - e. Other (please specify): \_\_\_\_\_
19. Please rate the extent to which you agree with the following statement: ***Pansexuality and bisexuality are similar sexual orientations.***
- a. Strongly disagree
  - b. Disagree
  - c. Neither agree nor disagree
  - d. Agree
  - e. Strongly agree
20. Please rate the extent to which you agree with the following statement: ***Pansexual youth are promiscuous.***
- a. Strongly disagree
  - b. Disagree
  - c. Neither agree nor disagree
  - d. Agree
  - e. Strongly agree
21. Please rate the extent to which you agree with the following statement: ***Pansexuality is the latest trend among youth.***
- a. Strongly disagree
  - b. Disagree
  - c. Neither agree nor disagree
  - d. Agree
  - e. Strongly agree
22. Please rate the extent to which you agree with the following statement: ***Pansexual youth are just confused.***
- a. Strongly disagree
  - b. Disagree
  - c. Neither agree nor disagree
  - d. Agree
  - e. Strongly agree

23. Please rate the extent to which you agree with the following statement: *Pansexuality is the same as polyamory.*

- a. Strongly disagree
- b. Disagree
- c. Neither agree nor disagree
- d. Agree
- e. Strongly agree

24. (OPTIONAL) Please elaborate on any of your responses above:

\_\_\_\_\_

Section III: Working Therapeutically with Pansexual Youth

25. Have you worked therapeutically with pansexual youth?

- a. Yes
  - i. If Yes,
    - 1. How many TOTAL have you worked with? \_\_\_\_\_
    - 2. How many are you CURRENTLY treating? \_\_\_\_\_
- b. No

**Note: If you answered YES to the question above, please continue. If you answered NO, please leave the rest of this section blank.**

26. What topics/issues have come up in your work with pansexual youth? (*Select all that apply*).

- a. Mental health
- b. Gender
- c. Coming out
- d. Sexual orientation
- e. Religion
- f. Dating and relationships
- g. Substance use
- h. Family
- i. Discrimination, stigma or social rejection
- j. School
- k. Other: \_\_\_\_\_

27. What have you noticed are some of the unique stressors experienced by this population?

\_\_\_\_\_

28. How have your personal beliefs about sexuality and gender influenced your clinical work with pansexual youth?

\_\_\_\_\_

29. What should clinicians take into account when working with this population?

\_\_\_\_\_

30. How can we help clinicians to be more aware of, accepting of, and effective in working with pansexual youth?

---

31. Please briefly describe your own reactions and experiences related to providing services for pansexual youth:

---

## Appendix C

### Consent Form

#### CONSENT TO TAKE PART IN A RESEARCH STUDY

#### **TITLE OF STUDY:** EXPLORING CLINICIANS' KNOWLEDGE, BELIEFS, AND CLINICAL EXPERIENCES RELATED TO PANSEXUAL YOUTH

**Principal Investigator:** Brisa Pena, Psy.M.  
Dissertation Chair: Karen Skean, Psy.D.  
Dissertation Co-Chair: Patrick Connelly, Psy.D.

This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. It is your choice to take part or not. If you wish to take part in the research study, you will be asked to click on the survey link located at the end of this consent form. Please print out this consent form if you would like a copy of it for your files. Your alternative to taking part in the research is not to take part in it.

#### **Who is conducting this research study and what is it about?**

You are being asked to take part in research conducted by Brisa Pena, Psy.M., a doctoral candidate in the Clinical Psychology Psy.D. Program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. The purpose of this study is to explore the knowledge and understanding that clinicians have about pansexuality. We also want to examine the clinical experiences of those clinicians who provide mental health services to pansexual youth. We hope to use these findings to better understand the unique stressors that affect this population and hopefully improve upon the services provided to pansexual youth in therapeutic settings.

#### **Who is eligible to participate?**

You are eligible to participate if you are a licensed clinician, school psychologist, licensed clinical social worker, or doctoral student in an APA accredited clinical or school psychology program. You must have prior and/or current experience working with children and/or adolescents. You must reside and work in the United States. You must also speak English.

#### **What will I be asked to do if I take part?**

Your participation in this study consists of completing a brief (approx. 15 to 20 min), anonymous online survey. The survey includes questions about demographic information, your knowledge and understanding of pansexuality, and your experiences working therapeutically with pansexual youth (if applicable). We anticipate 25 or more subjects will take part in the study.

#### **What are the risks and/or discomforts I might experience if I take part in the study?**



Breach of confidentiality is a risk of harm but a data security plan is in place to minimize such a risk. Because your responses will be anonymous, you are encouraged to provide honest responses about your knowledge and understanding of pansexuality as well as your experiences working with pansexual youth. Also, some questions may make you feel uncomfortable. If that happens, you can skip those questions or withdraw from the study altogether. If you decide to quit at any time before you have finished the survey your answers will NOT be recorded.

**Are there any benefits to me if I choose to take part in this study?**

There no direct benefits to you for taking part in this research. However, your participation will contribute to the knowledge and understanding of pansexuality in the mental health field as well as potentially highlight some of the unique needs and challenges faced by pansexual youth. The findings from this study may also benefit future practitioners.

**Will I be paid to take part in this study?**

You will not be paid to take part in this study.

**How will information about me be kept private or confidential?**

All efforts will be made to keep your responses confidential, but total confidentiality cannot be guaranteed. We will use an online Qualtrics system developed by Rutgers University to collect and forward your anonymous responses to us. We will not receive any information that can identify you or other subjects. We will download your responses to a secure file that requires a password to access. Only study staff will have access to the password. Responses will be deleted from the file three years after analysis is complete and study findings are professionally presented or published. No information that can identify you will appear in any professional presentation or publication.

**What will happen to information I provide in the research after the study is over?**

The information collected about you for this research will not be used by or distributed to investigators for other research.

**What will happen if I do not want to take part or decide later not to stay in the study?**

Your participation is completely voluntary. If you choose to take part now, you may change your mind and withdraw later. If you do not click on the 'submit' button after completing the form, your responses will not be recorded. You may also choose to skip any questions that you do not wish to answer. However, once you click the 'submit' button at the end of the form, your responses cannot be withdrawn as we will not know which ones are yours.

**Who can I contact if I have questions?**

If you have questions about taking part in this study, you can contact the Principal Investigator:

Brisa Pena, Psy.M.

Rutgers University, GSAPP  
152 Frelinghuysen Rd Piscataway, NJ 08854-8085  
Email: bap182@gsapp.rutgers.edu

You can also contact my faculty advisor:  
Karen Skean, Psy.D. Faculty Advisor  
Rutgers University, GSAPP  
152 Frelinghuysen Road Piscataway, NJ 08854-8085  
Email: kskean@aol.com

If you have questions about your rights as a research subject, you can call the IRB Director at: New Brunswick/Piscataway ArtSci IRB at (732) 235-2866 OR the Rutgers Human Subjects Protection Program at (973) 972-1149 in Newark.

If you do not wish to take part in the research, close this website address.

If you wish take part in the research, follow the directions below:

By beginning this research, I acknowledge that I am 18 years of age or older and have read and understand the information. I agree to take part in the research, with the knowledge that I am free to withdraw my participation in the research without penalty.

- I consent, begin with the study
- I do not consent, I do not wish to participate

## Appendix D

### Sample Data Extracts with Focused Codes Applied

Data Extracts	Focused Codes
Participant 5: “People misunderstanding who they are, making erroneous assumptions, and treating them poorly because they are seen as different, not fitting in”	people misunderstanding identity (1a) erroneous assumptions (1b) treated poorly for being different/not fitting in (1b)
Participant 12: “being able to be themselves, dealing with discrimination - both outside and within the community”	rejection by peers (1a) discrimination within/outside queer community (1b) self-exploration (2a) imposter syndrome (2c)
Participant 13: “Difficult to find others who understand, or 'just a phase' response from others”	difficulty finding a community (1a) stigma and discrimination (1b)
Participant 23: “Lack of understanding/misinformation. Lack of acceptance.”	people misunderstanding identity (1a) lack of acceptance (1a)
Participant 26: “Misunderstood by family”	family invalidation (1a & 2b)
Participant 40: “I can say I think some pansexual people experience a kind of courtesy stigma in that their affirmation and sometimes attraction to/openness to relationships with trans and gender diverse people can lead to stigma. This would be something bisexuals may not as readily experience.”	stigma associated with attraction to non-binary individuals (1b)

**Appendix E**

**Developed Major Theme: The Unique Challenges Experienced by Pansexual Youth**

Major Theme	Theme	Sub-theme	Focused Code
The Unique Experiences of Pansexual Youth	1. The Black Sheep Effect	1a. Misunderstood and Ostracized	People misunderstanding their identity Difficulty finding a community Lack of representation, support and acceptance Identity not recognized Invalidating environments Rejection by peers/family/queer community Lack of awareness and knowledge on pan Needing to explain/teach about pansexuality
		1b. Stigma and Discrimination	Erroneous assumptions Treated poorly for being different and not fitting in Discrimination within/outside queer community Panphobia Pansexuality “just a phase,” “trendy,” or “illegitimate” response from others Dealing with disrespect, confusion or bigotry from others Stigma associated with attraction to non-binary individuals Cycle of clarifying and correcting assumptions Microaggressions
	2. On Being Pansexual: Personal Narratives	2a. Identity Development	Self-exploration and self-acceptance Erasure of non-monosexual identities Dating Coming out Meaning making Intersectionality between sexuality and other cultural identities (e.g., religion) Dealing with pressure to conform
		2b. Navigating Familial Relationships	Family/parental rejection and invalidation Intergenerational divide Coming out Lack of support and acceptance Family distress Conflation of sexuality and gender
		2c. Impact of Identity on Self and Well-Being	Feeling frustrated, invisible, and alienated Emotional distress ‘Imposter syndrome’ Need for acceptance/understanding/validation Trauma history related to SGM identity Similarities to other LGBTQ+ youth Psychological distress unrelated to sexuality

**Appendix F**

**Developed Theme: Therapists’ Beliefs and Theoretical Assumptions**

Theme	Sub-theme	Focused Code
<p>1. Therapists’ Beliefs and Theoretical Assumptions</p>	<p>1a. Bisexuality versus Pansexuality</p>	<p>Bisexuality synonymous with pansexuality                      Tension between bi and pan community                      Conflation of identities ‘hurtful’                      Pansexuality more inclusive                      Stigma associated with attraction to non-binary individuals</p>
	<p>1b. Attitudes Toward Pansexuality</p>	<p>Right to sexual/gender exploration and expression                      All identifications valid                      Gender inclusivity                      No fixed truth                      Right to consensual and healthy relationships                      Societal values inform behaviors                      Personal views impact clinical care                      Equal treatment                      Varying definitions of pansexuality</p>
	<p>1c. The Sex and Gender Revolution</p>	<p>Change is constant                      Social progress                      Challenging the binary                      Open-minded                      Open, fluid, and evolving                      All identifications valid                      Discomfort with use of labels                      Gender as non-binary                      Liberal views</p>

**Appendix G**

**Developed Major Theme: Working Therapeutically with Pansexual Youth**

Major Theme	Theme	Sub-theme	Focused Code
<p>Working Therapeutically with Pansexual Youth</p>	<p>1. Supporting Pansexual Youth in the Therapy Room</p>	<p>1a. Personal Qualities</p>	<p>Open/open-minded and non-judgmental                      Respectful                      Accepting                      Affirming                      Remain curious                      Gender-affirmative and sex-positive                      Flexible views                      Supportive                      Willingness to learn                      Knowledgeable about sexuality/gender</p>
		<p>1b. Therapeutic Interventions</p>	<p>Importance of listening                      Assess social ecology                      Take a personalized approach                      Increase social support                      Connect patient to like-minded peers                      Ask how they define pansexuality                      Ask what pansexuality means to them                      Create an open space                      Share pronouns                      Understand/accept their perspective                      Patients are the experts on themselves                      Support                      Affirm and align                      Ask sensitive and clarifying questions                      Work with family</p>
		<p>1c. Combating Microaggressions</p>	<p>Avoid making assumptions and generalizations                      Learn as much as you can about sexuality and gender                      Sexuality only one part of identity                      Sexuality/gender not always the focus of treatment                      Normalize questioning identity                      Know what pansexuality is and is not                      Identity unique significance for patients                      Do not pretend to know                      Prejudice in the mental health field</p>

	2. Therapists' Reactions and Subjective Experiences	2a. Professional Experiences	<p>Similar to work with other LGBTQ+ youth</p> <p>Positive experience</p> <p>Humbling</p> <p>Empowering</p> <p>Fulfilling</p> <p>Challenging</p> <p>Rewarding</p> <p>Meaningful</p> <p>Expressed gratitude</p> <p>Growth as a clinician</p> <p>Level of awareness about sexuality and gender</p> <p>Enjoyment</p>
		2b. Kinship with Pansexual Youth	<p>Personal experiences with invalidation, discrimination, and non-acceptance of identity</p> <p>Positive bias</p> <p>Sensitivity and understanding</p> <p>Queer identified therapist</p> <p>Identification with the LGBTQ+ community</p> <p>Influence on clinical work</p> <p>Interests in working with population</p> <p>Therapist-patient match</p>
		2c. Qualities in Pansexual Youth	<p>Awesome</p> <p>Hope for the world</p> <p>Social progress</p> <p>Need for acceptance/validation</p> <p>Open-minded towards sexuality/gender</p> <p>Nuanced understanding of sexuality</p> <p>Resilient</p> <p>Flexible</p>
	3. Transforming the Mental Health Field	3a. Individual Action	<p>Know about various sexual and gender identities</p> <p>Become familiar with available resources</p> <p>Understand and explore personal identity and views about sexuality</p> <p>Connect with pansexual people</p> <p>Training with population</p> <p>Do your own research</p> <p>Be open</p> <p>Read the literature</p> <p>Seek consultation and education</p> <p>Educate others</p>
		3b. Systemic Change	<p>More resources/training/education</p> <p>Increase awareness</p> <p>Exposure to population</p> <p>Include in broader LGBTQ+ discussions</p> <p>Better training</p> <p>Provide workshops/webinars/online resources</p> <p>Increase accessibility to resources</p>

			<p>Educate on intersectionality</p> <p>Coursework and curriculum</p> <p>Funding for research</p> <p>Educate on microaggressions</p>
		<p>3c. Barriers and Biases</p>	<p>Inadequate training, supervision and resources</p> <p>Lack of experience and basic knowledge</p> <p>Feelings of incompetence</p> <p>Colleagues not accepting, willful, or dismissive</p> <p>Pansexuality ‘just a trend’ or youth ‘too young’</p>



## Appendix H

### Developed Themes: Expanding on Clinician Responses to Quantitative Questions

Theme	Sub-theme	Focused Code
1. The Gray Area: Pansexuality and Bisexuality	1a. Is Pansexuality Needed?	Bi erasure/label harmful to bisexual community Too many labels Pansexuality independent from bisexuality Varying definitions of labels
	1b. Similarities Between Labels	Bisexuality encompassing enough Pansexuality synonymous with bisexuality Terms used interchangeably by patients Attraction to more than one sex and/or gender Erasure of non-monosexual identities
	1c. Difference Between Labels	Pansexuality less binary, more accommodating, and specific Identities socially constructed Bisexuality an umbrella term Pansexuality independent orientation Bisexuality attraction typically more masculine/feminine or male/female
2. Understanding Perspectives About Pansexuality	2a. Addressing Misconceptions	Pansexual youth no more likely to be promiscuous or polyamorous than other youth Not ‘just’ a trend or confusion Valid orientation
	2b. More than just Another Trend	Increased awareness Youth more open to fluid gender and sexuality Development of language/concepts that best capture diverse gender/sexual expression Society more accepting and open Rates of identification Newest terminology Both a trend and a valid orientation
	2c. Reactions to the Study	Varying levels of clinical experience and awareness (no experience, expertise with LGBTQ+, etc.) Limited knowledge/awareness Personal reactions (e.g., neutral, sad, confident) Issues with wording of questions Varying definitions of pansexuality