CHAPTER V

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER AND QUESTIONING YOUTH

“Our greatest happiness does not depend on the condition of life in which chance has placed us, but is always the result of a good conscience, good health, occupation, and freedom in all just pursuits.”

- THOMAS JEFFERSON

WRITTEN BY: DONNA MATTHEWS, MSW
Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) Youth

Introduction

Lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) youth experience unique barriers and challenges as sexual minority, transition-age youth. The National Alliance for Mental Illness (2007) states that while sexuality is a normal part of development, youth who identify as LGBTQ may experience more “turbulence” than their heterosexual peers as they cope with stigma and social prejudice related to their sexual orientation or gender identity (Bostwick, 2007). It is the obligation of mental health professionals to provide care and administration of programs that assist LGBTQ youth through this turbulence and to do so in ways that provide respect and dignity for all individuals.

Though this chapter focuses on LGBTQ youth and young adults, this is not meant to imply that LGBTQ people have inherent psychological issues (American Psychological Association, 2008) or more psychopathology than heterosexual or non-transgender persons. In fact, the American Psychological Association (APA) (2008), the American Medical Association (2007) and the National Association of Social Workers (2006) all call upon professionals to promote the human dignity of LGBTQ individuals and hold them as experts in their own needs. This is especially critical given historical perception and treatment of LGBTQ people as abnormal, coupled with social and institutional discrimination.

\(^1\) As noted in the LGBTQ glossary at the end of this chapter, the “Q” in LGBTQ sometimes stands for “Questioning” and “Queer”, which is viewed by some as a pejorative term. However, many youth, particularly those who are still in the process of understanding their sexual orientation or gender identity, or who view sexual orientation and gender identity as fluid, prefer the term “Queer” or “Gender Queer”. Thus in this chapter, when we use the acronym “LGBTQ”, the “Q” stands for both “Queer” and “Questioning”.
Trust – always foundational to providing mental health services – is especially imperative to address with LGBTQ individuals and other members of stigmatized populations who have historically been marginalized, including by systems intended to support them. In fact, “connected to marginalization…is a sense of mistrust of governmental agencies grounded in these communities’ oppression” (University of California, Davis Center for Reducing Health Disparities, 2007, p.7). For LGBTQ youth, this mistrust is compounded by additional barriers they face: Being unable to consent for their own care, experiencing oppression within their own families, as well as racial, ethnic, religious, or economic oppression. Therefore, our most important charge is to establish trusting relationships with LGBTQ youth based upon respect and understanding of their unique experiences.

This chapter outlines four steps for developing a foundation for working with LGBTQ youth: Step One – Developing a “Big Picture” view of LGBTQ youth identity; Step Two – Working with LGBTQ youth and families; Step Three – Sample strategies for establishing one’s professional self and agency as being LGBTQ friendly; and Step Four - The language of being LGBTQ.

**Step One:**

*Developing a “Big Picture” view of LGBTQ youth identity*

_Theoretical Context_

An ecological systems perspective recognizes a “person in the environment” model in which a person is influenced by external stressors and, in turn, influences their environment. Germain and Gitterman’s life model – a prominent example of ecological
systems theory – examines this “back and forth” of one’s relationship to their environment. Individual capacities such as ability to form relationships, ability to cope with stressors, feelings of competence, esteem and self-responsibility are recognized as foundational. So, too, is the recognition that one exists within a greater environment where elements such as “coercive power, exploitive power, habitat, niche” and that the ability for an individual to “fit” within their environment is pivotal (Payne, 2005). Therefore, critical support for LGBTQ youth involves nurturing their capacity for living in a world or society that may feel and be hostile, as in the case of LGBTQ individuals who are not afforded equal civil rights (or when one’s socialization to what it means to be transgender is born from exposure to hate crime accounts and statistics).

Social construction theory furthers an ecological systems perspective by underscoring the impact and power of meanings attributed by society. When individuals fall within ostracized minority communities, they may experience a devaluing and dehumanization by virtue of the discourse in society about them (Payne, 2005). For lesbian, gay and bisexual individuals, society may recognize variation in sexual orientation, but attribute a negative, neutral, or positive value to this. For transgender or transsexual individuals, socially constructed beliefs of what it means to be male or female may prohibit having a gender identity that differs from one’s biological sex. Transgender youth may experience both disbelief and lack of acceptance for who they are. A marked benefit to social construction theory is the ability to shift from the power of the situation residing in a potentially oppressive society to one on the internal strength of the youth. In other words, youth then have permission to “reconstruct” their understanding of the situation, which allows them to value their own understanding of themselves.
In essence, there are multiple frameworks for understanding LGBTQ youth experience. Providers are challenged to increase their knowledge of LGBTQ issues within their local communities through direct engagement with LGBTQ community based organizations, or to seek training or consultation in working with LGBTQ youth. The importance of this cannot be stressed enough. LGBTQ youth are privy to unique challenges due to a predominance of negative social attitudes towards those who are lesbian, gay, bisexual, transgender, queer and questioning.

**Historical Context within Mental Health**

No empirical studies have shown that homosexuality is correlated with psychopathology (Hancock, 1995). The classification of homosexuality was in fact removed from the Diagnostic Statistical Manual (DSM) in 1973 as a disorder, with a subsequent derivation of homosexuality as a classification removed from the DSM III-R in 1984. In 1980, the addition of Gender Identity Disorder” (GID) to the DSM was believed by some advocates to be a cloaked diagnosis for homosexuality and, currently, it is a diagnosis that pathologizes transgender, transsexual or gender variant individuals. According to the APA (2006), transgender and transsexual individuals in fact are considered to have a mental disorder, per se, only when that psychological condition causes distress or disability. To apply a psychiatric label otherwise to transgender or transsexual individuals, such as Gender Identity Disorder as classified in the DSM-IV-TR (American Psychiatric Association, 2000), inappropriately pathologizes them.

Individuals – including transitional-age youth – may not experience distress or disability due to their internal feelings and thus feel outraged by labels qualifying their identity (transgender) as a disorder (Gender Identity Disorder). Many trans activists and
medical and mental health professionals, in fact, contest the classification within the
DSM-IV TR, stating transgender people face challenges from social and medical models
of what is “natural” and which perceives transgender and transsexual people as
“unnatural” (Feinberg, 2001). Those who oppose diagnostic labeling of transgender
people are reminiscent of laypeople, consumers and professionals whose advocacy led to
the removal of homosexuality as a psychological disorder from the DSM in 1973
(Lucksted, 2004). And yet, the diagnostic classification of Gender Identity Disorder is
recognized by many to be instrumental justification for medical health care sought by
transgender and transsexual individuals (APA, 2006) – health care which often hinges
upon having a psychiatric diagnosis.

Understanding this historical stigmatization of lesbian, gay, bisexual and
transgender people as mentally ill - and the continuing disempowerment of transgender
people within medical and mental health systems - is provided to illustrate the oppression
that many LGBTQ individuals have endured and continue to experience within the field
of mental health. This is a challenging dynamic; however, it presents a rich opportunity
for providers to adopt an ecological perspective that places the “problem” outside of the
individual and sees LGBTQ youth as operating within an environment which can often be
hostile and oppressive (Matthews, 2008). This chapter, therefore, provides
recommendations for working with youth to establish trusting therapeutic relationships to
address the needs of the youth through mutual respect and partnership.

An extension of the psychological literature on LGBTQ individuals is the
emerging biomedical research. This research, still in its early stages, suggests that there
may be some biological differences between homosexual and heterosexual individuals.
For example, a recent Los Angeles Times article (Gellene, 2008) described research showing that the brains of homosexual men are similar to those of heterosexual women. This research should be viewed critically. On the one hand, it may lessen discrimination by suggesting that one does not “choose” to be LGBTQ, which is an argument frequently used against LGBTQ individuals. However, this type of research can also contribute to false stereotypes about LGBTQ individuals, who are as unique as heterosexual people.

Institutional Barriers Impacting LGBTQ Youth

Transition-age youth by definition are moving from one sphere of life to another. They are shifting from the childhood sphere that inhibited their autonomy to adulthood, where they are expected to be responsible for themselves. Discrimination faced by LGBTQ people affects youth during this transition, whether through direct or indirect exposure. Ability to marry, to be “out” in service to one’s country, to be protected from discrimination in education, employment and housing are some of the very real issues that impact transition-age youth. Ability to access LGBTQ-friendly and appropriate healthcare, while having limited ability to consent (for those under 18 years of age) for their own care, is another impediment that LGBTQ youth may face. This is further compounded by lack of acceptance that youth may experience within their families.

Currently in the United States, there are many politicized issues related to being LGBTQ that carry stigma, deny equal rights, and interfere with one’s ability to maintain a sense of

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2 California Minor Consent Law permits youth over age 12 to consent to specific services without a parent or guardian. These services include abortion, birth control, STD testing/treatment, substance abuse counseling, and mental health services when the minor is determined to be mature enough to consent AND when the minor would present a physical or mental threat to him/herself or others without treatment OR is a victim of incest or abuse. For more information, see: http://www.californiateenhealth.org/download/WalletCard.pdf
belonging to family and society. For example, consider these facts about harassment of LGBTQ youth in schools:

- 80% of LGBTQ youth hear homophobic remarks often in their schools.
- Almost 40% of LGBTQ students report being verbally or physically assaulted, often with a weapon.
- Transgender students reported physical harassment 30% more than students that identified as lesbian, gay, or bisexual.
- Nearly 33% of LGBTQ students reported skipping school in the past month because they were simply too afraid to go (GLSEN, 2003).

For LGBTQ youth, as for all youth, succeeding in school is critical to later success in employment. Yet statistics on what LGBTQ youth experience in school is dismal even in California, despite the enactment of the CA Student Safety and Violence Prevention Act (also referred to as AB537) in January 2000 which added non-discrimination protections based upon one’s “actual or perceived sexual orientation or gender identity” in public schools. However, without consistent state and local application and enforcement, this legislation falls short of actually protecting LGBTQ students from harassment and assuring LGBTQ students equal access to education. Efforts by LGBTQ youth themselves, parents, supportive school staff and advocates – along with litigation - are currently driving much of the progress that does occur to improve school experience for LGBTQ youth.

Denial of the right to marry is also an important type of discrimination faced by LGBTQ people. Though LGBTQ youth may not be imminently planning to make a life commitment to a romantic partner, they are nonetheless coming of age in a time when
their desire to do so in the future is questioned critically by many. Being able to see one’s future as an equal participant in society, with the same rights and privileges accorded to others, including the right to marry, enhances well-being. Until very recently in California, this ability to imagine a future self as a legally married adult was denied to LGBTQ youth. The California Supreme Court’s decision on May 15, 2008 to allow same-sex partners to marry is a cause for optimism, and is encouraging for LGBTQ youth and their heterosexual allies. However, the right to marry in California and other states is not yet guaranteed; in November 2008, voters will be presented with Proposition 8, which would amend the state’s constitution to ban same-sex marriage. Thus, though promising, stigma and discrimination continue to be an important concern for LGBTQ youth.

“As children, we are conditioned to get married. That is why we are shown movies like ‘Cinderella’ and ‘Snow White’. At the end of each tale, they get married and ‘live happily ever after.’ Children make the connection that marriage equals happiness; even though in reality it doesn’t guarantee everlasting love…But it is still important that LGBTQ youth are given a chance to have a shot at this fairytale. I wasn’t able to dream a part of this full dream…”  
CALVIN WONG, 18 YEARS OLD

(Source: http://lyric.org/apifamilyproject/lyc_pgs/s02/02_index.html)

Vulnerability of LGBTQ Youth

Victimization and stigmatization by others has equally devastating effects on LGBTQ youth. This may cause LGBTQ youth to be more vulnerable to mental health problems such as depression, anxiety, substance abuse, and suicide (Hart and Heimberg as cited in Bostwick, 2007). A survey of transgender youth (Sausa, 2004) found that 71%
of transgender youth reported being sexually assaulted or raped because of their gender identity or expression. This illuminates the frequently violent effects of intolerance faced by all sexual minority youth. One study, not surprisingly, found that “gay, lesbian, and bisexual youth ages 14-21 were significantly more likely to report depression and anxiety than heterosexual peers” (D’Augelli, 2002).

DeAngelis (2002) cited that a study of the root causes of mental disorder of lesbian, gay and bisexual people found evidence of a relationship between discrimination and mental health problems. While not going so far as to say that discrimination caused mental health problems, DeAngelis (2002) noted that mental health treatment that attends specifically to stress caused by discrimination is needed. As helping professionals, it is also important to recognize that youth who may be perceived to be lesbian, gay, bisexual and transgender may experience similar symptoms as those who are LGBTQ and be victimized on this basis.

A “15-year-old… was murdered at school on February 12, 2008. Friends say the reason was his sexual orientation and gender expression.”

(GLSEN, 2008).

Substance Use and Methamphetamine Use

Alcohol and substance use. “In the general population, age is one of the most robust predictors of most types of substance use and abuse. Both men and women are more likely to drink heavily and use other substances in early adulthood; for the majority of the general population, both quantity and frequency of use decrease with age” (Eliason & Hughes, 2002, p.276). However; rates of drinking among gay men and lesbians decline
less dramatically with age than their heterosexual counterparts (McKirnan & Peterson, 1989a, Skinner, 1994 as cited in Eliason & Hughes, 2002). Explanations include the propensity of (adult) lesbians and gay men to be continuing patterns of substance use “developed when they were younger and gay bars were among the few places to socialize and meet potential partners” (Eliason & Hughes, 2002, p. 277). This insinuates that age, for lesbian and gay men, may therefore not be as much of a protective factor in the LGBTQ community as it is in the heterosexual community.

Methamphetamine use and gay and bisexual men. Up to 28% of gay men ages 15-21 in major urban areas use methamphetamine (Gay and Lesbian Medical Association [GLMA], 2006, p. i). Thus, addressing methamphetamine use is critical when working with TAY. In a 2006 report by GLMA, the following key themes were identified in an extensive literature review and focus groups: Methamphetamine use is a serious problem, a poorly understood problem, has potential for dependence, and is dangerous. There is greater need for compassion and understanding. Contrary to popular opinion, which may suggest that addiction, in particular addiction to methamphetamine, is not treatable, successful treatment options do exist (e.g. CBT, motivational interviewing) that should be tailored to the needs of gay men. Barriers to treatment, prevention strategies, and public education also need to be addressed in order for prevention and treatment to be effective for gay and bisexual men (GLMA, 2006).

Some of the unique needs and issues facing gay and bisexual men include “homophobia, discrimination, fear, loss and stigma resulting from HIV/AIDS, and a public discourse which denigrates the ‘lifestyle choices’ of LGBT persons, same-sex marriage, and equal rights – [and] often result in internalized homophobia, feelings of
low self worth, and depression, and these conditions increase susceptibility to drug addiction in some individuals” (GLMA, 2006, p. ii). Treatment programs should allow gay men with methamphetamine addictions to explore issues and triggers related to sex, provide referral lists to gay-sensitive treatment providers, and accommodate the unique needs of each person. Cost of care must also be address, as lack of insurance was cited as a barrier to expedient treatment.

While some aspects of systemic healthcare barriers are difficult to overcome for providers as well, a critical barrier over which individual providers do have control was also illuminated in the GLMA (2006) report:

An additional barrier to care that participants reported was that many healthcare providers who believe that methamphetamine dependence is an incurable condition, avoid addressing the addiction issues of gay male patients. Participants identified numerous negative thoughts that clinicians experience when thinking about methamphetamine users [including] they are a “lost cause” with no hope for recovery…. Some participants described healthcare providers intentionally ignoring signs that their patients or clients may be using methamphetamine, because of reluctance to open up an issue that would be difficult to address or that seems impossible to help (GLMA, 2006, p. 24).

Thus it is important for individual providers to remain nonjudgmental, and hopeful that their clients can recover from methamphetamine dependence.

Suicidality and LGBTQ Youth

Estimates suggest that 47% to 88% of transgender youth have experienced suicidal ideation or attempted suicide (Clements-Nolle, Marx & Katz, 2006; Israel &
Recent literature suggests that the rate of suicide attempts by GLB youth is 20 – 40% higher than among non-GLB youth (Kitts in Bostwick, 2007). Most LGBTQ youth who complete suicide are between ages 16-21 (Pollak, 1985, as cited in Blumenfeld & Lindop, 1994), which overlaps with the “transition age” range described throughout this guide. The younger an adolescent is when he or she realizes she or he is LGBTQ, the greater the risk of suicidal ideation, because younger adolescents lack the coping skills and support networks that older adolescents may have developed (Remafedi, 1985, as cited in Blumenfeld & Lindop, 1994). Other risk factors for suicide among LGBTQ youth include substance abuse, rejection by the family when coming out, religious discrimination, harassment by peers, and social isolation (Blumenfeld & Lindop, 1994).

**LGBTQ Youth of Color**

LGBTQ youth of color have unique challenges as compared to their Caucasian counterparts. These youth likely experience challenges integrating racial and ethnic culture with their lesbian, gay, bisexual or transgender identity. LGBTQ youth of color may face racism within the LGBTQ community, fear devaluation and rejection within their ethnic families and experience an overall sense of isolation within both ethnic and LGBTQ communities due to their dual identity (Ryan, 2002).

A foundational review of literature and research commissioned by the National Youth Advocacy Coalition (Ryan, 2002) about LGBTQ youth of color provides important considerations for working with ethnically diverse LGBTQ youth. One critical challenge is that youth of color have a greatly reduced likelihood of disclosure to families as compared to their white counterparts. While, for youth of color, families play a
valuable role in supporting them against mainstream racism, there may be cultural aspects that cause LGBTQ youth to hide their sexual orientation or gender identity from these same supportive families. Cultural aspects of ethnicity and race may encompass rigid attitudes, beliefs and values around sexuality. Issues related to religion, historical oppression in ethnic communities, the role of procreation and other norms may also inhibit disclosure by youth of color about their sexual orientation or gender identity (Ryan, 2002).

For example, the Lavender Youth Recreation and Information Center (LYRIC) in San Francisco provides information related to youth of color on their website that illuminate important nuances faced by youth within the Asian Pacific Islander (API) community. According to LYRIC’s API Family Project website:

Within Asian Pacific Islander (API) communities a strong, cohesive extended family has been identified as one of the most important indicators of good mental health. Unfortunately, holding together API families becomes especially challenging when API youth come out as lesbian, gay, bisexual, transgender, queer or questioning (LGBTQQ). API people are not any more homophobic or transphobic than any other racial/ethnic group. However, API sexual and gender identity traditions are different from dominant western norms and often lead to significant intergenerational communication challenges. The lack of intergenerational communication and shame around this issue, and the rejection of LGBTQQ youth by their parents, impacts not only the mental health of individuals and families, but the larger API community as well (LYRIC, n.d.).
Similarly, other youth of color may experience cultural barriers to disclosing within their families and communities, leading to heightened internal conflict about their sexual orientation or gender identity.

*Transgender: It’s NOT a sexual orientation*

“Sexual orientation refers to one’s sexual attraction to men, women, both, or neither, whereas gender identity refers to one’s sense of oneself as male, female, or transgender” (APA, 2006).

What does it mean to transcend traditional gender roles to be one’s true self? To the extent that individuals are prescribed gender roles at birth, based upon their discernable genitalia, society maintains a stronghold on the sense that biological sex defines one’s gender for life (Burdge, 2007). What must it mean then for youth who do not follow a stagnant, linear perception of what it means to be male or female in our culture? There are youth – in fact, children - who feel an overwhelming and compelling need to live according to their own internal sense of being male or female, which differs from their biological sex (Matthews, 2008). They are often referred to as “transgender”.

What does it mean for the families who raise transgender children and youth?

Historically, the prevalence of individuals who were considered “transsexual” (people profoundly unhappy in their birth sex and who seek to change, or have already changed, their bodies to match their gender identity) was considered to be 1:11,900 for “male to female” (MTF) and 1:30,400 for “female to male” (FTM) (Meyer et al, 2001). Current research estimates are now 1:500 (MTF) and 1:2500 (FTM) (Conway & Olyslager, 2007). Is the profession aware of the increased prevalence?
Furthermore, in U.S. culture, deviation from a rigid gender binary is generally considered a “disorder” by the mental health profession. Evidence of this is found in the classification of “Gender Identity Disorder” in the 4th edition of the Diagnostic Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR) (APA, 2000). A U.S. colloquialism for those whose gender varies from their biological sex encompasses terms such as “transgender”, “transsexual” or “queer”. Transgender youth may desire medical treatment similar to some transsexual adults or adopt a fluid sense of gender that does not involve transition (Matthews, 2008). For those who youth who do, there are standards of care to guide mental health and medical professionals. Mental health therapists and psychiatrists must be aware of the critical gate-keeper role they may play for any individual seeking transgender medical services or treatment. “It is important to understand that once transgender people are able to express their gender identities they are able to go on to lead happy, fulfilled lives” (Lambda Legal Defense and Education Fund, 2006, p. 2).

The World Professional Association for Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association’s Standards of Care (www.wpath.org) for Gender Identity Disorder is a foundational resource used by medical and mental health providers seeking to assist transgender and transsexual individuals. The Standards of Care is a recommended protocol to use in determining readiness for medical treatments of transgender/transsexual individuals with a goal to relieve the distress inherent in this psychological “disorder”. In doing so, the incongruity of medical treatment to address a psychological “disorder” prompts the question if one’s
transgender identity should actually be considered a medical disorder rather than a psychological disorder.

Mental health providers and administrators are, therefore, charged with acquiring the knowledge, beyond diagnosis, that exists for working with transgender youth and their families. A critical consideration in working with transgender transition age youth may, in fact, be assisting with connection to a primary care provider knowledgeable about transgender health care. As well, if concerns arise around changing identity documentation, linkage to advocacy organizations such as the Transgender Law Center in San Francisco could be facilitated. Most importantly, the profession is urged to develop partnerships with youth and families to enable them to guide the care they receive.

Addressing Myths about Bisexuality

- “Bisexuals are confused”: Bisexuality is a legitimate sexual orientation that can be as stable over the life course as straight, gay, or lesbian sexual orientations. “For some bisexuals, homosexuality was a traditional phase in their coming out as bisexuals” (University of Delaware [UD] Allies Program, 2008, p. 1).
- “Bisexuals are equally attracted to men and women”: Some bisexuals are equally attracted to men and women, but others feel a stronger attraction to one sex or the other. (UD Allies Program, 2008).
- “Bisexuals are not interested in monogamy/Bisexuals are promiscuous”: Bisexuals are no more or less interested in monogamy or promiscuity than anyone else. “Like lesbians, gays or heterosexuals, some have multiple partners, some have one partner, some go through periods without any partners. Promiscuity is no more prevalent in the bisexual population than in other groups of people” (UD
Allies Program, 2008, p. 2). Given that a bisexual individual can be in a monogamous relationship with someone of the opposite sex, practitioners may not always know that a client is bisexual unless the client discloses this.

Thus, it is important to avoid making assumptions about any client’s sexual orientation, no matter who they are romantically involved with, or how committed the relationship is. The American Psychological Association (APA) (2008) encourages providers to be conscious of the fact that “psychotherapy with bisexual clients involves respect for the diversity of their experiences and relationships (Fox, 1996; Klein, Sepekoff, & Wolf, 1985; Matteson, 1996)” (APA, 2008).

**Step Two:**

**Working with LGBTQ Youth and Their Families**

*Self Psychology*

Given the societal discrimination LGBTQ individuals confront, and the historical mistrust of mental health and other social services among marginalized populations, it is critical that the therapist or mental health professional begins by establishing trust in individual work with a client. Self psychology is a psychodynamic theory developed by Heinz Kohut in the 1970s that is well-suited to the task of building rapport and trust with clients from stigmatized communities. Self psychology can be distinguished from classical psychoanalytic theories in that its emphasis is on the individual’s need for empathy (Elson, 1986). Self psychology is focused on the building of a healthy self, rather than the elimination of beliefs or behaviors that the therapist believes to be maladaptive:
In self psychology, the self develops in relationship to self objects. A self object is an “intrapsychic experience of a function performed by a relationship to other people, symbols, or ideas.” (Abramovitz & Cohen, 1994, p. 206). The three main self object functions are mirroring, twinship, and idealizing: Mirroring self objects affirm the individual’s innate goodness and competency; twinship self objects give the individual a sense of belonging; and idealizing self objects provide safety and a feeling of calmness (Elson, 1986).

Self psychological treatment focuses first on the development of understanding and expression of empathy on the part of the therapist. This focus on building rapport is typically long in self psychological treatment, and the theory discourages the therapist from offering explanations too soon (Chenot, 1998). This focus on empathy implies that the client’s experiences be viewed subjectively and in context (Klugman, 2002); the therapist attempts to understand the client’s experiences as the client experiences them, not as the therapist would experience them, or as the therapist believes the client should experience them (Goldstein, 2001).

Using Self Psychology with LGBTQ Clients. Self psychology’s emphasis on developing empathic relationships, and many of its other principles, are in keeping with the treatment issues and strategies recommended for working with LGBTQ clients, many of whom have been stigmatized or traumatized as a result of their orientation or gender identification. Some scholars and therapists argue that other theoretical orientations might be inappropriate for working with some of the issues that LGBTQ people present. For example, in their article on working with transgender clients, Carroll, Gilroy, and Ryan (2002) describe the lack of fit between cognitive behavioral approaches and the
treatment of issues of many transgender clients. Transgender people do not “believe” they are being stared at or verbally assaulted; they actually are. Relational theories that seek to fortify the self-esteem against these real attacks are often more suitable for LGBTQ clients.

Treatment issues that come up in the course of work with LGBTQ clients are as diverse as the clients themselves; however, a few common areas of concern often surface. Many LGBTQ clients suffer from a lack of mirroring as they see few, if any, positive images of themselves in their families of origin, in the media, and in public spaces (Beck & Stepakoff, 2000; Bobbe, 2002; Carroll et al., 2002; Cornett, 1993; Kassoff, 1997). As a result of this lack of mirroring, combined with stigmatizing experiences, some LGBTQ people feel shame about their sexual orientations and experience internalized homophobia (Cornett, 1993; Kassoff, 1997; O'Dell, 2000). Misinterpretation of clients’ sexual choices may also be an important treatment issue in work with LGBTQ clients (Cheuvront, 2002).

Lack of mirroring. Lack of mirroring, while it can be experienced by an absence of positive images of LGBTQ people, is also experienced through as active efforts that deteriorate self-esteem. Cornett (1993) argues that this is why self psychology may be popular with therapists who work with LGBTQ clients – a primary focus is in the repair of the self-esteem. Cornett (1993) writes, “No other group faces as many assaults on its collective self-esteem as do gay men.” (p. 50-51). This statement is arguable, as many groups face assaults on their collective self-esteem, however, the fact that the statement was made is a testament to the need for clinical intervention that focuses on the building of the cohesive self.
Shame and internalized homophobia or transphobia. Failure to consider the impact that homophobia or transphobia plays in the symptomatology of LGBTQ clients is a mistake many therapists make when working with LGBTQ clients (Hancock, 1995). Hancock (1995) argues that homophobia is “the most serious and prevalent problem gay men and lesbians continue to face…” (p. 407).

Many LGBTQ people feel shame as a result of the homophobia or transphobia they may experience in a range of environments, including with family, in school, at work, and in society at large, as noted above. Cornett (1993) argues that self psychology’s focus on empathic mirroring can restore pride in the client. As a constructionist theory, self psychology has the potential to challenge heterosexual norms by encouraging the client to explore his or her subjective experience: “Basically counselors need to create an atmosphere in which the larger cultural narratives concerning heterosexism and gender are deconstructed.” (Carroll, Gilroy, & Ryan, p. 134). For some LGBTQ people, the response to shame and homophobia or transphobia can contribute to vulnerability to depression, suicidality, and substance abuse (Bobbe, 2002).

Sexual choice and risk. For most people, whether LGBTQ or not, sexuality is an important aspect of positive identity development. Abramovitz and Cohen (1994) describe the identity-developing function of sexual expression in self psychological terms: “Sexual contact, whether in its more primitive and defensive form, or in its mature form, is a fundamental route for fulfilling mirroring, alterego, and idealizing self object needs.” (p. 214). Thus any consideration of the sexual choices of LGBTQ people must take into account not only that sexual expression provides self object functions for all
Cheuvront (2002) deals with the issue of sexual risk-taking specifically in an excellent article titled, “High-Risk Sexual Behavior in the Treatment of HIV-Negative Patients”. He begins by describing the prejudice many people have towards sexual risk-takers. He and two colleagues informally create a list of adjectives about sexual risk-takers: profoundly disturbed, emotionally detached, suicidal, impulsive, isolated, and suffering from low self-esteem (p. 10). Cheuvront argues that whether or not these descriptors are accurate is irrelevant; once we apply these terms and others to our clients, we begin to narrow opportunities for open, empathic, and potentially healing discussions of the underlying issues and the client’s subjective reality.

Naturally, these negative stereotypes are part of the client’s consciousness as well, therefore, if both therapist and patient approach discussions of sexual risk-taking from a pathologizing point of view, it is unlikely that an authentic, healing interaction can occur (Cheuvront, 2002). Cheuvront (2002) recommends that therapists “…recontextualize risk-taking as within the domain of self-care…It often emerges in the context of emotional needs, hopes, and fears in mutual interplay with the interpersonal world.” (p. 13-14). Effective treatment requires the therapist to understand and empathize with the specific circumstances and states of mind in which the risk-taking takes place.

“With an open heart I sat silently listening, knowing that just being present was important. I didn’t expect the rollercoaster of emotions that would sweep over me.”

— Rich Franklin

(Source: Positive Images, 2006)
In addition to providing individual therapy to fortify LGBTQ youths’ self-esteem against the discrimination they experience, it can be very helpful to involve the youth’s family in therapy, if the youth and family are open to it. Family therapy can be particularly useful when the young person is ready to “come out” as this disclosure can be extremely stressful (LaSala, 2000). Even though many parents are likely to express disapproval, about 75% of LGB individuals decide to disclose their sexual orientation to their families (LaSala, 2000). While disclosure may prompt a temporary family crisis, the cost of maintaining secrecy is high; LGB individuals who are unable to reveal their sexual orientation to their families experience greater stress over time (LaSala, 2000). However, “coming out” is not the right decision in all cases; part of the therapist’s task is to help the youth weigh the costs and benefits of disclosing sexual orientation, as some families may never be able to accept that their child is LGBTQ, and the therapist needs to support the youth’s decision either way. When the youth is ready to disclose his or her sexual orientation or gender identity, the therapist can help the client “come out” to his or her family in a way that is more likely to be accepted by the family, and can help manage the family’s process.

The therapist can work with the youth to identify a time, place, and context for “coming out” in which his or her parents are more likely to be accepting. For example, disclosing sexual orientation during an argument is less likely to be accepted than when all parties are calm and have ample time to process their feelings.

The management of the coming out process can include helping parents who have difficulty accepting the news by discussing the stages of grief with them, normalizing the
feelings they are experiencing, while reminding parents that their son or daughter needs support at this time. The therapist can provide support to the young person, and tell him or her that the parents’ response is likely to be temporary (LaSala, 2000). In order to provide opportunities for members of the family to fully process their feelings, it is recommended that the therapist offer separate and joint sessions as needed (LaSala, 2000).

As some of the initial feelings subside, the therapist will need to provide psychoeducation to the parents, correcting misinformation and stereotypes they may have about LGBTQ individuals. Many parents will fear that their child cannot lead a fulfilling life as a LGBTQ individual, and the therapist must challenge that assumption. Parents may also fear that they will “lose” their child; the therapist can assuage some of these fears by reminding parents that their son or daughter’s decision to “come out” arises from a desire for more closeness and honesty with parents (LaSala, 2000).

It is important to remember that though the initial family crisis may be resolved within a few months, families may require as many as five years to adjust completely (Lasala, 2000). Therefore, therapists should make efforts to provide follow-up care and connect families with ongoing community and peer support resources once the immediate crisis is resolved (LaSala, 2000), recognizing that families too experience a period of “coming out” to others about their LGBTQ son or daughter.

Support Groups

Other effective vehicles for supporting LGBTQ transition-age youth used by therapist and community centers are drop-in or “coming out” groups. Perceived by many youth as less intimidating than individual therapy, support groups can also counter the
social isolation that youth may experience as they explore or become aware of their sexuality and gender identity. The fluid nature of a group that is discussion driven, focused on different topics each meeting or allowing for an unstructured “check in” format can be used to allow for a natural progression of what youth may need. At the Ark of Refuge in San Francisco, for instance, a transgender social support group addresses a variety of issues including relationships, effective communication, hormone therapy, living clean and sober, and building self-esteem and provides an environment where individuals can both learn from and support each other.

“This is my refuge in the world. My hiding place from chaos.
This is where my self-esteem awaits. This is my refuge.
A place where I can smile and hold my head up high.
This is my refuge where no one judges me and they are there to catch me when I fall. This is my refuge in the world where there is no hate, only open arms.”
(Source: http://www.arkofrefuge.org/tgrsuppgrp.html)

**Step Three:**

**Strategies to demonstrate a provider & agency are “LGBTQ friendly”**

**Safe Zones**

The establishment of places which are safe “havens” or which signal a clear respect for and welcome of LGBTQ individuals is based upon the Gay, Lesbian, Straight Education Network’s (GLSEN) Safe Zone program for schools. It has since been adapted for use in other settings, including agencies, businesses and by individuals who wish to be a visible ally of LGBTQ people. Within mental health settings, it is a way to
proactively signal that an agency or professional is open-minded about sexual orientation and gender identity issues, will be respectful and affirming and – thereby – may alleviate fears that youth may have about being judged.

_How does a Safe Zone work in Schools versus Agencies?_ There really is no difference to establishing a safe zone at a school site or within an agency. The ultimate goal is the same: To provide a welcoming environment, celebratory of each individual’s identity.

For many [youth], the presence of allies to whom they can turn for support—or even the simple knowledge that allies exist—can be a critical factor in developing a positive sense of self, building community, coping with bias, and working to improve school climate. Safe Zone programs therefore seek to increase the visible presence of student and adult allies (GLSEN, 2003).

The main purpose of a Safe Zone program is to visibly mark people and places that are "safe" for LGBTQ [youth]. This is usually accomplished through a sticker with a pink triangle, a rainbow flag or some other recognizable LGBTQ symbol. When staff affix stickers to their desks, office doors or agency doors, it signifies an affirmation of LGBTQ people and lets others know that they and their agency are safe to approach for support or guidance. Other strategies related to safe zones include the development of strategies to publicize the agency’s commitment to supporting LGBTQ individuals, distribute materials inclusive of LGBTQ people, adoption of internal policies that promote non-discrimination based on sexual orientation and gender identity and, providing a trainings to staff about LGBTQ issues.
What You Can Do to Provide Support to LGBTQ Youth

Based upon the Lambda Legal Defense and Education Fund’s “Getting Down to Basics about Lesbian, Gay, Bisexual, and Transgender Youth In Foster Care” (2002):

- Recognize that some of the youth you work with may be LGBTQ young people, even if this is not evident initially.
- Be aware of your own feelings of beliefs that might conflict with your professional responsibilities to LGBTQ youth.
- Educate yourself and others about LGBTQ youth.
- Let youth you work with know you are comfortable with people who are LGBTQ.
- Visibly demonstrate acceptance of LGBTQ people with posters, stickers, books and health education material (see www.journeyworks.org).
- Eliminate LGBTQ slurs (i.e.-“That’s so gay”) and stereotypes.
- Use gender-neutral language: Don’t presume a boy may have a “girlfriend”, rather ask if he has anyone special in his life.
- Adapt (agency) forms to be gender neutral. Do not ask about “mothers” and “fathers”, rather ask about “parents”.
- If a youth discloses being LGBTQ, don’t ignore it. Talk to them about it. Do not presume their problems are necessarily associated with being LGBTQ, although they may have unique needs as such.
- Respect confidentiality. Do not presume it is ok to discuss a youth’s LGBTQ identity with parents / caregivers. Doing so may pose a safety risk for some youth.
- Use pronouns and names that transgender youth prefers. When in doubt, ask the youth. Respect the attire youth may choose.
- Assist LGBTQ youth in being protected in school, foster care and elsewhere.
- Offer to assist youth in obtaining sensitive and knowledgeable health care.

Transgender youth may need help to locate a sensitive and knowledgeable medical provider.

Other Resources

For continued education for providers and empowerment of LGBTQ youth and families, providers are encouraged to explore the following links:

- Ambient Joven: http://www.ambientejoven.org/
- American Psychological Association: www.apa.org/topics/
- Family Diversity Project: www.familydiversity.org
- Gay and Lesbian Medical Association: www.glma.org
- Gay, Lesbian and Straight Education Network: www.glsen.org
- Gay, Straight Alliance (GSA) Network: www.gsanetwork.org
- Gender Spectrum: www.genderspectrum.org
- Lambda Legal: www.lambdalegal.org
- National Youth Advocacy Coalition: www.nyacyouth.org
- Parents, Families, and Friends of Lesbians and Gays: www.pflag.org
- Safe Schools Coalition: www.safeschoolscoalition.org
- World Professional Association for Transgender Healthcare: www.wpath.org
- Transgender Law Center: www.transgenderlawcenter.org
Step Four:
Learning the Language of “LGBTQ” Youth

One of the clearest ways to show respect for and understanding of LGBTQ youth is to be familiar with the “language” of being LGBTQ, thus reducing a practitioner’s need to “quiz” youth or to put them in the role of educating their own provider. The following glossary is provided with permission from the Safe Schools Coalition in Washington State (www.safeschoolscoalition.org/glossary.pdf). It must be noted that different cultures use different language to describe their identity and providers are encouraged to ask youth directly what language is most respectful of who they are.

“LGBTQ” Glossary

Allies: A member of a historically more powerful identity group who stands up against bigotry. For example, a man who confronts his friend about harassing women, a Christian who helps paint over a swastika, or a heterosexual person who objects to an anti-gay joke.

Bisexual: Romantically and sexually attracted to people of both genders. Does not presume non-monogamy (or, for that matter, any sexual activity). Some people self-identify as bi rather than bisexual.

Coming Out: The process of first recognizing and acknowledging non-heterosexual orientation or transgender identity to oneself and then sharing it with others. Developmentally, many sexual minority youth will initially erect emotional barriers with acquaintances, friends and family by pretending (actively or through silence) to be heterosexual and congruent. Coming out means dropping the secrecy and pretense and becoming more emotionally integrated. This usually occurs in stages and is a non-linear, lifelong process.

Congruent: Having a gender and a gender identity that match. Non-transsexual and post-operative transsexual people are congruent.

Co-parents: Grown-ups who are raising a child together, who may or may not be biologically related to the child. Sometimes refers to the partner of a biological parent. Sometimes refers to both (or all) parents, stepparents, partners and other guardians.

Cross-dressing: Wearing clothing most often associated (in one’s culture and historical timeframe) with people of a different gender.

Dyke: Pejorative term for a lesbian. Some young women self-identify as dykes, but it is still a slur in many contexts and is generally prohibited in schools with anti-harassment policies.

Fag, faggot: Pejorative terms for a gay man. As unacceptable at school as racial or religious slurs.
**Failure-to-report:** The crime (a gross misdemeanor, in Washington State) committed by certain professionals who are required by law to contact child protective services and/or law enforcement when they know or suspect that a child or teen has been neglected or physically or sexually assaulted, when they fail to do so.

**Failure-to-protect:** Refers to the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. This clause states that all citizens are due equal protection under the law and cannot be discriminated against through selective enforcement. This means that schools are responsible for equally protecting all students. Sexual harassament policies, for instance, must be applied consistently, regardless of a student’s (or an employee’s) gender or race or religion or sexual orientation or gender expression.

**GLBTQ (or LGBTQ):** Abbreviation for gay, lesbian, bisexual, transgender and questioning. Sometimes used, for example, to identify the young people who attend a school-based support group. Some groups also welcome heterosexual friends and allies and/or students with GLBT family members.

**Gay:** Preferred synonym for homosexual.

Age-appropriate ways to explain what it means to be gay to children:

- Kindergarten-3rd grade: “A man who loves another man or a woman who loves another woman.”
- 4th-grade-8th grade: “A man who gets strong crushes on other guys more often than on women, or who falls in love with a man. Or a woman who falls in love with another woman (but she might prefer to call herself lesbian than gay).”
- 9th grade-12th grade: “A person who is romantically and sexually most attracted to people of his or her own gender. The term refers to people of any gender, but when possible, it’s more respectful to use the terms gay and lesbian.”

**Gay relationships:** Gay, lesbian and bisexual people date, court, and sometimes make homes together. They use various terms to describe their commitments (e.g., boyfriend, girlfriend, spouse, lover, husband, wife). Ask the individual what term he or she prefers, if possible. If not, partner is generally acceptable.

**Gender identity:** One’s understanding or feeling about whether one is emotionally or spiritually male or female or both or neither. A person may be congruent (i.e., his/her gender identity and physical gender are consistent) or transsexual (born biologically one gender; but emotionally and spiritually, the other) or not quite either one.

**Gender role:** One’s gender expression and one’s beliefs and feelings about the appropriate and/or comfortable expression of one’s gender. To some degree, gender role is clearly learned (socially constructed and culture-specific). To some degree, people are probably biologically predisposed to be more “feminine” or “masculine.”

**Heterosexism:** Presumption that heterosexuality is superior to homosexuality or bisexuality. Also: prejudice, bias or discrimination based on that presumption.

**Heterosexual:** Clinical synonym for straight.

Age-appropriate ways to explain what it means to be straight to children:

- Kindergarten-3rd grade: “A man who loves a woman or a woman who loves a man.”
• 4th grade-8th grade: “A man who gets strong crushes on women more often than on men, or who falls in love with a woman. Or a woman who falls in love with a man.”

• 9th grade-12th grade: “A person who is romantically and sexually most attracted to people of the other gender.”

Homophobia: Originally coined to mean, in classic psychological terms, irrational fear of homosexuality. Now refers usually to bias against or dislike of gay, lesbian, bisexual and transgender people or of stereotypically gay/lesbian behavior, or discomfort with one’s own same-sex attractions, or of being perceived as gay or lesbian. A less inflammatory term is anti-gay (as in anti-gay harassment).

Homosexual: Avoid this term; it is clinical, distancing and archaic. Sometimes appropriate in referring to behavior (although same-sex is the preferred adj.). When referring to people, as opposed to behavior, homosexual is considered derogatory and the terms gay and lesbian are preferred, at least in the Northwest.

Inclusive language: The use of terms such as family or parents/guardians, instead of mother-and-father in a letter about an upcoming open house. Or of gender-neutral terms (e.g., partner, instead of boyfriend or girlfriend) in a lesson on communication. Terms that allow every child and family to feel they belong at school, including those who are gay or lesbian (as well as children who live with a single parent or grandparents, etc.).

Intersexed or intersexual: An adjective to describe a person (referred to archaically as a hermaphrodite, a term which is now considered pejorative) who was born with an anomaly of the reproductive system – with genitals or chromosomes that were not clearly male or female. At least 1 in 2,000 children is born with genitals that make it difficult for even an expert to determine their sex. Some doctors consider such anomalies as hypospadias (in which the urethral opening is somewhere other than the tip of the penis), which occur in 1 of every 200 baby boys to be intersexed conditions.

Lesbian: Preferred term for gay women. Many lesbians feel invisible when the term gay is used to refer to men and women.

Lifestyle: An inaccurate term sometimes used to describe the lives of gays, lesbians and bisexuals. Implies that the homes, careers, and relationships of all sexual minorities are identical. There is a GLBT culture, with its own performing arts and body of literature. There is a GLBT community, with gay- and lesbian-identified businesses, publications and holidays. But the degree to which people who identify as gay, lesbian, bisexual or transgender take part in this culture and community varies from not-at-all to almost exclusively. There is no gay lifestyle, just as there is no straight lifestyle.

Malicious harassment: Physical injury, damage to property, or threats based on a person’s (real or perceived) sexual orientation; race; color; religion; ancestry; national origin; gender; or mental, physical, or sensory handicap.

Openly gay/lesbian: Preferred over self-avowed or practicing. For example: He is an openly gay principal.

Outing: Publicly revealing the sexual orientation or gender identity of someone who has chosen not to share it.
**Pink triangle:** A symbol originally used by the Nazis, who forced gay men to wear pink triangles on their clothing, imprisoned them in concentration camps, and put many thousands of gay men to death. Now, the downward-pointing, equilateral, pink triangle is a symbol of GLBT pride and the struggle for equal rights.

**Queer:** Pejorative term for gay. Now being reclaimed by some young gays, lesbians, bisexuals and transgender people and those whose identities are fluid, especially White young people living on the Coasts, as a self-affirming umbrella term, but it is still a slur in many contexts and is generally prohibited in schools with anti-harassment policies.

**Questioning:** A process of understanding one’s sexual orientation or gender identity, which may encompass a fluidity of sexual orientation and gender expression and exploration. [Note: this term has been added to this glossary by chapter authors and does not appear in the Safe Schools Coalition glossary.]

**Rainbow flag:** A flag of six equal horizontal stripes (red, orange, yellow, green, blue and lavender or violet) adopted to signify the diversity of the lesbian, gay, bisexual, transgender community.

**Sex:** The sum of the biological (chromosomal, hormonal, and anatomical) factors that make one male, female, or intersexual.

**Sexual harassment:** Any unwanted sexual advance, request for sexual favors, or verbal or physical behavior of a sexual nature that alarms or annoys someone, or interferes with someone’s privacy, or creates an intimidating or hostile environment.

**Sexual minorities:** Gay, lesbian, bisexual and transgender people.

**Sexual orientation:** One’s core sense of the gender(s) of people toward whom one feels romantically and sexually attracted. The inclination or capacity to develop intimate emotional and sexual relationships with people of the same gender, a different gender or more than one gender. Doesn’t presume sexual experience/activity (i.e., sexual minority people are as capable as heterosexual people of choosing to abstain). To some degree, the qualities one finds attractive may be learned, probably in the first few years of life. There is growing evidence that people may be, however, biologically (hormonally, genetically) predisposed to be more attracted to one gender or another or to people of more than one gender. In all instances, use this term instead of sexual preference or other misleading terminology.

**Sexual preference:** Avoid this term; it implies a casual choice, which is rarely if ever the case. Sexual orientation is the correct term.

**Sissy:** Pejorative term for a gay man or a man who doesn’t fit masculine gender role stereotypes. As unacceptable at school as racial or religious slurs.

**Stonewall:** The Stonewall Inn tavern in New York City's Greenwich Village was the site of several nights of rioting/rebellion following a police raid on June 28, 1969. Although not the nation's first gay-rights demonstration, Stonewall is now regarded as the birth of the modern gay-rights movement.

**Straight:** Heterosexual; non-gay. Term preferred by some straight people as less clinical and formal than heterosexual, but some dislike it because it gets confused with not using drugs or with being a rigid person. Some GLBT people object to it as implying that they must be, in contrast, bent.
Transgender: An umbrella term increasingly preferred by people whose appearance, personal characteristics or behaviors are gender role nonconforming … individuals who might otherwise call themselves transsexual, cross-dressing or gender-bending. Also preferred by some people who are emotionally neither sex or both sexes or whose gender role expression is significantly different from what society expects of people of their sex or changes from time to time. Transgender people may be heterosexual or gay, lesbian, or bisexual. Some people self-identify as trans rather than transgender.

Transsexual: A person (pre, post or non-operative) who is biologically one sex (at birth), but emotionally and spiritually another. Female-to-male transsexual (FTM) people are born with female bodies, but identify as male. Male-to-female transsexual (MTF) people are born with male bodies, but identify as female.

Transvestite: A person - not necessarily gay - who dresses in clothing most often associated with another gender. The increasingly preferred term is a person who cross-dresses.

Conclusion

Given the unique concerns of LGBTQ youth as described above, including stigma and discrimination in school and in the community, the often challenging coming-out process, and the potential for increased risk of suicidality, it is imperative that providers acknowledge the incredible vulnerability of LGBTQ youth and adopt an immediate and proactive approach to engaging with these youth and their families in supportive ways.

In Nurturing Queer Youth, Stone Fish and Harvey (2005) encourage family therapists to utilize a model that encompasses creating refuge, fostering difficult dialogues, nurturing [youth’s] “queerness” and encouraging transformation. These have application to the relationships providers develop with LGBTQ youth individually as well. Ethical care for LGBTQ youth includes creating safety, facilitating communication, demonstrating appreciation of the individual youth because of their sexual orientation or gender identity, and encouraging continued development of all youth. In essence, providers are called upon to celebrate the unique aspects of youth who are LGBTQ.
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Authors: Donna Matthews & Sarah Taylor, CMHDA TAY Subcommittee Members

Contact Information
Donna Matthews, MSW
California Institute for Mental Health
916-556-3480, x153;
dmatthews@cimh.org

Sarah Taylor, Ph.D, M.S.W.
Postdoctoral Fellow & Associate Research Scientist
University of California, School of Public Health and Prevention Research Center
1995 University Ave., Suite 450
Berkeley, CA 94704
Phone: 510-883-5778
Fax: 510-644-0594
Email: staylor@prev.org