

EDITED BY EMILY S. FISHER AND KAREN KOMOSA-HAWKINS

Creating Safe and Supportive Learning Environments

A Guide for Working with Lesbian, Gay, Bisexual,
Transgender, and Questioning Youth and Families

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Edited by

Emily S. Fisher and

Karen Komosa-Hawkins

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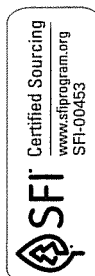
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12 Counseling Lesbian, Gay, Bisexual, Transgender, and Questioning Students

Grady L. Garner, Jr. and Dennis M. Emano

In recent years, there has been greater attention directed toward the needs of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students and the impact that discrimination, bullying, and harassment have on their well-being. School-based counseling can serve to promote positive development for LGBTQ students when mental health professionals provide affirmative and responsive services. At the core of all counseling services is the moral/ethical principle of non-maleficence or do no harm (Rowson, 2001). Yet, many mental health professionals risk violating this principle and potentially harming LGBTQ students due to inadequate training in LGBTQ issues (Walker & Prince, 2010), a lack of understanding of the systemic prejudice and ignorance that exists in the counseling profession related to LGBTQ issues (Pearson, 2003), and the failure to effectively address LGBTQ harassment in schools (Russell, Kosciw, Horn, & Saewyc, 2010).

Graduate programs historically have failed to adequately prepare school professionals, including school-based mental health professionals, in providing LGBTQ-affirmative services (Biaggio, Orchard, Larson, Petrino, & Mihara, 2003; Callahan, 2001; Fontaine, 1998; Israel & Hackett, 2004; Phillips & Fisher, 1998; Savage, Prout, & Chard, 2004; Sherry, Whiled & Patton, 2005). In a qualitative study conducted with graduate students in school counseling, school psychology, and teacher preparation programs, McCabe and Rubinson (2008) found that graduate students did not view lesbian, gay, bisexual, and transgender (LGBT) individuals as an oppressed group, did not view themselves as change agents in schools, and were unlikely to correct injustices against LGBT individuals. Additionally, participants reported receiving minimal to no exposure to LGBTQ topics in their graduate programs. Similarly, Savage, Prout, and Chard (2004) found that school psychologists reported lacking the preparation from graduate programs to address gay and lesbian issues. See Chapter 8 of this volume for an in depth review of pre-service training for school professionals.

School-based mental health professionals need to be adequately equipped to provide effective individual and group counseling services to LGBTQ students, as well as to serve as system change agents. This chapter focuses on important areas to consider when counseling LGBTQ students, including: the need for counseling, ethically and culturally competent counseling, LGBTQ-affirmative counseling approaches, supporting sexual and gender identity development, suicide prevention, and expanding counseling roles. Notably, not all counseling involving LGBTQ youth will focus on sexual or gender identity development or related concerns as LGBTQ youth may present with a variety of problems similar to their heterosexual peers (Fisher et al., 2008). Nonetheless, given the

increased life-stressors LGBTQ students may face due to discrimination and harassment and the associated risks, it is critical to ensure that culturally competent and affirmative counseling practices are employed.

A Need for Counseling

Prevalence of Mental Disorders

Lesbian, gay, and bisexual (LGB) youth historically have shown higher rates of mental disorders compared to heterosexual youth (Fergusson, Horwood, & Beautrais, 1999; Fergusson, Horwood, Ridder, & Beautrais, 2005), which is consistent with research on LGB individuals as a whole (Bostwick, Boyd, Hughes, & McCabe, 2009; King et al., 2008). King et al. (2008) conducted a meta-analysis of 25 studies from around the world that involved samples of both LGB adolescents and adults and found that mental disorders occur at a higher rate in these populations as compared to heterosexual adolescents and adults. However, that is not to say that sexual minority status predicts mental health disorders; but rather, sexual minority status is associated with an increased propensity or vulnerability to experience maladjustment if risk factors far outweigh protective factors for any given individual at any particular time. Notably, the higher prevalence of mental health disorders is likely attributable to the heightened environmental stressors experienced by LGBTQ individuals along with a limited availability of adequate supports or resources.

Studies using population-based samples show that LGB individuals are at higher risk for depression and suicide (Fergusson et al., 1999; Hatzenbuehler, Keyes, & Hasin, 2009; Russell & Joyner, 2001; Udry & Chantala, 2005). These results were confirmed in a recent study by Lucassen et al. (2011) who evaluated data from a population-based survey of New Zealand youth health and well-being, finding that adolescents who reported same-sex attraction or attraction to both sexes were more likely to report having experienced suicidality, self-harming behavior, and depression compared with adolescents attracted to the opposite sex. Population-based studies improve external validity or the generalizability of the results to a defined population—in this case LGB youth—because they are based on large cohort samples.

Research suggests that bisexual adolescents may experience even higher rates of mental health problems than their lesbian and gay (LG) peers, and they may be less likely to get help with their concerns (Lucassen et al., 2011). One possible explanation for this is that bisexual youth have different experiences from LG and heterosexual youth and may feel marginalized by both heterosexual and LG groups (Lucassen et al., 2011). Bostwick et al. (2009) suggest that bisexual individuals often are misunderstood and stereotyped by heterosexual and LG individuals, resulting in a “double stigma” (p. 6). Similarly, many myths and misconceptions about bisexual individuals abound, which may contribute to further misunderstanding and marginalization (Kennedy & Fisher, 2010).

Research also suggests that questioning youth may experience unique risks associated with mental health problems (Birkett, Espelage, & Koenig, 2009). In two large studies of high school students, youth who were confused about their sexual orientation reported greater levels of truancy, homophobic teasing, peer victimization, alcohol/marijuana

use, and depression/suicidality compared with LGB and heterosexual students (Birkett et al., 2009; Espelage, Aragon, Birkett, & Koenig, 2008). This could be explained by the availability of social support, such that heterosexual and LGB youth have identified supportive communities which may help reduce isolation and substance use, whereas questioning students do not fit with either group (Espelage et al., 2008). Yet, contrary to these results, the national study by Lucassen et al. (2011) showed that questioning youth were at a lower risk for depressive symptoms and suicidality. These inconsistent results point to the need for further research into this population and their differences from LGB individuals.

Transgender students, who are managing gender identity issues along with possible issues of sexual orientation, are another group that are potentially at risk for mental health problems due to victimization from harassment and assault. According to the Gay, Lesbian, and Straight Education Network (GLSEN)'s 2007 *National School Climate Survey* of 13 to 20 year old transgender students, 90% reported hearing negative comments from other students in school about someone's gender expression, and 39% reported hearing them from school personnel (Greytak, Kosciw, & Diaz, 2009). In addition, transgender students reported verbal harassment (87%), physical harassment (53%), physical assault (26%), and feeling unsafe at school (65%) due to their gender expression. When levels of harassment were high, there was an increase in poor academic performance, a decrease in educational aspirations, and an increase in absenteeism. A full review of the needs of transgender students can be found in Chapter 5 of this volume.

Suicide Risk

A review of the literature shows that there is a relationship between sexual orientation and suicidal behavior (Haas et al., 2011; Lucassen et al., 2011). While the exact nature of this relationship has been questioned in the past due to research limitations (e.g., studies using non-representative samples and inadequate measures), more recent studies using population-based studies have helped to confirm and clarify this risk (Haas et al., 2011; King et al., 2008; Remafedi, 1999; Russell, 2003). A meta-analysis of studies examining the prevalence of suicide attempt, suicidal ideation, mental disorders, and substance misuse revealed that LGB adolescents and adults are approximately 2.5 times more likely to report a suicide attempt (in both lifetime and 12 month period) than heterosexual peers (King et al., 2008).

Savin-Williams and Ream (2003), however, argue that the literature should move away from the question of whether gay youth are suicidal to the question of “which youth are suicidal and how being a sexual minority informs that experience” (p. 522). Research has demonstrated that when LGBTQ students' needs either go unmet or far exceed the support provided, symptoms likely worsen and might render the adolescent less able to cope (Savin-Williams & Ream, 2003).

Certain LGBTQ subgroups may be at higher risk than others, although research is not always consistent in this finding (e.g., Mustanski, Garofalo, & Emerson, 2010; Saewyc et al., 2007). In their meta-analysis, King et al. (2008) found that the lifetime prevalence of suicide attempts for LGB individuals was higher than their heterosexual peers. However, when comparing men and women, the rate for gay and bisexual males was even higher than for lesbian and bisexual females. Similarly, Lucassen et al. (2011) found that

bisexuals were at greater risk for suicide and self-harm than individuals reporting same-sex attraction. Students questioning their sexual orientation or gender identity may also be at greater risk for suicidal behavior (Birkett et al., 2009; Poteat, Aragon, Espelage, & Koenig, 2009). Continued research is needed in order to clarify these findings, but there is no doubt that assessing and addressing suicide risk is an important part of counseling with LGBTQ students.

Ethical and Culturally Competent Counseling

One step toward improving conditions for LGBTQ students is for school-based mental health professionals to invest in and adopt an affirmative approach to treating LGBTQ students. Professional organizations have provided mental health professionals with a clear ethical path to follow related to counseling LGBTQ students.

According to the National Association of Social Workers (NASW, 2008), the American Counseling Association (ACA, 2005), and the National Association of School Psychologists (NASP, 2006), LGBTQ youth have the right to equal access to clinical services that foster the development and expression of a personal identity free from discrimination, harassment, violence, and abuse. More directly, the American School Counselor Association (ASCA, 2007) reissued the following position statement:

Professional school counselors promote affirmation, respect and equal opportunity for all individuals regardless of sexual orientation or gender identity. Professional school counselors also promote awareness of issues related to sexual orientation/gender identity among students, teachers, administrators, parents and the community. Professional school counselors work to eliminate barriers that impede student development and achievement and are committed to the academic, career and personal/social development of all students.

(p. 29)

Therefore, mental health professionals must engage in self-discovery and determine if they unwittingly espouse heteronormative attitudes and biases (McGeorge & Carlson, 2011). In addition to critical self-exploration, increased awareness and knowledge are essential. Therefore, mental health professionals are responsible for securing training, consultation, and supervision to ensure competent service delivery (Fassinger, 1991; Israel, Ketz, Detrie, Burke, & Shulman, 2003; Kocarek and Pelling, 2003).

One of the more contentious LGBTQ-related counseling issues is the use of conversion therapy, also known as reparative or coercive therapy. It is arguably unethical and remains a concern given traditional religious and political efforts to publically promote a heterocentrist paradigm. This unsanctioned therapeutic approach is dedicated to eliminating a homosexual identity and promoting a heterosexual identity along with its concomitant heteronormative worldview. Proponents of this approach have argued that gay men are simply having difficulty realizing their full masculine identity, and to that end, continue searching for it in the pursuit of male-male homosexual relationships—referred to as a *gender identity deficit* (Nicolosi, 1991). Robinson (2006) found the following regarding the effectiveness of conversion therapies: (a) most therapists do not accept any of them; (b) at no time in the past were they accepted by most therapists;

(c) only a minority of therapists or clergy are using or have used them; and (d) there is no meaningful evidence to support their utility. A bounty of evidence reveals conversion therapy to be harmful, damaging, and potentially resulting in serious psychological trauma (APA, 2009; Beckstead, 2003; Beckstead & Morrow, 2004; Blackwell, 2008; Cianiottto & Cahill, 2006; Shidlo & Schroeder, 2002).

As a result, a coalition of 13 education, health, mental health, and religious organizations including the APA, ACA, ASCA, NASP, and the American Association of School Administrators (AASA), among others, published a booklet, entitled *Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel*, that addresses the health and well-being of all students including LGBTQ students in the wake of a rapid increase in efforts to change individuals' LGBTQ sexual orientation through psychotherapy and religious ministries (Just the Facts Coalition, 2008). The coalition reported that the use of conversion therapy is potentially harmful to LGB students and "exacerbate[s] the risk of marginalization, harassment, harm, and fear experienced by lesbian, gay, and bisexual students" (p. 10) and thereby may lead to "potential legal liability for school districts and officials" (p. 11).

The ACA addressed the issue of reparative therapy directly. As reported in Just the Facts Coalition (2008), the ACA adopted the following resolution in 1998:

[The ACA] opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation; and supports the dissemination of accurate information about sexual orientation, mental health, and appropriate interventions in order to counteract bias that is based on ignorance or unfounded beliefs about same-gender sexual orientation. Further, in April 1999, the ACA Governing Council adopted a position opposing the promotion of "reparative therapy" as a "cure" for individuals who are homosexual.

(p. 6)

Therefore, mental health professionals must consider the policy positions of ACA, ASCA, NASP, and APA in support of LGBTQ students' right to develop a positive sense of self, including a positive sexual orientation in an equally supportive, protective, and harassment-, violence-, and stigma-free educational environment, similar to that of their heterosexual contemporaries. In addition, mental health professionals need to refer to the APA's (2009) Task Force report which concluded that "the appropriate application of affirmative therapeutic interventions for those who seek Sexual Orientation Change Efforts (SOCE) involves therapist acceptance, support, and understanding of clients and the facilitation of clients' active coping, social support, and identity exploration and development, without imposing a specific sexual orientation identity outcome" (p. v).

LGBTQ-Affirmative Counseling

In spite of the nation's growing tolerance of LGBTQ individuals, LGBTQ youth are more likely than their heterosexual contemporaries to experience additive psychosocial distress during key developmental periods in childhood and throughout adolescence because of sexual orientation, same or both sex attraction, and/or gender identity-based oppression, victimization, and feelings of differentness (Callahan, 2001; Cooley, 1998;

D'Augelli, 1998; Henning-Stout, James, & McIntosh, 2000; Richardson, Myers, Bing, & Satz, 1997; Whitman, Horn, & Boyd, 2007). When LGBTQ students experience sexual orientation, same or both sex attraction, and/or gender identity-based distress, counseling can help shape and enhance healthy development of youths' sense-of-self.

Therefore when LGBTQ students seek counseling, mental health professionals will need to assess the extent to which these students experience sexual orientation, same or both sex attraction, and/or gender identity-based discrimination, harassment, and/or internalized heterosexism, and to what extent, if any, these experiences contribute to students' presenting clinical problems like anxiety, depression, suicidal ideation, and social isolation (Fisher et al., 2008). When sexual orientation, same or both sex attraction, and/or gender identity appear to be at the heart of the presenting concern, mental health professionals should focus on ensuring client safety and facilitating the development of a healthy sense of self, which will in turn foster positive sexual orientation, same or both sex attraction, and/or gender identity development. We consider the latter goal to be driven by affirming and guiding identity integration in the face of socially hostile heterosexist environments. Heterosexism is covered in the next section of this chapter. Sexual and gender identity development are covered in Chapters 3 and 5 of this volume.

Theoretical Approach

The twenty-first century has ushered in a growing debate contrasting ethically affirmative LGB-oriented therapy and LGB-affirmative therapy. According to Langdridge (2007), the debate rests on the following distinctions: ethically affirmative therapy is a form of therapy whereby LGB identities are valued as much as heterosexual ones with an equitable consideration of LGB cultures; whereas LGB-affirmative therapy goes beyond simply recognizing the LGB individual's value. The LGB-affirmative therapeutic approaches also involve: affirming lived experiences, eradicating the influence of internalized heterosexism, and encouraging the development of supportive networks. Furthermore, this approach emphasizes the development of an integrated and positive sense of self with respect to individual expression and experience of sexual orientation, same or both sex attraction, and/or gender identity (Langdridge, 2007; McGeorge & Carlson, 2011; Whitman et al., 2007). The focus of this section will be on LGBTQ-affirmative therapy.

Regardless of theoretical orientation, mental health professionals who integrate LGBTQ affirmation into their therapeutic work with youth likely will see favorable outcomes in the development of a positive LGBTQ sense of self (Cornett, 1993; McGeorge & Carlson, 2011; Whitman et al., 2007). In addition to heterosexual mental health professionals (and school professionals) being allies to LGBTQ youth (Ji, 2007), mental health professionals have a unique opportunity and ethical obligation to provide affirming, direct clinical service to LGBTQ youth and develop in-service educational opportunities for school staff and administrators. As it relates to LGBTQ student mental health, the utility of affirmative therapy is an effective way of addressing issues specific to this population (Clark, 1987; Langdridge, 2007; McGeorge & Carlson, 2011; Perez, DeBord, & Bieschke, 2000; Safren & Rogers, 2001).

Gay-Affirmative Therapy, in particular, has enjoyed positive growth and acceptance as a viable approach for use with sexual minority clients since its inception in the late 1990s (Leslie, 1995). At its core, gay-affirmative therapy engenders affirmation of the individual's LGBTQ sense of self germane to improving his or her lived experience. This approach requires the mental health professional to explore and possess a deeper understanding of the nexus of intrapsychic processes and maladaptive sociocultural homophobic, heterosexist, and heteronormative messages—at both the individual and institutional level (Glassgold & Drescher, 2007; Leslie, 1995; McGeorge & Carlson, 2011). The aforementioned terms *homophobia*, *heterosexism*, and *heteronormative* typically are used interchangeably yet their differences connote distinct meanings worth exploring.

The term *homophobia* has been subject to many interpretations, and, in fact, is the most difficult of terms to operationalize in empirical research (Smith, Oades, & McCarthy, 2012). Clinically, the term represents an irrational fear of homosexuals. From an exhaustive literature search of the term, Smith et al. (2012) found that the problem with the term *homophobia* is that it is so ambiguous that it leads to many interpretations: fear of, dislike, hatred, contempt, negative attitudes, prejudice, discrimination, harassment, violence, marginalization, disenfranchisement, oppression, and ignorance toward homosexual, bisexual, transgender, and questioning individuals. Due to this lack of precision, the term is replaced here with *heterosexism*.

Heterosexism is a more accurate and appropriate term to use in defining sexual orientation, same and both sex attraction, and gender identity-based discrimination with subsequent negative outcomes experienced by members of homosexual, bisexual, and transgender communities. According to Smith et al. (2012), *heterosexism* does a better job of capturing the social pathology behind the maladaptive personal attitudes toward non-heterosexuals. Herek (1990) defined *heterosexism* as an ideological mechanism used to deny, denigrate, and otherwise stigmatize non-heterosexuals' ways of being. Of key interest here is how the term *heterosexism* moves us away from individual pathologies to a larger cultural or societal illness that can unknowingly contribute to negative individual and institutional beliefs, attitudes, and acts against LGBTQ youth.

Heteronormative assumptions are the offspring, if you will, of heterosexism. They tend to be reinforced by a more liberal-humanistic perspective that focuses on similarities between lesbian, gay, and heterosexual individuals in an effort to be more tolerant of lesbians and gay men. At one end of the spectrum, the dominant group holds positive attitudes toward LGBTQ individuals (relatively speaking) but still within the context of a heterosexual norm. On the other end of the spectrum, LGBTQ individuals are dehumanized, discriminated against, denied, and disregarded based on a rigid adherence to a socially sanctioned heterosexual norm. Either way, LGBTQ individuals are not afforded a distinct expression of sexual orientation, same or both sex attraction, and/or gender identity that is valued in the absence of the heterosexual norm. Heteronormative assumptions relegate LGBTQ individuals to sexual orientation, attraction, and/or gender identity-based oppression and discrimination and promote heterosexual privilege (McGeorge & Carlson, 2011).

In conclusion, if mental health professionals lack an awareness of both heterosexual privilege and the negative impact of heteronormative assumptions (or heterosexism), the result can be devastating for LGBTQ students. These students may be subjected to comparing and valuing their sense of self and well-being in relation to their heterosexual

peers. It is logical then to conclude that facilitating an LGBTQ student's self-exploration in a safe, supportive, affirming environment is essential to a healthy developmental experience. Creating that space for the student may be challenging indeed, especially one absent of social pressure to measure his or her value against that of the heterosexual and gender identity norms. Therefore, school professionals are encouraged to consider LGBTQ students as individuals with personal histories, ambitions, concerns, and developmental needs that should be validated, given their vulnerability to subtle forms of harassment, bullying, and physical violence as they relate to oppression of LGBTQ individuals.

Similarly, mental health professionals are ethically obligated to create and maintain an environment of respect, support, and affirmation, and one that is free of heterosexism and gender conformity. To maximize effective care of LGBTQ students, we recommend that school mental health professionals do the following: (a) become aware of the oppression that LGBTQ individuals experience; (b) engage in their own self-exploration examining their beliefs about varying expressions of sexuality; and (c) explore their own heteronormative and gender conforming assumptions. The next section of this chapter will explore how school professionals and mental health providers can engage in this process. A therapeutic model is detailed and recommended as a process from which both school and school-based mental health professionals can benefit.

Theory into Practice

The American Psychological Association has developed guidelines for clinical practice when working with LGB clients (APA, 2000, 2012), which we recommend for your review. More specifically, the therapeutic model proposed by McGeorge and Carlson (2011) is designed to address unconscious and, in some cases, conscious heterosexist/heteronormative assumptions in the treatment of LGBTQ individuals. One can quite easily interject gender identity assumptions in the ensuing line of questioning as well. Future scholars may consider adapting this model to specifically address gender identity. Also keep in mind that even though the model is developed for mental health providers, all school professionals can benefit from this process of self-exploration.

As mentioned earlier, it is the mental health professionals' ethical responsibility to at least explore their heteronormative assumptions, such as assuming that students are heterosexuals and/or in heterosexual relationships. In fact, for examples of heteronormative assumptions that are often times unintentional and unconscious, one only needs to turn to pop culture, literature, film, advertisements, video games, and school-sanctioned heterosexual events (e.g., dances, prom, and homecoming). Moreover, the media is replete with cycles of national monologues proposing a ban of gay marriage and civil unions of same-sex partners, which contributes considerably to the invalidation of non-heterosexual expressions of love thereby reinforcing the heteronormative status quo. Mental health providers are encouraged to consider the following model and how this barrage of non-affirming and anti-homosexual, -bisexual, or -transgender messaging might impact the self-esteem and the development of a healthy sense of self for LGBTQ students.

McGeorge and Carlson (2011) offer a universal Three-Step Model or approach to becoming an optimally affirming mental health professional for LGB (and we have added

transgender and questioning, or LGBTQ) individuals. We propose that this three-step model is used not only by heterosexual therapists, but also homosexual, bisexual, and transgender mental health professionals who may engage in the mental health treatment of LGBTQ youth. At the heart of this model is a deepening and critical self-exploration of how heterosexism can influence all parties' personal and professional understanding and attitude towards LGBTQ clients. McGeorge and Carlson's (2011) three-step model addresses this through the mental health professionals' exploration of (1) heteronormative assumptions, (2) heterosexual privilege, and (3) a heterosexual sexual identity. This approach represents the essential first steps in therapeutic work with youth grappling with their sexual orientation, sexual attractions, and/or gender identities.

McGeorge and Carlson (2011) recommend that mental health professionals use this model not only to challenge their internal dialogue, but also as accountability dialogue with which they can support mental health colleagues and student trainees as they challenge their own unconscious beliefs, attitudes, and practices. Again, we recommend that this process is brought to bear on all mental health professionals and school professionals (perhaps in the form of an in-service activity) regardless of professionals' sexual orientation, attractions, or gender identity. In fact, it is recommended that anyone who has meaningful and influential contact with school-aged youth engage in this level of self-awareness and exploration. The following three sections are a description of McGeorge and Carlson's (2011) self-exploration guide. In each of the three steps, we have modified some of the sample questions in order to make them more applicable to transgender and questioning individuals (indicated by the term "modified" following the question). We also have added school-based questions for consideration (indicated by the term "add-on" following the question).

Step 1: Exploring Heteronormative Assumptions. As previously discussed, heterosexist assumptions are the unconscious and automatic activation of beliefs and expectations of an ideal psychosexual norm centered on heterosexuality and heterosexual relationships (Ingraham, 2006; Oswald et al., 2005).

Mental health professionals should consider and reflect on the following sample questions originally proposed by McGeorge and Carlson (2011, p.17):

1. Were sexual orientation and same-sex and bisexual relationships talked about in my family? If so, what values were communicated? If not, what did that silence communicate?
2. Are there any LGBTQ members in my family? If so, how were/are they talked about and treated in my family? (modified)
3. If appropriate, what did/does my religious or spiritual community teach me about sexual orientation and same-sex and bisexual relationships? What do the religious or spiritual texts of my particular faith teach me about sexual orientation and same-sex relationships?
4. What are my beliefs about how a youth "becomes" gay, lesbian, bisexual, transgender, queer, or questioning? (modified)
5. What are my beliefs about why I did not "become" gay, lesbian, bisexual, transgender, queer, or questioning? (modified)
6. When I first meet a student, how often do I assume that s/he is heterosexual? What values and beliefs inform this assumption? (modified)

7. Do I believe that healthy personal development includes exploring one's sexual orientation and gender identity in a safe social space that normalizes all forms of sexual orientation, attractions, and gender identity? If so, how did I come to this realization? If not, why not? (add on)

It is helpful to consider that LGBTQ youth are faced with developing a sense of self in social environments that are often not supportive or safe, which can significantly affect LGBTQ youths' personal and academic development.

Step 2: Exploring Heterosexual Privilege. McGeorge and Carlson (2011) succinctly conceptualize heterosexual privilege as an experience of "unearned benefits" (p. 18). For example, they note that heterosexuals can see positive representations of themselves in many places including television, movies, and publicly endorsed displays of affection. LGBTQ mental health professionals can modify some of the following questions, as appropriate, to help them think more deeply about heterosexual privilege (McGeorge & Carlson, 2011, p.19):

1. How has your involvement in heterosexual relationships been encouraged, rewarded, acknowledged, and supported by your family, friends, and the larger society?
2. As a child, how were you encouraged to play according to heterosexual norms?
3. Have you ever had to question your heterosexuality? Has a family member, friend, or colleague ever questioned your heterosexuality?
4. Have you ever had to defend your heterosexuality in order to gain acceptance among your peers or colleagues?
5. Have you ever worried that you might lose your job because of your heterosexuality?
6. When you were young, did you ever experience internal conflict about who to ask to the dance, prom, or homecoming? Was that person of the same sex? Can you imagine the degree of worry, dread, and risk of losing your social status among your peers by taking a same-sex date? (add on)
7. Have you ever wondered why you were born heterosexual? Whether you could change your heterosexuality?
8. As a youth, did you ever worry that if you sought therapy your therapist might try to change your heterosexuality? (modified)
9. Have you ever worried that you might be "outed" as a heterosexual?
10. Have you ever feared that you would be physically harmed based solely on your heterosexuality?

Step 3: Exploring Heterosexual Identity. The final step that can lead to a more affirmative therapeutic process for heterosexual mental health professionals involves a critical self-exploration of heterosexual identity. Worthington, Savoy, Dillon, and Vernaglia (2002) refer to a heterosexual identity as one in which the individual not only identifies as such but also engages in its expression. McGeorge and Carlson (2011) argue that once heterosexual therapists explore their own identity, they are less likely to allow heteronormative assumptions and heterosexism to influence the therapeutic process. The following are recommended sample questions for reflection and consideration (McGeorge & Carlson, 2011, p. 20):

1. How do you describe your sexual identity? How do you explain how you came to identify as a heterosexual? Why do you think you identify as a heterosexual?
2. What role does your sexual identity play in who you are as a person?
3. What factors were most important or influential to your development of a heterosexual identity?
4. What societal beliefs or norms influenced your development of a heterosexual identity?
5. What spiritual or religious beliefs influenced your development of a heterosexual identity?
6. What family beliefs or norms influenced your development of a heterosexual identity?
7. When you were in your youth, when did you have your first opposite sex sexual attraction? What meaning did you assign to that attraction? If you experienced that attraction as natural or normative, where did those beliefs come from? (modified)
8. Have you experienced attraction to members of the same sex? If so, how did you make sense of those attractions? If not, how do you make sense of not having attractions to members of the same sex?
9. How does your identification as a heterosexual influence how you make sense of how a person comes to identify as an LGBTQ individual? How does your identification as a heterosexual influence how you perceive LGBTQ-identified individuals? (modified)
10. How does your identification as a heterosexual influence the way you do therapy with all of your young clients (regardless of their sexual orientation)? (modified)

Application. McGeorge and Carlson (2011) recommend the following guidelines for a mental health professional to create a more LGBTQ-affirmative counseling environment: (a) within the first session, identify as someone who is committed to providing services to all clients including LGBTQ individuals; (b) adopt non-heteronormative language and gender-neutral language (e.g., significant other, partner, etc.) until sexual orientation, attraction, and/or gender identity has been established; and (c) have a variety of magazines, brochures, and books in the waiting area, including some that are LGBTQ-friendly. Equally important, McGeorge and Carlson (2011) suggest that next steps include "coming out" as an LGBTQ affirming therapist and ally. This can be accomplished by posting an LGBTQ affirming symbol outside one's office, indicating a "safe space" for LGBTQ students. This should also involve publicly advocating for LGBTQ students' rights and needs. During therapy, where appropriate, address the presence and unconscious influence of heterosexism and the development of a healthy and positive sense of self.

Supporting Sexual and Gender Identity Development

The previous sections outlined the underlying process by which heterosexual therapists—and we would argue all therapists regardless of sexual orientation—become aware of the presence and impact of heterosexism on the therapeutic process. The previous section also addressed the specific application of an LGBTQ-affirming approach

regardless of therapeutic orientation. This universal perspective also applies to specific treatment goals in the development of healthy sexual and gender identities. For example, rapport building is essential, including identifying oneself as someone who treats clients of all expressions of sexuality. Respecting clients' right to privacy and confidentiality also is essential, in addition to assessing the extent to which sexual orientation, sexual attraction, and/or gender identity play a role in the presenting psychological distress. If they do play a role, it is important to focus on helping the person become aware of the presence and impact of heterosexism on his or her sexual and/or gender identity. In an effort to appreciate the distinction, sexual and gender identity will be described.

Sexual Identity Development

Scholars seem to agree that the ultimate end-state of sexual identity development is self-acceptance/integration (e.g., Cass, 1979; Coleman, 1985; D'Augelli & Patterson, 2001; Fassinger, 2000; Troiden, 1979), although for many individuals there are shorter-term goals that may be the focus of school-based counseling. As mental health professionals work to promote healthy identity development, they must take into consideration the tremendous hardships LGBTQ students may be encountering both at school and home, which may substantially increase and/or sustain the likelihood of internalizing heterosexual messages. Lacking strategies to effectively manage these negative messages, students may use alternative coping mechanisms including hyper-investment in academics, private and public denial of sexual orientation, attraction, and/or gender identity, heterosexual attitude and behavior, anti-homosexual attitude and behavior, discretion, controlled disclosure, substance abuse/use, and/or suicide (Pachankis & Goldfried, 2004). To help students develop the internal resources to counter homonegative messages and to support self-acceptance/integration of sexuality and gender identity, mental health professionals will need to keep the developmental stage of LGBTQ students in mind as they conceptualize the case and develop and implement theory-based interventions (Savin-Williams, 2001). See Chapter 3 of this volume for a comprehensive review of sexual identity development.

Gender Identity Development

Chapter 5 of this volume provides a comprehensive review of transgender, intersex, gender identity, and gender identity disorder (GID). In providing counseling services for students who are managing gender identity issues, school-based mental health professionals are encouraged to examine their beliefs about whether or not GID should be classified as a mental disorder. The definition of GID often fails to capture the lived internal experience of transgender individuals, and evidence suggests that adolescents and adults diagnosed with GID function just as well as non-clinical populations (Cohen-Kettenis & Pfäfflin, 2010; Meyer-Bahlburg, 2009). In fact, it is likely that the American Psychiatric Association (APA, 2011) will make significant changes to the language used and diagnostic criteria related to gender dysphoria and GID in the coming years.

For school-based mental health professionals, a helpful place to begin is to understand that children and adolescents with gender identity dysphoria are those who present

with a "strong and persistent cross-gender identification" (APA, 2000, p. 581), also understood as an incongruence between expressed and experienced gender and assigned gender. Factor and Rothblum (2008) give a rather comprehensive account of the complexities of gender expression and identity including: male to female (MtF), female to male (FtM), gender queer, sex radical, gender blender and more. Understandably, assigning labels unilaterally can be both uninformative and arresting to client autonomy. Another source worth considering is Devor's (2004) 14-stage model of transsexual and transgender identity formation. He posits that there are stages of development through which one moves from an observation that one is different to a stage of confusion, and, ultimately to integrating identity into one's sense of self.

Suicide Prevention and Risk Assessment

Given the increased risk for suicide among LGBTQ youth, the issue of prevention becomes a necessary and critical focus. Suicide prevention strategies exist at the national level, but their efficacy has not been adequately studied (Mann et al., 2005). Therefore, through a narrative synthesis of 93 studies (i.e., meta-analyses, quantitative studies, and population-based studies) related to suicide prevention, Mann et al. (2005) found that the most effective strategies for reducing suicide rates were primary care provider education (e.g., informing providers about suicide risk factors), suicide means restriction (e.g., enacting laws to control firearms), and gatekeeper education (e.g., informing school personnel, clergy, or first responders of suicide risk factors). However, Haas et al. (2011) reported that the suicide prevention strategies used at the national or state level have not been sufficiently developed or evaluated for LGBTQ individuals.

In an effort to identify suicide prevention programs that focus on LGBTQ youth, the Suicide Prevention Resource Center (SPRC, 2008) found only one program of this kind, *The Trevor Project*, which offers a national 24-hour crisis and suicide lifeline, a safe space for LGBTQ youth to find community and support, advocacy for mental health and suicide prevention programs, and educational resources (see <http://www.thetrevorproject.org/Programs>). *The Trevor Project* has received recent media coverage as a benefactor of the *It Gets Better* campaign, (see <http://www.itgetsbetter.org/pages/about-it-gets-better-project/>; Savage & Miller, 2011).

Although *The Trevor Project* may begin to fill the void in suicide prevention programming for LGBTQ youth, national suicide prevention programs otherwise have yet to fulfill their obligation to incorporate LGBTQ concerns into suicide prevention (Haas et al., 2011). As a result, in order to improve suicide prevention programs, Haas et al. (2011) recommended that national and state prevention programs, LGBTQ organizations, and general suicide prevention programs specifically address LGBTQ suicide risk and that program staff who may come into contact with suicidal individuals receive training specific to LGBTQ suicide risk and prevention.

When youth begin to experience isolation, rejection, victimization, and other factors related to being LGBTQ in a world that is non-affirming of LGBTQ individuals, they become at increased risk for suicidal behavior (SPRC, 2008). At that moment, it becomes critical for mental health professionals to ask LGBTQ students if they have ever thought about hurting themselves or taking their own lives. Mental health professionals need to conduct a thorough suicide risk assessment to determine how to best help the struggling

students. The literature on suicide risk assessment is rich with protocols for conducting assessments that identify certain at-risk groups, but it often fails to include LGBTQ youth in this at-risk category (e.g., Berman, Jobes, & Silverman, 2006; Sanchez, 2001; Simon, 2004; White, 2011). Nonetheless, there are some universal procedures that apply regardless of the population being assessed. We will briefly summarize them in the following paragraph as we integrate some of the more idiosyncratic issues specific to LGBTQ youth.

In assessing for suicide risk, Bryan and Rudd (2006) identified several areas that are important to address based on empirical support: (a) precipitating factors; (b) predisposition to suicidality; (c) current symptomatology; (d) history of suicide attempts; (e) nature of suicidal thoughts; (f) impulse control; (g) hopelessness; and (h) protective factors. The precipitants vary from person to person. However, in the case of LGBTQ youth, it could be harassment from peers, bullying, or being "outed" by someone against their will. Sadly, these precipitants were true in the cases of Billy Lucas, Seth Walsh, Tyler Clementi, and Asher Brown, whose suicides reached national attention and propelled the *It Gets Better* campaign (Savage & Miller, 2011). When an LGBTQ student is getting bullied in school or exhibiting great emotional distress, it is incumbent upon school mental health professionals to inquire about suicidal ideation and conduct a suicide risk assessment when necessary.

Issues of safety supersede confidentiality when students report suicidal ideation with a specific plan, even when students request that their report be held in confidence. This might create an ethical dilemma for mental health professionals as they need to maintain confidentiality about students' sexual or gender identity (Janson, 2002). Therefore, so long as an adolescent is deemed competent and not a danger to self or others, confidentiality is maintained by the mental health professional (Swann & Herbert, 1999). However, if mental health professionals need to break confidentiality to ensure students stay safe, they should take care to avoid unnecessarily revealing information about students' sexual or gender identity.

Expanding the Counseling Role

In addition to providing LGBTQ-affirmative counseling, school-based mental health professionals are encouraged to engage in efforts that foster social change through advocacy and outreach (APA, 2009; Russell et al., 2010; Vera & Speight, 2003; Whitman et al., 2007). Indeed, advocacy work is essential in helping students who are at risk of harassment, poor academic performance, and problems with identity development (Whitman et al., 2007). Professional organizations expound on the necessity of advocacy work, and ASCA goes so far to state, "professional school counselors . . . monitor and expand personal multicultural and social justice advocacy awareness, knowledge and skills . . . [and] strive for exemplary cultural competence by ensuring personal beliefs or values are not imposed on students or other stakeholders" (ASCA, 2010, section E.2.a.). With this shift in emphasis, mental health professionals can lead the process of school climate change and pave the path for a safer and more affirmative environment for LGBTQ students. The other chapters in this volume provide excellent recommendations and make reference to resources that will aid professionals in undertaking systemic change.

In conclusion, mental health professionals in schools play a pivotal role in an era when issues of bullying, harassment, and heterosexism continue to exist but also face greater public scrutiny as more and more victimized LGBTQ individuals and their allies are speaking out. School-based counseling potentially can be an effective means of promoting healthy development for LGBTQ students when it is ethical, affirming, compassionate, empathic, and responsive. Through a greater awareness, understanding, and prevention of homophobic, heteronormative, and heterosexist school environments, and the psychological impact these have on LGBTQ youth, mental health professionals can assist in turning this potential for healthy LGBTQ development into a reality. Indeed, mental health professionals can assist in saving young lives.

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13 Educating and Empowering Families of Lesbian, Gay, Bisexual, Transgender, and Questioning Students

Caitlin Ryan and Stuart F. Chen-Hayes

Although schools have remained the focus of challenges and opportunities to meet the needs of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth for more than two decades, schools and school professionals should also recognize the need to empower and promote the well-being of LGBTQ youth by supporting their families (Toomey, Ryan, Diaz, Card, & Russell, 2010; Toomey, Ryan, Diaz, & Russell, 2011).

Faced with many pressing needs including budget challenges, academic success expectations, and career and college readiness, school professionals, including school counselors, psychologists, and social workers, also need to understand the critical role that families play in contributing to LGBTQ children's risk and well-being; to serve LGBTQ students in the context of their families; and to view parents, families and caregivers as a critical support for students' academic, career/college, and personal/social success (American School Counselor Association [ASCA], 2010; Chen-Hayes, 2001; National Association of School Psychologists [NASP], 2010; National Association of Social Workers [NASW], 2008a, 2008b; Singh & Burnes, 2009; Smith & Chen-Hayes, 2004). However, many school and community professionals are reluctant and uncomfortable asking adolescents about their sexual orientation and gender identity. Moreover, school professionals routinely serve LGBTQ youth without asking about experiences with their families. This chapter examines experiences encountered by diverse families of LGBTQ children and adolescents, how family reactions affect LGBTQ youth, and ways school professionals can support families of LGBTQ students to promote well-being.

A Note About Language

Although community members have used the term "questioning" for a number of years and the practice literature has increasingly included "questioning" as a category related to lesbian, gay, bisexual, and transgender (LGBT) populations, predominantly youth, little is known about youth (or adults) who are questioning their sexual orientation or gender identity/expression, and this category has not been validated empirically (Hollander, 2000). The first specific discussion of *questioning* youth in the practice literature provides information on language and meanings associated with youth who may be questioning their sexual orientation and notes that:

questioning youths are often referred to in school and community programs as part of the increasingly long abbreviation used to include all sexual minority youths