What are the rights needs and concerns of Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex and Asexual clients and students? How can counselors effectively work with this population? How do youth needs differ from those of the elderly? Why is the suicide rate for youth GLBTQ populations so high? These are pertinent questions that mental health professionals need to answer in order to serve the GLBTQIA population. This minority population has endured oppression and prejudice extending into every facet of their lives. Theses individuals face violence, threats, stress, family tension, abandonment, lack of healthcare, discrimination in the workplace, a homelessness epidemic and aging issues. DiPlacido states "minority stress can be experienced in the form of ongoing daily hassles (such as hearing anti-gay jokes) and more serious negative events (such as loss of employment, housing, custody of children, and physical and sexual assault)" (DiPlacido, 1998). For some GLBTQIA individuals these stressors are daily battles. This paper will examine the concerns of the GLBTQIA population, what legal rights are involved, and what needs mental healthcare providers can accommodate.[1]

According to the American Psychological Association, social stressors affecting lesbian, gay, and bisexual youth, such as verbal and physical abuse, have been associated with academic problems, running away, prostitution, substance abuse, and suicide (D'Augelli, Pilkington, & Hershberger, 2002; Espelage, Aragon, Birkett, & Koenig, 2008; Savin-Williams, 1994, 1998). Research also shows that fear of discrimination and stigma cause many GLBT individuals to postpone or even decline seeking medical care. This indicates there is a population in need that is unwilling or scared to seek help. Counselors need to be aware that this population may be timid and that making services accessible as possible is key to reaching out.

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[1] For the sake of the paper, and to accommodate the research, I will use GLBT to refer to this population.

In the therapeutic relationship GLBT individuals have the right to non-discrimination on the basis of sexual orientation of gender identity. Policies written for mental health organizations should specifically include the family of clients, and mental health professionals should be aware that in the GLBT community family is an extremely broad term. In this sense "family" is not restricted to blood and/or legal relationships. In the event of an incident or infraction, the client also has the right to be able to file complaints against an agency. The agency should ensure that the procedure to file a complaint is accessible and easy to submit. In a mental health setting policies should be translated into languages spoken by all employees and clients. Also, the agency needs to emphasize confidentiality of client information including sexual orientation and gender identity issues. All clients should be informed of when such information might be disclosed and how and by whom information may be used (http://www.glbthealth.org/CommunityStandardsofPractice.htm, 2011).

According to the American Civil Liberties Union, public schools must establish anti-harassment policies and give students the opportunity to create a Gay-Straight Alliance (GSA). The Equal Access Act passed in 2008 grants student the right to a GSA if the school allows for other extra-curricular groups. Schools must also be willing to run an anti-harassment training if the employees ask for it. No one has the right to out a student or client without his or her permission. This can have tragic repercussions as seen in a 1997 Pennsylvania case when police officers told a teenager that they were going to tell his family he was gay and he committed suicide. In a court case won by his family a federal appeals court decided that threatening to disclose private information of this nature is a violation of privacy protected by the constitution. Students also have the right to bring same-sex dates to school dances. The 1980 court decision from *Aaron Fricke v. Richard B. Lynch* states that taking a date is free expression protected

under the First Amendment (American Civil Liberties Union, 2010). In public employment some states like Iowa prohibit discrimination based on sexual orientation and gender identity. Nebraska public employers only prohibit discrimination based on sexual orientation (National Gay and Lesbian Task Force, 2011).

While it is necessary to clarify the rights of GLBT individuals, the concerns of this population are what counselors should focus on. Some of the concerns of the GLBT population include coming out, feeling accepted, loneliness, housing, suicide, discrimination, safety, healthcare, aging, hate crimes and compounding GLBT identity with minority identification. GLBT individuals face all of these issues in a world where intolerance of sexual minorities is sometimes the norm. According to a probability sample study, antigay victimization has been experienced by approximately 1 in 8 lesbian and bisexual individuals and by about 4 in 10 gay men in the United States. Also according to this study, enacted stigma, violence, and discrimination can lead to "felt stigma," an on-going subjective sense of personal threat to one's safety and well-being (Herek, 2009). The American Psychological Association states that "anti-gay harassment is one of the most pervasive, frightening, and potentially damaging threats GLBT students face in our public schools" (APA, 2011). Sue and Sue concur that schools can be volatile places for GLBT students. They state that in a study of Massachusetts high school students, 32.7% of GLBT students were confronted with a weapon at school compared with 7.1% of students not-identifying as GLBT. Sue and Sue also state that 25.1% of GLBT individuals did not attend school because of a safety concern in comparison to just 5.1% of students not identified as GLBT (Sue and Sue, 2008). A specific study on transgender individuals found that those who expressed a transgender identity or gender non-conformity while in grades K-12 reported alarming rates of harassment (78%), physical assault (35%) and

sexual violence (12%), and that harassment was so severe that it led 15% to leave a school at some point in their education (Grant, et al., 2011).

Along with the oppression GLBT individuals experience at school and work, they suffer intolerance from their families. According to the National Runway Switchboard, family conflict is the number one reason for homelessness among GLBT individuals, and family conflict often arises out of the parent's religious beliefs contradicting a GLBT individual's beliefs (Vines, 2010). When GLBT individuals are forced out onto the streets because of family tension and disapproval, they have a bigger hole to dig out of than heterosexual homeless individuals. In a 2011 survey issued by the National Gay and Lesbian Task Force, 19% of transgender or gender non-conforming individuals reported experiencing homelessness at some point in their lives. Fifty-five percent of these individuals reported being harassed by homeless shelter staff or residents and 22% reported some kind of sexual assault. Twenty-nine percent of surveyed individuals were turned away altogether. Considering all of these levels of discrimination, it is no surprise then that the suicide rate of GLBT individuals is 41% compared with 1.7% of the general population (Grant et al., 2011). Sue and Sue note that the high rate of suicide is not due to sexual orientation, but due to the stressors brought on by school, home, work, and social environments (2008). In the elderly GLBT population, stress can arise from figuring out transitioning into assisted living where accommodations for non-gender conforming persons are ignored. Also, non-heterosexual persons might not have a say in the healthcare issues of their partners (Sue and Sue, 2008).

Of the 5,000 suicides committed among 15 to 24 year olds each year, 30% of these are among the GLBT population. In men, five out of six committed suicide before age 20. While these statistics are alarming, Kulkin et al. note that studying suicide among this population can

be tough because of the myriad of definitions and terms, sampling the population, and biases in the literature. Also, many youth may not want to identify as GLBT because of the social stigma that goes along with it. The authors also admit biases in the literature for this topic: studying suicide in this population is difficult because researchers can not obtain random samples and the population who is willing to participate in research is usually already involved in some type of counseling or prevention program. They also state that most of the research focuses on predicting risk factors and not on statistics. In the research for this paper, much of the literature focused on White homosexual men. There seems to be a lack of information on lesbian women, minorities and their rates of suicide. Minority status can affect the oppression GLBT individuals face, and Grant et al. state African American men fare far worse than White transgender or non-conforming gender males. Kulkin et al. consistently found that family acceptance and high self-esteem are correlated to a lower suicide risk while family intolerance and poor self-esteem are significant risk factors. These studies also show that seeking help can be tough for minors who need their parent's permission to participate in therapy of GLBT support groups because it involves disclosing their sexual orientation and vulnerability (Grant et al., 2011, Kulkin et al., 2000).

The literature surrounding this topic suggests that there are many needs in the GLBT community. The American Psychological Association states that mental health professionals should increase safety and reduce stress levels of the client, help to resolve trauma, empower the individual with personal and social resources and support the client in confronting the social stigma he or she faces, when appropriate. The APA asserts that for clients who are more comfortable with their GLBT identity it "may be appropriate to refer them to a support group or social service, but for clients who are less comfortable with their non-heterosexual orientation,

online resources may prove helpful." Above all, the APA affirms that a GLBT identity is absolutely not a mental illness. In school settings, mental health professionals help students protect their right to free expression, to establish gay-straight alliance clubs, and to be promote an environment respectful of sexual orientation and gender identity (APA, 2008). Sue and Sue suggest moving from a sickness model to a wellness model when approaching mental health issues of GLBT individuals. They argue that historically GLBT issues have been looked at as a medical condition, and there is a need for counselors to use positive regard and wellness in practice (Sue et al., 2008).

Job placement is imperative with this population because GLBT individuals have double the employment rate of the general population and GLBT individuals of color are at four times the national rate. Transgender individuals are nearly four times as likely to have an income $10,000 less annually than the general population. This is disturbing because those who are "currently unemployed experience debilitating negative outcomes, including nearly double the rate of working in the underground economy (such as doing sex work or selling drugs), twice the homelessness, 85% more incarceration, and more negative health outcomes, such as more than double the HIV infection rate and nearly double the rate of current drinking or drug misuse to cope with mistreatment, compared to those who were employed" (Grant et al., 2011). Counselors need to be aware that a lack of jobs contributes to substance abuse and homelessness.

Another need of the transgender population is help obtaining and/or changing identification records. Among the Transgender population 21% have been able to update their identification records with their preferred gender. Forty-one percent of transgender individuals live without identification that matches their preferred identity, and this is a problem because upon presenting identification they do not prefer, 40% experienced harassment, 3% were

attacked and 15% were asked to leave the premises (Grant et al., 2011). The issue of identification is especially important on intake forms at mental health and healthcare facilities. Leaving the "gender" space open with a blank for the client to fill in is a non-biased way for the client to feel that he or she can express a true identity. Forcing a client to check a "male" or "female" box can make a client feel uneasy at the very beginning of treatment. Sue and Sue suggest making workshops available and offering trainings in the use of nondiscriminatory intake forms. Issues that Sue and Sue suggest may be common among the GLBT population are: hate crimes, depression, anger, Post Traumatic Stress Disorder, and self-blame. The authors assert that GLBT individuals who are attacked may believe that the assault was deserved and exhibit a low sense of mastery over the situation. The authors also want counselors to be aware of internalized homophobia, the coming out process, the lack of peer, social, school and community supports, the high rate of assault, suicidal ideation or attempts and substance abuse (Sue et al., 2008).

The needs of the elderly GLBT population revolve around healthcare. It is unclear about whether or not people involved in GLBT relationships will be able to make healthcare decisions for their partner, and this can cause stress and anxiety. There may also be a negative perception in nursing homes or hospitals about GLBT relationships. "It is estimated that up to 3 million GLBT individuals in the United States are over the age of 65" (King, 2001). If these individuals have not come out, then they may be hesitant to share it with government or social services organizations, and to apply for services they may need. Counselors can offer coping skills to this population and to refer them to support groups for elderly GLBT individuals. Advocating for services and obtaining resources will also be helpful (Sue et al., 2008).

In agencies and at schools offering "trans-inclusive" services and facilities can help to make the Trans client feel welcome and non-discriminated against. Making something trans-inclusive means to focus on raising awareness of transgender issues and provide trans-related information, and implementing long-term policy changes. In the fall of 2011 25 universities covered transition-related identification needs on student health plans. These included hormones, surgeries and counseling. Because the chance of murder for Trans individuals is one in twelve, compared to the general population of one in 18,000, giving clients resources and counseling is imperative to creation of equality and safety. In health care settings Transgender students should be asked about their health care experiences and how services can be improved. Staff should attend trans health concerns trainings and should ask clients their preferred name. Both schools and health care facilities should "offer gender-neutral bathrooms and private changing rooms for patient use." Having an activity that commemorates the annual Transgender Day of Remembrance (November 20th) can help students and clients grieve losses and let them know that there are counselors and teachers aware of trans issues (Beemyn et al., 2005). A survey states that "it is part of social and legal convention in the United States to discriminate against, ridicule, and abuse transgender and gender non-conforming people within foundational institutions such as the family, schools, the workplace and health care settings, every day" (Grant et al., 2011). If this is true it is the responsibility of mental health professionals to advocate for GLBT individuals on individual, programming, and training levels, and to work to make documentation, records, restrooms, health care, and housing trans-inclusive.

The rights, needs and concerns of the GLBTQIA population revolve around safety, emotional support, advocacy and social services. Both the suicide and homelessness rates are epic indicating that this population is in need of programs, therapy, and shelters that are

inclusive, accessible, and non-discriminatory. This population deals with stressors like coming out to their intolerant families, oppression in the workplace, not knowing where a safe restroom is, feeling like an outsider, anxiety and conflict, assault, lack of healthcare, and aging. It is important to recognize that an GLBT identity may not be the reason an individual is presenting for therapy, but that it is a part of who a person is. Having staff that are trained in GLBT issues and using appropriate language and intake forms are small ways that can have a big impact on this population. Working with the client to establish an identity that he or she is comfortable with and using the support of groups can be therapeutic. Treating GLBT clients using a wellness model and not treating sexual orientation as an illness that can be cured are necessary to treatment. Mental health providers have a responsibility to know the legal issues GLBT clients face and to treat every client with dignity and respect.

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Resources

http://www.adl.org/

http://community.pflag.org/Page.aspx?pid=194&srcid=-2

http://www.gaychurch.org/Find_a_Church/united_states/us_nebraska.htm

The Gay and Lesbian Psychotherapy Treatment Planner, Arthur E. Jongsma-Series Editor

http://safespace.glsen.org/index.cfm

http://www.hrc.org/

http://www.glaad.org/