



# Working With Suicidal and Homeless LGBTQ+ Youth in the Context of Family Rejection

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## Abstract

LGBTQ+ individuals are at increased risk of suicide. Homelessness further increases the risk, as does family-of-origin rejection. A model that combines suicidal risk factors and minority stress theory is useful in clinical practice. An openness to “hearing” the lived experiences of LGBTQ+ individuals is essential to treatment. An LGBTQ+ affirming therapeutic approach is recommended. It is also frequently helpful to rebuild family relationships and support for the LGBTQ+ individual, particularly with younger youth. Principles of practice are described and illustrated.

## Clinical Vignette

Eva is a 21-year-old transgender individual, assigned as male at birth, who has been hospitalized at your facility after a suicide attempt. You have been assigned to provide psychological input for her discharge plan. She reports using alcohol since middle school to manage social anxiety and feelings of alienation. In college, she self-identified as gay. Her parents reluctantly accepted it, as long as Eva did not tell her younger siblings. Eva connected with LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning, and other sexual and gender minorities) peers through online gaming, but continued to drink alone. Eva recognized her continued unhappiness related to the suppression of her gender identity. She came out as transgender to a trusted college counselor. She also disclosed her alcohol and gambling problems. The counselor helped her connect to an LGBTQ+ community center where Eva attended a transgender AA meeting, which she reported was a powerful and affirming experience. She told her mother she was transitioning as a female. Her mother accused her of seeking attention and stopped paying for her education and housing. This sent Eva into both emotional crisis and homelessness, during which she had suicidal ideation. She disclosed a plan to jump off a bridge to her counselor, who persuaded her to get evaluated at a psychiatric E.R. and be hospitalized. What are the primary psychological issues? What needs to be addressed first and what can wait? What is your assessment of her aftercare needs?

## Clinical Challenge

### New Data on LGBTQ+ Youth Suicide

Lesbian, gay, bisexual, transgender, queer, and other sexual/gender minority (LGBTQ+) youth have long been known to have higher suicide risk than non-LGBTQ+ youth (see Hottes et al., 2016, for review). Recently, an opportunity emerged to assess risk factors among a large number of cases of LGBTQ+ youths' deaths by suicide. Some years ago, the American Psychological Association, the Trevor Project, and several other clinical practice and advocacy groups persuaded the Centers for Disease Control and Prevention (CDC) to add sexual orientation and transgender identity variables to its National Violent Death Reporting System (NVDRS; Haas and Lane, 2015; The Trevor Project, 2016).

The NVDRS compiles several sources of information about deceased persons, including medical examiner reports and law enforcement reports. This makes NVDRS data useful for what suicide research calls “psychological autopsy” studies. The first papers about LGBTQ+ youth cases in NVDRS have now come out (Clark et al., 2019, 2020; Ream, 2019c; Ream, 2020). They affirm many things that psychologists had already known or suspected about LGBTQ+ youth suicide, and also provide some novel findings that are relevant to clinical concerns.

LGBTQ+ specific risk factors definitely feature in some LGBTQ+ youth suicide cases, according to a study that involved coding all 394 valid NVDRS cases of LGBTQ+ youths' deaths by suicide available at the time (Ream, 2020).

Family/peer rejection for being LGBTQ+ was found in 11%, recent coming out was mentioned in 9%, and LGBTQ+ related bullying was found in 7% of cases. Criminal or disciplinary issues, reputational stressors, social stigma, or financial, employment, or academic stressors connected with being LGBTQ+ were found in 2% of cases. Another NVDRS study found that the odds of bullying being found in LGBTQ+ cases were 4.9 times that of non-LGBTQ+ cases (Clark et al., 2020).

LGBTQ+ specific risk factors explain at least part of the LGBTQ+/non-LGBTQ+ suicide disparity. Figure 1 presents findings about the LGBTQ+/non-LGBTQ+ disparity separately by age range. Among 12- to 14-year-olds who died by suicide, 31% were LGBTQ+, while only 10% of 25- to 29-year-olds who died by suicide were LGBTQ+ (Ream, 2019b). That 10% is still a significant disparity, given that only 3–4% of the general population is thought to be LGBTQ+ (Savin-Williams and Ream, 2007). Greater incidence of LGBTQ+ specific risk factors may help explain why the disparity is wider at earlier ages, according to data presented in Fig. 2. While 30% of 18- to 29-year-olds' cases mentioned one of the LGBTQ+ specific risk factors described earlier, 59% of 12- to 17-year-olds' cases did (Ream, 2020).

NVDRS data also affirmed existing conventional wisdom (e.g., Taliaferro and Muehlenkamp, 2017) that each subgroup within the broad category of LGBTQ+ youth has its own unique risk profile. Gay and bisexual males' cases were likely to mention bullying and family/peer rejection. Transgender youths' cases were especially unlikely, and lesbians' especially likely, to mention a recent romantic breakup. The category with the highest burden of risk factors was bisexual females. Their narratives mentioned some of the highest rates of family/peer rejection (for reasons other than being LGBTQ+), bullying, psychological pain, and physical pain or disability (Ream, 2019c; Ream, 2020). These findings suggest that, while putting all LGBTQ+ people in one analytic category may be helpful in making policy arguments, understanding

LGBTQ+ youths' experiences for clinical purposes requires considering LGBTQ+ subgroups separately.

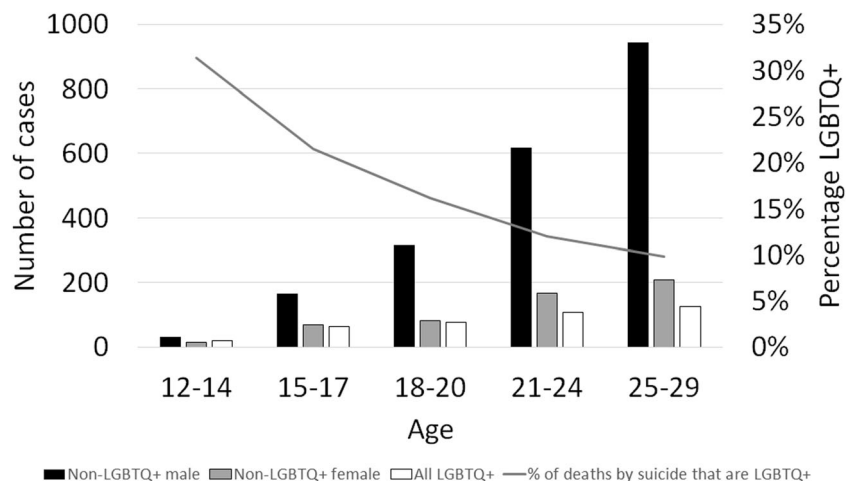
One last clinically relevant insight from NVDRS is that the most common risk factors in LGBTQ+ cases were issues that could also occur for non-LGBTQ+ youth. More than half (51%) had evident depression, anxiety, or other psychological pain, 28% had given some kind of warning, 23% had previously attempted suicide, and 21% had endured a recent romantic breakup. According to findings presented in Fig. 2, although the LGBTQ+/non-LGBTQ+ suicide disparity was higher among 12- to 17-year-olds than among 18- to 29-year-olds, raw number of deaths was higher among LGBTQ+ 18- to 29-year-olds (Ream, 2020), which suggests that these more general risk factors become more prominent at later ages.

Findings, specifically about bullying, were that the average LGBTQ+ young person who dies by suicide is likely to have been bullied—indeed, two-thirds of LGBTQ+ 10- to 13-year-olds who died by suicide had been bullied—but the average bullied young person who dies by suicide is not LGBTQ+ (Clark et al., 2020). These findings dovetail with suggestions made elsewhere that LGBTQ+ persons' mental health issues are not wholly qualitatively different clinical phenomena from non-LGBTQ+ persons' mental health concerns, and they may often be addressed by adapting more general theories and approaches (Pachankis, 2018). Accordingly, what follows is a theory of LGBTQ+ youth suicidality that is an elaboration upon a more general theory.

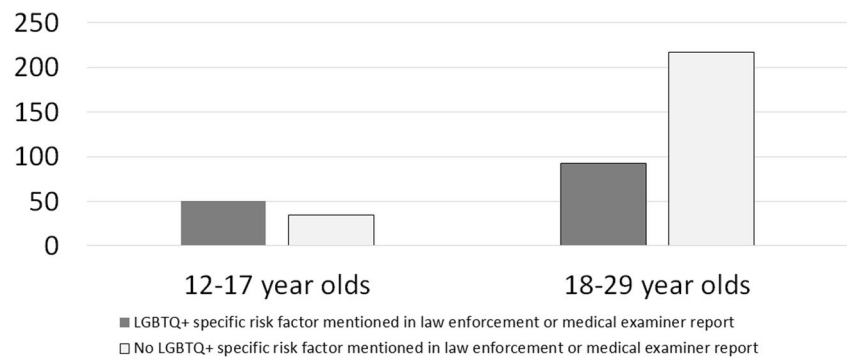
## A Theory of LGBTQ+ Suicidality

A general theory of suicidality that has trended in recent years is the interpersonal psychological theory of suicidality (IPTs; Joiner, 2005). IPTs reconciles the broad suicide risk factors literature with the reality that the vast majority of people, even if they have a large number of risk factors, do not die by

**Fig. 1.** Proportions of deaths by suicide in National Violent Death Reporting System Data that are LGBTQ+, separated by age group. Includes only cases with valid data for sexual orientation and transgender identification.



**Fig. 2.** Prevalence of LGBTQ+ specific risk factors in LGBTQ+ youths deaths by suicide reported in the National Violent Death Reporting System. Includes only cases with valid data for sexual orientation and transgender identification.



suicide (Ream, 2016). Risk factors, according to IPTS, only increase likelihood of dying by suicide if they increase *perceived burdensomeness*, a sense that one is a burden to others; *thwarted belongingness*, the experience of trying and failing to belong among other people; and *acquired ability for suicide*, which accumulates over time as painful and provocative experiences erode instinctual barriers against lethal self-harm (Joiner Jr et al., 2009).

To create a theory of LGBTQ+ suicidality, IPTS may be used alongside of minority stress theory (Meyer, 2003), the basis of most current research on LGBTQ+ youth suicide. Minority stress theory's premise is basically that LGBTQ+ persons have the same fundamental psychological makeup as non-LGBTQ+ persons, and that it is exigencies of dealing with anti-LGBTQ+ pressures in the social environment that are responsible for their higher rates of psychological challenge and risk. Minority stress theory helps explain how LGBTQ+ youth have higher rates of IPTS risk dimensions as follows:

- *Perceived burdensomeness.* According to some traditional values systems, people who do not follow strict norms for gender, especially if they are males who do not give off a certain appearance of strength, are legitimate targets of bullying and victimization. Their families and communities may feel burdened by the need to keep them safe and/or secret. Families and communities may also think they have to keep non-LGBTQ+ youth safe from sexual harm by LGBTQ+ youth, and feel burdened by this (Johns et al., 2019; Johns et al., 2018; Stanford, 2013). LGBTQ+ youth may internalize this sense of burdensomeness.
- *Thwarted belongingness.* LGBTQ+ youth may experience this if they have trouble finding their place among families, friends, schools, workplaces, and communities (Hill et al., 2017). Modern movie and television depictions notwithstanding, most early romantic attractions of same-sex attracted adolescents will be toward others who cannot reciprocate their feelings (Savin-Williams, 1994; Waidzunus, 2011). Romantic rejection is a well-known risk factor in youth suicidality.
- *Acquired ability for suicide.* The natural human instinct to avoid harm to one's body may be eroded over time by

painful and provocative experiences like bullying, abuse by family members, self-medication with substances, and exigencies of homelessness, all of which are more likely to happen to LGBTQ+ youth (Ream and Forge, 2014). Also included in the category of painful and provocative experiences is major surgeries (Joiner, 2005), such as gender-affirming operations.

One of IPTS's central features for clinicians is that it is unhelpful to think of suicide attempts as acts of cowardice. Rather, attempting suicide requires a certain kind of courage to overcome one's own self-preservation instincts. Many stories of suicide attempts are stories of self-rescue and of strengths people did not know they had. Another feature is that suicide attempts should not be dismissed as "gestures" or a normal part of being LGBTQ+ (see Waidzunus, 2011), but taken seriously as potentially adding to someone's acquired ability for suicide. It is possible that NVDRS research finds a higher raw number of deaths among older youth (Ream, 2019c; Ream, 2020) partially because suicidality, according to IPTS, is a process that develops over time (Joiner Jr et al., 2009).

### The Context of Family Rejection

LGBTQ+ youth are often at least temporarily rejected by their parents and other members of their families of origin (Savin-Williams and Ream, 2003), and family rejection is a significant LGBTQ+ specific risk factor for suicide (Ream, 2020). Resources to help both parents and clinicians have historically been scarce (Ryan et al., 2010). Family rejection runs along a spectrum from expulsion, violence, name-calling, non-physical punishment, ignoring, and more, all of which may be experienced as traumatic by adolescents (Savin-Williams, 2001).

A family's ability to understand and respond appropriately and positively to their LGBTQ+ child may be one of the strongest protective factors for LGBTQ+ youth and an asset to their successful transition to adulthood. Amid all the aforementioned environmental challenges, family acceptance can have a powerful buffering effect through raising self-esteem, improving social support and overall health, and even

lowering the incidence of suicidal ideation, depression, and substance abuse.

What we mean by family or parental acceptance is a set of supportive attitudes and behaviors such as the youth's ability to talk openly about their sexual identity at home, family members welcoming the child's LGBTQ+ friends and supporting their involvement in LGBTQ+ youth groups, and responding positively to the child's gender expression, including hairstyle, dress, and appearance, among other characteristics (Ryan et al., 2010). Family acceptance, in conjunction with a strong parent-child attachment, is believed to be critically important to LGBTQ+ adolescents' ability to successfully navigate stigma, isolation, and bullying (Katz-Wise et al., 2016).

If families can be convinced to refer to transgender youth by their own chosen names, this could have a measurable effect on their depression levels and suicide risk (Russell et al., 2018). Parental cognitive flexibility helps families to be accepting, while religious fundamentalism has been shown to be a barrier (Rosenkrantz et al., 2020). Families of LGBTQ+ youth experience stigma and shame, thus the minority stress theory could be useful to consider in understanding their needs as much as those of their children (Tobkes and Davidson, 2017).

LGBTQ+ affirmative family treatment is very much needed to help suicidal LGBTQ+ youth, but stigma and shame are formidable obstacles. Some families are reluctant or completely refuse to participate in clinical services due to their own homophobia/transphobia and/or their worries about being identified as a parent of an LGBTQ+ child. They may also refuse to allow their child to participate in LGBTQ+ youth organizations due to the belief that they, as parents, can discourage or contain their child's non-heteronormative identity by keeping them away from LGBTQ+ "influences." Practitioners can intervene to educate parents but, barring an extraordinary situation where parents are mandated to participate in treatment, parents choose whether or not to engage with their child's practitioner. Too often, those who need LGBTQ+ affirmative therapy the most are the hardest to engage.

The families' previous behavior towards the youth may make practitioners reluctant to attempt to involve family members in a youth's treatment. Practitioners who are LGBTQ+ themselves know firsthand the pain of family judgment, condemnation, and violence. Any practitioner may experience a sense of moral injury over what anti-LGBTQ+ people have done to their clients (Pingel and Bauermeister, 2018). Tension between families and LGBTQ+ organizations creates unhelpful attitudes on both sides. For the parents, the narrative becomes: "you're making my child queer," and for the clinicians: "this homophobic/transphobic parent is a lost cause who is hurting their child."

LGBTQ+ affirmative services are located in visibly LGBTQ+ organizations, in many parts of the country, which is both precisely what a young person needs in order to banish

internalized anti-LGBTQ+ attitudes and build self-esteem and pride, and also what triggers homophobic/transphobic parents and puts them in a defensive stance. LGBTQ+ service-providing organizations frequently affiliate with "ally" groups like Parents and Friends of Lesbians and Gays (PFLAG), who can successfully reach family members who might never step through the doors of the agency where their child is receiving services. Peer-led parent organizations can play a powerful role in family reunification and acceptance. Some families do not tolerate even that lower threshold entry to service, and other families need more structured, therapeutic intervention than a peer support group can provide.

## The Context of Homelessness

In assessing the suicide risk of an LGBTQ+ young person who has experienced homelessness, it is important to address how they became homeless. Some currently homeless LGBTQ+ youth lived lives that were relatively free of adverse childhood experiences (see Felitti et al., 1998) until they were suddenly turned out of the family home for being LGBTQ+. These youth have had fewer opportunities to accumulate painful and provocative experiences (which contribute to suicide risk) than the much larger category of youth who probably would have been homeless anyway due to family substance use, poverty, abuse, violence in the home, and other issues that can also happen to non-LGBTQ+ youth.

Many currently homeless LGBTQ+ youth were once clients of the child welfare system (Ream and Forge, 2014), where they almost certainly faced discrimination from workers and other youth. A classic study of LGBTQ+ child welfare clients found that more than half had, at some point, left the system for the *relative safety* of the streets (Mallon, 1998).

The exigencies of homelessness are especially hard on LGBTQ+ youth, who face higher rates of suicidality and several other risk factors than non-LGBTQ+ homeless youth (Ream and Forge, 2014). Homeless Black transgender women might be at especially high risk because shelters discriminate against them, they face pressure to become involved in sex work, the COVID-19 pandemic has made it harder to make money at sex work (Chowdhury, 2020), and a recent spate of anti-trans violence has many of them wondering/fearing that they might be next (Human Rights Campaign Foundation, 2018).

Connecting a homeless LGBTQ+ young person to clinical help can be difficult because the services that are available to them differ widely based on geographical location and age. A homeless LGBTQ+ youth under 18 coping with suicidality might have trouble finding a clinician who is LGBTQ+ friendly, but one who is over 18 might be unable to find a clinician at all. The child welfare system is obligated to keep working with some adolescents after they turn 18, but there is not much of a young-adult welfare system at all, even in major cities.



What exists is a patchwork quilt of services for which capacity is dwarfed by the demand (Ream and Forge, 2014).

There are some stable supported arrangements like transitional living programs that have a goal of preparing young adults for independent living, but LGBTQ+ youth often complete those and then move on to another programs that are supposed to prepare them for independent living, rather than to actual independent living (Forge, 2012). Each transition comes with a risk that they will end up back in an emergency shelter or on the streets, because capacity in stable supported housing programs is even more limited than that of emergency shelters (Ream & Barnhart, in press). Any transition, including the eventual one to independent living, also comes with a risk that they will lose access to the case managers and clinicians who knew their situation. Disruption in clinical services is risky for someone coping with suicidality.

## Intervention With Suicidal LGBTQ+ Youth

### How Clinicians Should Prepare for Working With LGBTQ+ Youth

Clinicians need to be open to “hearing” the experiences of LGBTQ+ youth—and staying with the affect expressed. When a youth describes their experiences of oppression, it is not helpful for the therapist to say “things are so much better now than 10 years ago.” Beyond being dismissive of the youth’s feelings, such knee jerk responses do not reflect reality. The benefits of global progress toward LGBTQ+ rights are unevenly distributed, particularly to youth who come from “traditional values” oriented immigrant communities, conservative religion, urban poverty, or high schools that do not have anti-bullying programs (Connell, 2016; Peñas Defago et al., 2018; Ream, 2021).

It is helpful to adopt a trauma-informed approach (Elze, 2019), which essentially asks “what happened to this person?” instead of “what is wrong with this person?” and accepts that any LGBTQ+ person who is seeking clinical help probably experienced bullying, harassment, violent victimization, discrimination, and stressors of living in an intolerant society that may have traumatized them. Clinicians need to be willing to try to empathize with LGBTQ+ youths’ lives and developmental experiences.

A non-LGBTQ+ clinician may not know from personal experience what events, meaning, and feelings occurred, but they can listen and attempt to understand what the youth experienced. Clinicians should adopt an attitude of “cultural humility” and regard developing of cultural competence at treating LGBTQ+ patients as a learning curve that may require some personal transformation (Ruud, 2018). This process starts with critically examining one’s own beliefs about sexuality and gender that they may have learned from their own family, culture, or religion (Elze, 2019).

One study found especially high rates of negative attitudes toward transgender patients among cisgender male psychologists and psychology trainees (Riggs and Sion, 2017). Additional practice guidelines (American Psychological Association, 2012, 2015) call for clinicians to differentiate gender from sexual orientation, recognize effects of stigma and discrimination, appreciate various forms and meaning of biological and non-biological family and family roles, and adopt an ideological stance that LGBTQ+ status itself is neither a mental health problem nor inherently connected with mental health problems.

It is important to affirm the value and importance of romantic relationships, especially as the voices of HIV prevention in LGBTQ+ youths’ lives dovetail with those of anti-LGBTQ+ ideologies to regard romantic relationships as a liability. Romantic partner problems precede many deaths by suicide, especially impulsive ones (Ream, 2019c). LGBTQ+ youth who live in small towns or are keeping their relationships secret in conservative environments might not have any other in-person supportive LGBTQ+ connections other than their romantic partners. The story behind some deaths by suicide in the NVDRS research cited above (Ream, 2020), particularly that of young lesbians, seemed to be that the romantic partner was the only in-person LGBTQ+ community the young person really had—and that a problem in their relationship triggered a crisis. One basic but powerful intervention is to ask a young person who, if anyone, they want to be involved in their treatment, which may include a same-sex romantic partner or friend who is a critical source of emotional support.

It is also important to recognize that gender identity and sexual orientation comprise only some of the many dimensions of an individual’s experience and position in society. Best practice generally calls for matching LGBTQ+ clients to LGBTQ+ clinicians where possible, because LGBTQ+ clinicians are equipped with similar life experience and can provide positive role modelling. From the young person’s perspective, they may also be more comfortable talking to an LGBTQ+ clinician with whom they can share concerns and questions without fear of judgment.

### Managing Suicidality

If an LGBTQ+ young person is presently feeling suicidal, their safety plan does not necessarily have to involve hospitalization. Involuntary hospitalizations can traumatize people and result in a lack of trust in the system, and even voluntary hospitalizations can put patients’ employment, relationships, and housing at risk, which jeopardizes whatever fragile progress they had made in rebuilding their lives since their last crisis (Paris, 2007). Clinicians should remember that LGBTQ+ youth are already disenfranchised, and stripping their autonomy away entirely should be a last resort.

With or without hospitalization, preventing future suicide attempts requires recognizing that a potentially lethal suicide attempt can be a watershed moment in a patient's life. It identifies them with a stigmatized demographic, increases their risk for post-traumatic stress disorder (Stanley et al., 2019), and often leaves them in a worse position to make progress on their mental health issues than before.

Clinicians should aim to not only treat the mental health concerns that gave rise to the attempt, but manage suicidality itself as a distinct issue (Ryan et al., 2010; Sommers-Flanagan 2018). One method is to explicitly teach patients that strong suicidal impulses represent an abnormal mental state, and train them to recognize and avoid triggers that would lead to that state. Also recommended is personalized letters to patients who are not in regular therapy sessions, just to “check up” on them (Gysin-Maillart et al., 2016). Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2016) is an evidence-supported manualized system for keeping suicidal clients safe and engaged in treatment.

Suicidality that is severe or chronic will cause youth to be excluded from services, including homeless services, in a manner similar to substance use and other conditions. Clinicians making referrals have to be careful not to send patients to organizations that will turn them away or treat them badly.

“Housing First” programs employ an ideology that trended during the AIDS epidemic, which holds that people will have a much easier time addressing their risk behavior and other issues if they have stable housing. Housing First programs can probably be counted on to be relatively less stringent about mental health and other concerns that suggest that a young person might not be “ready” for housing (Dodd et al., 2018; Ream and Barnhart, 2021). Even if a program is willing to accept a client who is struggling with suicidality, it is very possible for a client to come back to that program from a psychiatric hospital and find that their bed has been given away to someone else.

It is also possible for clients to move from program to program several times on their path to stability. This can interrupt their access to their usual clinician, which can cause a crisis for any suicidal patient. It can also cause a total lapse in clinical attention, because some programs have trouble connecting youth with clinical services at all (Forge, 2012). Even LGBTQ+ youth who are not homeless experience employment instability and residential mobility that characterizes modern emerging adulthood (Arnett, 2019). Without some intervention to create continuity in clinical services, there is a risk that any one of them may be “lost to follow-up.”

## LGBTQ+ Affirmative Therapy

Best practices for working with LGBTQ+ youth generally involve approaches that most clinicians already know, adapted to LGBTQ+ specific issues (Pachankis, 2018). For

instance, a clinician can follow a cognitive-behavioral approach to help a patient understand how their maladaptive behaviors may have once been adaptive in an environment of stigma, then teach them how to cope adaptively with stigma they still face and replace maladaptive behaviors with ones that are more useful in their present situation. As an example, many youth initially hide and/or lie about their identity due to the realistic fear that they will be shunned or physically attacked. Their hiding serves the purpose of self-protection, but it reinforces shame and guilt and creates social isolation. A clinician can help such clients understand the link between their negative feelings (fear, shame, guilt) and their behaviors (hiding and avoidance) and collaborate with the client on a plan to come out safely. This often begins with research on the client's part to learn about the LGBTQ+ community, which can be done anonymously online, and movement toward self-disclosure with trusted peers.

Clinicians who are not sure how to adapt their approaches to LGBTQ+ persons can still be helpful through nonjudgmentally applying standard approaches. We recommend clinicians take a positive LGBTQ+ identity development approach with LGBTQ+ youth, having critically examined any implicit biases or beliefs of their own that might get in the way of this. They should be ready to address issues such as body image disturbances, internalized stigma, the coming out progress, and expectations that others will reject them.

A recent summary of the rich case history literature on LGBTQ+ patients suggests that clinicians should be prepared to help patients with the following (italicized portions quoted from Pachankis, 2018, p. 1210):

- *Reworking negative attitudes about themselves and [LGBTQ+] peers that had been internalized across early development.* These may include negative attitudes socialized during sexual orientation change efforts (SOCE) and gender identity change efforts (GICE). SOCE (Blosnich et al., 2020) and GICE (Turban et al., 2020) participation are associated with increased suicide risk.
- *Facing fears related to sexual orientation disclosure.* Youth should have a plan based on realistic expectations for coming out conversations and have someone supportive to talk to afterward (Savin-Williams, 2001). The plan may also include having somewhere safe to go. In the NVDRS studies cited earlier, 9% of LGBTQ+ youth who died by suicide had recently come out (Ream, 2020). Regardless of the expected outcome, postponing the conversation indefinitely is probably not ideal, because the process may slip out of the youth's control. NVDRS research also found youth who died by suicide after being “outed” or after people guessed about them (Ream, 2020).
- *Reframing self-as-victim narratives into empowered coping narratives.* Clinicians can guide clients to adopt

narratives of resilience and health, and to move from themes of shame to themes of pride (Pachankis, 2018). Part of this work is educational. Stigma gets internalized from early childhood and reinforced by negative messages and interactions with family members, peers, and the broader culture. A narrative therapy approach helps LGBTQ+ youth tell their story and see what they have been taught about their sexual orientation or gender identity via these interactions. Clinicians can then help their patients externalize those messages as a problem of society. Group therapy can be particularly effective towards achieving this goal as patients hear the stories of LGBTQ+ peers and experience a sense of universality. Youth's internalized preconceptions are also challenged by meeting many different kinds of LGBTQ+ group members, thus the group often becomes a place where members "relearn" what it means to be LGBTQ+ (Peters, 1997).

- *Forming relationships with SGM community members as a form of behavioral activation to build resilience and pride.* If clinicians expect to be able to help LGBTQ+ clients with this, then they have to develop some working knowledge of local and online LGBTQ+ communities.
- *Understanding current symptomatology in the context of societal homophobia while promoting an active stance against homophobia.* This is incompatible with traditional values narratives, which hold that an LGBTQ+ person is deviant or sick and wholly personally responsible for the problems that their LGBTQ+ status brings onto their families, themselves, or their communities (Stanford, 2013). Putting an active stance against homophobia into practice could involve such actions as using non-gender-specific language not just with clients but with colleagues as well, creating an LGBTQ+ "friendly" office/facility environment through an inclusive posted client bill of rights and diverse images, and establishing clear policies for addressing homophobic language and behaviors among clients in group settings.

Clinicians should not expect miracles. Just as a racist environment limits the life chances of a person of color, a transphobic and homophobic environment can make certain normative developmental tasks prohibitively difficult for an LGBTQ+ person. If coming out to family would put an LGBTQ+ patient in physical danger, a clinician may have to let that goal go for the time being and help the patient find an alternative path to positive LGBTQ+ identity development (Pachankis, 2018).

### Working With Families

Directly working with families to help them accept their LGBTQ+ children (or at least to take them back in) might be difficult and, sometimes, impossible. However, the

potential benefits make family engagement an important strategy to consider. The best chance at stability for homeless LGBTQ+ youth is often for their families to take them back (Forge, 2012), and families of origin that support their LGBTQ+ children have great potential to buffer them against suicidality and other negative outcomes (Diamond et al., 2012).

The work must be guided by our ethic to ensure the physical and emotional safety of young people. It is rarely as simple as bringing everyone together to facilitate the repair of past wrongs. Such an approach can create further harm and/or alienate family members who need treatment.

When including family members in an LGBTQ+ youth's treatment plan, clinicians begin by assessing the family across dimensions of functioning, including how they have historically and currently responded to their child's sexual identity (American Psychological Association, 2012). This may sound straightforward, but in the writers' experience, it is hardly so. Non-LGBTQ+ clinicians can over-identify with the LGBTQ+ youth's parents—and miss attitudes and behaviors that are contributing to the youth's alienation and depression. LGBTQ+ clinicians can over-identify with the LGBTQ+ patient—and miss opportunities to support the family's positive functioning.

The critical question for clinicians is: what am I really looking at with this family? To see that clearly, one must set aside a heterocentric lens as well as any screens from one's own family-related trauma. Good supervision is key. Inexperienced clinicians are susceptible to two common pitfalls at opposite extremes: deemphasizing the youth's sexual identity completely (sometimes in the act of joining with the parents' discomfort and denial) or focusing on sexual identity to the exclusion of all other family dynamics (often in the service of defensive overcompensation). A mirror of the family's struggle to understand their child is not productive.

Clinicians should probe for what parents know about LGBTQ+ people, correct prejudices and misinformation, and contextualize. Parents who are unfamiliar with LGBTQ+ people make well-intentioned mistakes. They wonder whether they should treat their gay son different from how they treat their other sons. They can be simultaneously overprotective and negligent. At times they may be inappropriately restrictive and overprotective, and at other times swing completely in an overly permissive, even negligent, direction. In working with a 16-year-old gay male youth with high risk sexual behaviors, one clinician was shocked to discover the parents were well aware their son was having relationships with older men and going to gay bars. When questioned by the clinician, they acknowledged that they did not allow their other sons and daughters such free rein. The parents said, with all sincerity, they thought these behaviors were "normal" for gay men, as though their son's gayness necessitated an entirely different rulebook. This may be an extreme example of the

kinds of lapses in parenting that occur with LGBTQ+ youth, but it underlines the need for education and support in some families. Setting realistic boundaries for teenagers is healthy and needed. Setting boundaries that crush a youth's ability to socialize and experiment with same-sex relationships is harmful.

A basic tenet of family work is separating the parents' personal struggles from the child. When families reach out for help managing an adolescent's behavior, the unspoken posture is often: "I don't need to be part of this. Just fix my kid." Of course, a youth's behavior is often a product of parental role dysfunction, so it is really the entire family that needs to be "fixed." In the case of LGBTQ+ youth, parents may need to examine their negative attitudes and behaviors and reconstruct positive ones. A recommended clinical approach is to outline the work the parents have to do and the work they all have to do as a family. This reframes the problem realistically and protects the youth from harmful parental negativity while the clinician addresses their feelings and behaviors in a confidential environment. For the clinician, authentic and transparent engagement of parents is crucial as is making obstacles explicit and establishing realistic agreements for participation in treatment.

With families that are hostile, rigid, and resistant, the clinician's capacity for hope is critical, and often they will need to be flexible in order to meet the family "where they are." For example, with parents who refuse to take part in their child's treatment at an LGBTQ+ center, productive work may be able to be accomplished via telephone sessions or home visits. Clinicians can also prepare for difficult family work by establishing linkages with parent organizations such as PFLAG and LGBTQ+ affirming religious groups like DignityUSA (a Catholic organization) and Muslims for Progressive Values, where parents can find support within their faith communities.

## Lessons Learned

- LGBTQ+ youth suicidality may be understood using approaches adapted from more general theories, such as the interpersonal-psychological theory of suicidality (IPTS).
- Practice suggestions generally involve approaches that clinicians already know, adapted to LGBTQ+ persons' specific issues.
- Family and peer rejection of LGBTQ+ youths should be addressed, as this is probably related to their higher suicide rates, especially among young teens.
- When and where possible, work to help families of origin to accept their LGBTQ+ child. This will reduce psychological risk factors for suicidality and may also prevent their becoming homeless, which is correlated with suicidality.

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