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Suicide, Associated Factors, and Treatment Recommendations for Youth Who Identify as LGTBQ

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CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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This is to certify that the Capstone Project of

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Has been approved by the faculty advisor and the CE 695 – Capstone Project Course Instructor in partial fulfillment of the requirements for the Master of Science Degree in Counselor Education

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Abstract

Research has shown that sexual minorities such as youth who identify as Lesbian, Gay, Bisexual, Transsexual, and Queer or Questioning (LGBTQ) have faced inequalities and stigmatization compared to nonsexual minority peers, leading some individuals to experience health risk behaviors including suicide. The purposes of this literature review are to present evidence on suicide in youth who identify as LGBTQ including suicide incidence, causative factors in this population, resiliency factors, treatment recommendations including community-based resources to prevent suicide in these youth

Contents

Introduction

Suicide is a significant public health concern. It is the second-leading cause of death among adolescents, the first being car crashes (National Center for Health Statistics, 2016). Even more alarming statistics are adolescents who identify as gay, lesbian, bisexual, transgender, questioning or queer (LGBTQ), are four to six times more likely to attempt suicide than heterosexual youth (U.S. Department of Health and Human Services, 2012). Actual suicide rates among adolescents who identify as LGBTQ are not known because sexual orientation and gender identity are not reported in death records but what is known about suicidality among youth who identify as LGBTQ is through surveys in which people self-report suicide attempts and suicidal ideation (National LGBT Health Education Center, 2018).

Identifying as LGBTQ is not a mental health risk factor in and of itself; the majority of sexual minority adolescents are well-adjusted and healthy, however, on average, 28% report suicidal ideation and up to 40% make a suicide attempt each year, which makes suicidal ideations and suicide attempts at two to seven times higher rates than their heterosexual peers (Levy, Russon, & Diamond, 2016). This literature review aims to understand factors that lie underneath this alarming elevation and look at factors that differ between those who experience adverse health outcomes and those who experience positive health outcomes. As well as understand as clinician's what we can do to help those who experience adverse health outcomes such as suicidal ideations.

Suicide risk in people who identify as LGBTQ is thought to be highest during the teenage years and during the early 20s (National LGBT Health Education Center, 2018). The American Association of Suicidology (2017) reports, 39% of LGBTQ youth have seriously considered attempting suicide in the past twelve months, with more than 50% of transgender and non-binary

youth having seriously considered attempting suicide. James et al. (2016) note as many as 40% of transgender individuals have attempted suicide in their life, and 92% of these individuals reported having attempted trying to kill themselves before the age of 25.

Suicide attempt history is the strongest predictor of future suicide attempts (Liu & Mustanski, 2012). Participants who previously attempted suicide are noted to have ten times greater odds of making another attempt during the one-year follow-up period than were those who had made no previous attempt (Liu & Mustanski, 2013). Of nine variables examined, seven factors were significantly related to lifetime history of attempted suicide, including hopelessness, depression symptoms, conduct disorder symptoms, impulsivity, victimization, age of first same-sex attraction, and low family support (Liu & Mustanski, 2013). Mental disorders were seen as the single most significant risk factor for suicidal behavior, and studies have also reported a significantly strong correlation between mental disorders and suicide attempts (Hass, Rodgers, & Herman, 2011). A history of attempted suicide, impulsivity, prospective LGBT victimization, and low social support were all associated with increased risk for suicidal ideation (Liu & Mustanski, 2012). Of all the suicide attempts made by youth, Lesbian Gay Bisexual youth suicide attempts were almost five times as likely to require medical treatment than those of heterosexual youth (Center Disease Control [CDC], 2016).

The U.S. Surgeon General issued suicide as a significant public health problem in 2012 but also emphasized suicide can be reduced and prevented (American Association of Suicidology, 2016*;* U.S. Department of Health and Human Services, 2012). Research indicates environmental factors associated with sexual orientation, can be targeted and changed through prevention and intervention efforts which can minimize the role of distress experienced by environments in this population (Safren & Heimberg, 1999). Liu and Mustanski (2013) note the

need for suicide prevention programs for youth who identify as lesbian, gay, bisexual, and/or transgender, and suggest these programs need to address depression and hopelessness as internal determinants of suicidal ideations and behaviors and family support and victimization, for external or environmental determinants. Current literature that describes social contexts that impact resilience or appear causative towards suicide will be explored.

Review of Literature

Challenges to Resilience

Depression. Suicide rates are particularly high among individuals with mood disorders such as major depression, having a mood disorder can be one of the highest risk factors associated with suicidal behaviors (U.S. Department of Health and Human Services, 2012). Sexual minority individuals are two to four times more likely to report depression (King et al., 2008) When looking at LGBTQ youth's reported feelings of sadness or hopeless for a period of at least two weeks in the past year, 71% endorsed these feelings (American Association of Suicidology, 2017). Both depression and hopelessness are significantly related to attempted suicide (Liu & Mustanski, 2013). Baams, Grossman, & Russell (2015) found in their study on lesbian gay and bisexual youth, feeling like a burden was critical in understanding the higher levels of depression and suicidal ideation among these youth. Much research shows perceived burdensomeness, and lack of belongingness is connected to suicidal behavior and ideation (Ma, Batterham, Calear, & Han, 2016).

Other factors directly linked to increases in depressive symptoms were sexual harassment victimization (Hatchel, Espelage, Yuanhong Huang, & Huang, 2018). Some of these incidents of victimization frequently occur in schools. Individuals who were feeling a lower level of school

belonging further predicted depressive symptoms and perceptions of belonging may be a mechanism connecting victimization with depressive symptoms (Hatchel et al., 2018). Even individuals whose depressive symptoms preexisted being victimized were still seen to have increased in depressive symptoms after victimization (Hatchel et al., 2018). Transgender and gender-nonconforming children and teens were three to thirteen times more likely to be diagnosed with conditions like depression, anxiety, and attention deficit disorders than cisgender youth (Becerra-Culqui et al., 2018). The increased risk of depression may be explained in part by lower satisfaction with family relationships, greater exposure to cyberbullying and peer victimization, and more unmet medical needs, the study found (Luk, Gilman, Haynie, & Simons-Morton, 2018). Prevention programs need to address depression and hopelessness as the internal determinants of suicidal ideation (Liu & Mustanski, 2013).

Anxiety. The presence of any anxiety disorder is significantly associated with suicidal ideation and suicide attempts (U.S. Department of Health and Human Services, 2012). A systematic review of mental health problems in youth who did not identify as heterosexual showed that this group reported increased levels of anxiety compared to heterosexual adolescents (Ploderl & Tremblay, 2015). Possible reasons responsible for this elevated rate of anxiety seen among sexual minority adolescents generally have been attributed to minority stress (Meyer, 2003). Sexual minorities are predicted to experience stigmatization and discrimination from their social environment resulting in anxiety-related concerns such as internalized homophobia, homophobia, concealment, expectations of rejection, lower self-esteem, and rumination (Hatzenbuehler, 2009; Meyer, 2003). Being bullied during adolescence was a significant independent risk factor for an anxiety disorder at around age 17 (Stapinski et al., 2014). This is

consistent with previous studies in general population samples in which bullying was associated with elevated rates of anxiety disorders (Stapinski et al., 2014). Lower self-esteem was also an associated risk of an anxiety disorder. Sexual minority youth had lower self-esteem than heterosexual participants, and, in line with the study hypothesis, adjusting for self-esteem reduced the strength of the association between non-heterosexual orientation and anxiety. (Jones, Robinson, Oginni, Rahman, & Rimes, 2017).

Substance abuse. Some adolescents explore a gay identity in venues such as dance clubs and bars where alcohol and drugs are used, these youth may be at heightened risk of substance abuse because of peer pressure and availability of drugs (American Academy of Child and Adolescent Psychiatry [AACAP], 2012). Alcohol and drug abuse are second only to mood disorders as the most frequent risk factors for suicidal behaviors (U.S. Department of Health and Human Services, 2012). A systematic review of 25 studies (that did not include transgender people) found that the risk of dependence on alcohol and other substances was 1.5 times higher in those who identified as Lesbian Gay and Bisexual as compared with those who identified as heterosexual (King et al., 2008). They may use drugs and alcohol to achieve a sense of belonging or to relieve painful feelings such as shame, guilt, and a lack of confidence associated with their romantic and sexual feelings (AACAP, 2012). LGBT youth are more than twice as likely as non-LGBT youth to experiment with alcohol and drugs (AACAP, 2012).

McCabe, West, Hughes, and Boyd (2013) found that more than 60% of lesbian and bisexual women met the criteria for a lifetime DSM-IV substance use disorder compared with 24% of heterosexual women. According to the US National Survey of Substance Abuse Treatment Services, LGBT individuals were more likely to be users of illicit substances as

compared to their heterosexual counterparts, along with being identified at an increased risk for abuse as well (Medley et al., 2016). Substance users who identified as lesbian, gay, bisexual, or transgender tend to favor marijuana, prescription pain medication, tranquilizers, and cocaine, among other substances (Medley et al., 2016). Substance use disorders tended to be more prevalent among Lesbian Gay Bisexual respondents who reported discrimination than among those who reported no discrimination (McCabe et al., 2010). Therefore, culturally sensitive, affirming, and available prevention and treatment programs are critical for addressing alcohol and substance use among sexual minority communities.

Discrimination, stigma, and victimization. Although the majority of persons who identify within the LGBTQ population have normal mental health, AACAP (2012) noted this group experiences unique stressors and developmental challenges, which puts them at an elevated risk for mental health problems. Some of these health disparities relate to minority stressors such as discrimination, stigma, and prejudice (AACAP, 2012; Mereish, & Poteat). Individual and institutional discrimination are connected with social isolation, low self-esteem, negative sexual/gender identity, depression, anxiety, and other mental health diagnoses (U.S. Department of Health and Human Services, 2012). These adverse health outcomes, rather than minority sexual orientation or gender identity in itself, appear to be the main risk factors for LGBT suicidal ideation and behavior (U.S. Department of Health and Human Services, 2012).

Anti-LGBT victimization in regard to harassment was related to the risk of suicide attempts, suicide planning, and suicidal ideation (Barnett, Molock, Nieves-Lugo, & Zea, 2019). The most active association out of these was found between anti-LGBT harassment victimization and suicide attempts, with those who were victims being more than 2.5 times likely to report a

suicide attempt in the past year (Barnett et al., 2019). In fact, two in three LGBTQ youth said that someone tried to convince them to change their sexual orientation or gender identity, with adolescents who have undergone conversion therapy more than twice as likely to attempt suicide as those who did not (American Association of Suicidology, 2017). Many countries have begun legislation to protects the rights of lesbian, gay, bisexual, transgender, and queer people, but victimization and stigma remain most strongly associated with the risk of suicide and self-harm in this group (King et al. 2008).

Mereish & Poteat (2015) found internal and external stressors on psychological and physical distress were mediated through feelings of shame as well as indirect associations of shame, leading to more unsatisfactory relationships and feelings of loneliness. These findings suggest that attention to the effects of minority stressors on shame and relational dynamics is critical in order to understand the process by which minority stressors might affect health (Mereish, & Poteat, 2015). Lesbian, gay, and bisexual individuals who are also persons of color or racial/ethnic minorities (LGBT-POC) are a multiply marginalized population subject to microaggressions associated with both racism and heterosexism (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). In the 2015 National School Climate Survey, 85% of students identifying as LGBTQ reported experiencing verbal harassment, and 27% said they were physically harassed because of their sexual orientation (Gay, Lesbian and Straight Education Network [GLSEN], 2016). It is known from other studies that youth who identify as trans are very likely to experience discrimination and victimization. For example, 78% of children adolescents who identify as transgender have been bullied at school (Haas et al., 2014).

This population also may experience internalized prejudice, which can lead to self-hate or internalized homophobia (AACAP, 2012). Ideally, all adolescents developmentally form healthy

sexual identity between the years of 13-19. However, it is also important during these years that they experience being accepted by their peers (AACAP, 2012). The combination of these two healthy growth and development outcomes can be negatively impacted in the form of sexual prejudice.

Prejudice can come from perceptions of family, friends, or people who are within one or more social context. Commonly it comes in the form of disrespecting or humiliating gay individuals (AACAP, 2012). This conflict leads to lower self-esteem, denial of same-sex attractions, prevention of healthy relationships, and difficulties with identity (AACAP, 2012). A dilemma for these adolescents relating to identify is deciding whether they want to publicly disclose their LGBTQ identity to others or hide a part of who they are, or risking rejection is a real concern. The process of letting others know a sexual orientation for some may bring relief, but for others, it could bring a wide range of struggles and denial may be temporarily adaptive depending on the environment (AACAP, 2012). For example, in an unsupportive home environment, homelessness, physical assault, bullying, or increased mental health concerns could be a result of disclosing one's sexual orientation or gender identity (Gragg, 2012). When coaching clients through this challenging process, there is no right or wrong decision, but maturity, social content, safety, and coping skills are all factors that should be considered (AACAP, 2012).

Parental rejection. Roe (2017) found comments made by students showed various levels of sexual orientation acceptance, specifically, unacceptance from parents, which ranged from disappointment, anger, choosing to ignore, refusing to acknowledge their child's disclosure to telling their child that they will go to hell. In addition, family members within the same home often reacted differently.

(Roe, 2017) LGBTQ youth did not want to have to assume if parents and family members are supportive, they would like support to be verbalized. (Roe, 2017). LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection (Ryan, Huebner, Diaz, & Sanchez, 2009).

One prominent risk factor for these youth is a parental rejection of their sexual orientation. Research on LGB adolescents suggests that over half of parents initially react to their child's disclosure with some degree of negativity (D'Augelli, Grossman, Starks, & Sinclair, 2010; Heatherington & Lavner, 2008; Samarova, Shilo, & Diamond, 2014). Parental criticism, invalidation, and rejection of a child's sexual orientation negatively impact the adolescent in two ways. First, such messages from parents directly convey that something is wrong with the adolescent (Goldfried & Goldfried, 2001), increasing the likelihood that the child will perceive him/herself as inadequate, shameful, or unlovable (Rohner, 2014). In Human Rights Campaign (2019) it was found 67% of LGBTQ youth hear their families make negative comments about LGBTQ people, and 78% of youth who have not come out to their parents as identifying as LGBTQ listen to their families make negative comments about LGBTQ people.

Second, parental rejection leaves adolescents without a supportive attachment figure to turn to when they face LGB-related discrimination, victimization, and rejection from others, further putting them at risk for suicidal ideation and behavior (Meyer, 2013). Fear of rejection may lead some youth to be truant, run away, become homeless, be sexually exploited, or become involved in prostitution (AACAP, 2012).

Homelessness. Unfortunately, parental rejection can lead to another risk factor in youth homelessness. This susceptibility to rejection can be seen in the disproportionate rates of LGBT homeless youth

in comparison to the general population (Russell, & Fish, 2016). It is estimated 40% of youth served by drop-in centers, street outreach programs, and housing programs identify as LGBT(Durso & Gates 2012). In a sample size of 381 LGBT youth who were homeless across the united states the top five reasons for homelessness were, running away due to family rejection of sexual orientation or gender identity, kicked out due to sexual orientation or gender identity , physical, emotional, or sexual abuse within the home setting, aging out of the foster care system, and financial or emotional neglect from their family (Durso, & Gates, 2012). Sexual minority youth who experienced homelessness are more than four times likely to report suicidality, and almost three times as likely to report a suicide attempt (Walls, Freedenthal, & Wisneski, 2008).

Factors that promote Resilience in LGBTQ Youth

Resilience is identified as bouncing back from painful experiences and adapting in the face of adversity, trauma, tragedy, threats, or significant stress (American Psychological Association, n. d.). Resilience is not a trait that people either have or do not have; it involves behaviors, thoughts, and actions that can be learned and developed in anyone American Psychological Association, n. d.). It is something that can be cultivated and grown. The following section will review protective resiliency factors in youth who identify as LGBTQ.

Honoring myself: asserting personal agency. Asserting personal agency is a trait resilient youth who identify as LGBTQ have learned to capitalize on feeling a sense of control, which can buffer against abuse from others for identifying as LGBTQ (Asakura, 2017). Despite some individuals experiencing discrimination, marginalization, and threats of safety from social systems, however other youth who identify as LGBTQ daily are challenging, resisting, and changing their environments (Wernick, Dessel,

Kulick, & Graham, 2013). Personal agency is self-efficacy, a belief one can produce the desired results by one's own actions (Bandura, 1997).

Personal agency is the foundation for human agency; without this trait, individuals have little incentive to act or to persevere in the face of difficulties (Bandura, 1997). This can be done through youth, putting a spotlight on their own needs, limitations, and future visions, and taking ownership for their own decision making (Asakura, 2017). When looking at situations in which youth who identified as LGBTQ had to make tough decisions, comparison cases found it was not the decisions per se (e.g., leaving or staying at home when faced with family rejection), but the amount of ownership they felt over those decisions (Asakura, 2017). The amount of ownership was seen to positively correlate with resilience (Asakura, 2017). This intervention is more effective for older youth, as younger youth often do not have as much physical and financial autonomy to make decisions independently and had less practice in gaining self-efficacy as independent beings (Asakura, 2017). Finally, this process was particularly meaningful for youth who experienced being controlled and limited in the past by their social environments which resulted in pain (Asakura, 2017) — finding ways to prioritize their own needs and take greater control of their decision-making process facilitated resilience in these youth helping them navigate their way to better their well-being (Asakura, 2017).

Sound support systems. The minority stress model suggests that the causal effect of minority stress can be moderated by coping and social supports, such as support from community, friends, and family (Meyer, 2013). Asakura (2017) found resilient youth who identified as LGBTQ sought and cultivated relationships with both adults and peers who also identified as LGBTQ and could reflect those youth's specific LGBTQ experiences as well as connect with others, regardless of

their sexual orientation or gender identity, which provided youth with physical or emotional support and resources (Asakura, 2017). The following supports family, LGBTQ community involvement, peer networks, and safe supports at school were reviewed to see their unique contributions to resilience and protection against elevated mental health concerns.

Family connectedness. Positive health outcomes (self-esteem, social support, general health) are associated with family acceptance in adolescence, and this is a protective factor against suicidal ideation and attempts, substance abuse, and depression (Cambre, 2011; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Just as parental criticism, invalidation, rejecting messages, and a chaotic home environment can negate protective mechanisms associated with parental support and adolescents enhances their vulnerability to suicide (Klott, 2012; Levy, Russon, & Diamond, 2016). When treating this population, parental and family support and response are essential to determine the risk for depression and suicidal ideation (Cambre, 2011). Family support has been linked with increased well-being across a number of areas in youth who identify as LGBTQ, including lower suicidality, distress, depression, hopelessness, and substance use (Hass et al., 2011; Ryan et al., 2010). Provided earlier on could help prevent more adverse consequences (Cambre, 2011). The lasting influence of accepting family comments, attitudes, behaviors, and interactions related to the adolescent's LGBT identity goes on to affect their personal emotional and physical states (Ryan et al., 2010).

LGBTQ community involvement. Rejection and loneliness are intolerable to adolescents and pose a risk for both suicide and maladaptive behaviors for any teenager (Klott, 2012). A main protective factor in dealing with adversity and in suicide prevention for LGBTQ youth was seeking and developing meaningful

relationships (Asakura, 2017). Resilient LGBTQ youth found and cultivated relationships with LGBTQ adults and peers who reflected their LGBTQ-specific experiences (Asakura, 2017). Relationships with other LGBTQ peers and adults have the ability to serve as reflections of common challenges and opportunities presented in the lives of LGBTQ youth allowing them to feel less alone and share the burden of marginalization and how to navigate it with those who have also encountered and overcome those experiences (Asakura, 2017). While all youth realized the importance of meaningful relationships, this resilience process was especially important for those who experienced rejection or victimization from peers or family as it provided a corrective experience (Asakura, 2017). By participating in LGBTQ youth organizations, youth can experience empowerment in the face of discrimination (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014) through social and peer support (Asakura, 2010), connection to a broader LGBTQ community, and engagement in activities that involve youth in change efforts.

Peer network/ school safety. Some of the factors involved with a more supportive community include schools that have LGBTQ supportive clubs, such as Gay Straight Alliances (GSA), as this can improve overall acceptance by peers (Cambre, 2011). Compared to LGBTQ students who did not have a GSA in their school, students who had a GSA in their school were less likely to hear homophobic remarks and negative remarks about gender expression and were more likely to report that school personnel intervened when hearing discriminatory remarks (Gay, Lesbian, and Straight Education Network [GLSEN,] 2016). Those with gay, straight alliances in their school were also less likely to feel unsafe because of their sexual orientation than those without a GSA, experienced lower levels of victimization related to their sexual orientation and gender

expression and reported a higher number of supportive school staff and more accepting peers. This results in feeling more connected to their school community (GLSEN, 2016).

Another factor that contributes to school connectedness in LGBTQ youth in schools that include sexual orientation in anti-discrimination policies and antibullying policies to protect sexual minority students who are often targets of bullying by peers (Cambre, 2011). Although a majority (83.6%) of students had an anti-bullying policy at their school, only 10.2% of those students indicated that their school had a policy that specifically mentioned and cited both sexual orientation and gender identity/expression (GLSEN, 2016). Schools with comprehensive and inclusive policies such as stated above were less likely to hear homophobic or negative remarks about gender expression and were more likely to report victimization incidents and report that staff intervened effectively when hearing anti-LGBT comments or victimization incidences (GLSEN, 2016). As a result, students experienced less anti-LGBT victimization (GLSEN,2016). Other school policies and practices that need to be considers are those related to dress codes and school dances, to ensure these policies do not discriminate against LGBTQ students (GLSEN, 2017).

Inclusive curriculum. A final factor that can increase school safety is including an inclusive curriculum that allows students to access appropriate and accurate information regarding LGBT people, history, and events through curricula, the library, and Internet resources (GLSEN, 2016). LGBTQ students in schools with an LGBT-inclusive curriculum were again less likely to discriminatory anti-LGBTQ remarks and were less likely unsafe because of their sexual orientation (GLSEN, 2016). Students with this inclusive curriculum also were less likely to miss school in the past month, less likely to say they might not graduate high school, and less likely to not plan on pursuing post-secondary education (GLSEN, 2016). Inclusive curriculum made students more

likely to report that their classmates were somewhat or very accepting of LGBTQ people and made these individuals feel more connected to their school community (GLSEN, 2016).

Treatment Recommendations for LGBTQ individuals ages 13-25

The *American Psychological Association Code of Ethics* recognizes a duty to make sure that all groups of people benefit from the field of psychology, including psychotherapy (American Psychological Association [APA], 2017). However, lesbian, gay, bisexual, transgender, and queer (LGBTQ; sexual and gender minority) individuals are less likely to find therapy beneficial (Avery, Hellman, & Sudderth, 2001) and more likely to end therapy early (Senreich, 2009) than non-LGBTQ individuals. With any psychotherapy or treatment process, the basis of establishing trust, collecting sensitive and relevant information, establishing a working alliance, and creating an ethically sound environment is crucial to effective treatment. However, clinical practice with LGBTQ youth, in particular, involves additional challenges that correlate highly with these tasks. The first task being a well-rounded diagnostic assessment, including psychosexual development and family dynamics in relation to cultural values (AACAP, 2012). Confidentiality and social cues, although always necessary, are especially important to this population. Due to past rejections, these clients are keen to assess if the clinician is safe to explore their orientation and identity with and watch closely at cues of their therapist to gage this (AACAP, 2012).

As the clinician broaching the subject of sexual orientation and gender identity can be helpful (Cambre, 2011). Capuzzi. & Stafffer (2016) suggest instead of broaching this conversation in a confronting matter, instead explore, work collaboratively, and use empowerment strategies with the client. Other things that are suggested to help provide a safe environment is reviewing what the cues in the environment say about the agency. For example,

in a study by the American Association of Suicidology (2017), 58% of transgender and non-binary youth reported being discouraged from using a bathroom that corresponds to their gender identity. Make sure to identify cues that may validate heterosexism and correct these cues to ensure a welcoming space. It also should be noted, and there is no evidence that shows a person's sexual orientation can be altered; doing this in therapy would be harmful to both the client and the counseling alliance (AACAP, 2012). If a therapist feels their personal values may cause harm to the client, it is suggested they refer out.

Research by Wagaman (2016) indicates a youth development approach may also be helpful when working with adolescents who identify as LGBTQ. This approach includes (1) analyzing power within social relationships, (2) making identity central, (3) promoting systemic change, (4) encouraging collective action, and (5) embracing the youth's culture (Wagaman, 2016). In addition, Solomon, Heck, Reed, & Smith (2017) and Capuzzi & Stauffer (2016) note building competency in relevant terminology, theories, and youth development are essential as well as becoming familiar with negative connotations of words that reflect societal biases.

With all mental health concerns, suicide is not an uncommon factor to come up in treatment. Being that youth who identify as LGBTQ are seen to have higher rates of suicidal ideation and attempt, it is crucial to know how to address these concerns. Some therapists become fearful when working with suicidal clients, while some fear can be helpful the challenge is not to become paralyzed by fear for this can lead to concerns of avoiding the topic of suicide, conducting only an initial risk assessment, or superficial interventions (Jahn et al, 2016). When addressing suicidal ideation, one author was observed to stand out in the research, Freedenthal. Freedenthal (2018) suggests seeking out trainings, knowledge, and support to combat fear that

may come with working with suicidal clients. A summative hand out on tips and techniques Freedenthal recommends using with suicidal clients is provided in Appendix A

Goldbach, Rhoades, Green, Fulginiti, & Marshal (2019) found LGBT-specific crisis services appear to play an important role in suicide prevention. This may indicate when incorporating hotlines as part of the safety plan, LGBTQ specific ones may be beneficial to have listed. A list of LGBTQ specific suicide prevention hotlines can be found in Appendix B.

Family dynamics relevant to sexual orientation, gender nonconformity, and gender identity should also be explored in relation to the cultural values of the youth, family, and community (AACAP, 2012). Improving parental support is a focus of treatment in LGBTQ youth, but counselors also need to help LGBTQ clients individually identity supports to buffer against the impact of limited parents support (Roe, 2017). Having friends, counselors, teachers, or LGBTQ extended family members is essential to buffer the impact of negative family reactions (Roe, 2017). One way to do this can be through support groups in the community or in the schools. Resources specific to Rochester, MN, are listed in Appendix B.

Table 1. Recommendations for practice

Treatment Recommendations	Citations
Well-rounded diagnostic assessment, including psychosexual development and family dynamics in relation to cultural values. As well as including questions related to sexual and gender identity, coming out, internalized stigma, previous experiences of discrimination, and expectations of discrimination.	AACAP (2012) Solomon, Heck, Reed, & Smith (2017)
Building competency in relevant terminology, theories, and youth development.	Solomon, Heck, Reed, & Smith (2017) Capuzzi & Stauffer (2016)
Be familiar with physical and mental health disparities that are most common among LGBTQ youth and stressors that created these disparities and influence how LGBTQ youth understand and express their identities.	Solomon, Heck, Reed, & Smith (2017)
Improving parental/familial support or identifying supports to buffer against the impact of limited parental/familial support.	Roe (2017)
Know resources for sexual and gender minorities (see Table 3) and be prepared to advocate or be a liaison for them in different social systems	AACAP (2012)
Clinicians should also work to become aware of the negative connotations of words that may reflect societal biases.	Solomon, Heck, Reed, & Smith (2017)
Broach the subject of sexual orientation and gender identity as the clinician. Do not confront it but rather explore, work collaboratively, and use empowerment strategies.	Cambre (2011) Capuzzi & Stauffer (2016)
LGBT-specific crisis services appear to play an important role in suicide prevention	Goldbach, Rhoades, Green, Fulginiti, & Marsha, (2019)
Clinicians who are helping clients through the transition process. are encouraged to become familiar with the *World Professional Association for Transgender Health Standards of Care,* which provides specific guidance for clinicians	Coleman et al. (2012)
Use a youth development approach.This include: (1) analyzing power within social relationships, (2) making identity central, (3) promoting systemic change, (4) encouraging collective action, and (5) embracing youth culture	Wagaman, A. M. (2016)
A summative table of recommendations for mental health treatment based on the literature provided and authors who recommended it.	

Discussion

LGBTQ youth face elevated incidences of mental health such as anxiety, depression, substance abuse which suicide. An essential part of prevention suicidal behaviors is improving the identification of depression, anxiety, substance abuse, and other mental disorders so they can be treated (U.S. Department of Health and Human Services,2012). Many of these concerns are due to stressors, such as victimization, stigma, rejection, and discrimination. Increasing positive support systems within these youth, improving safety in schools, and advocating for inclusive policies, clubs, and curricula, while also growing culturally appropriate mental health services all can serve as protective and resilience enhancing factors for the marginalization some of these individuals face.

Because marginalization led to elevated rates of mental health and public health concerns such as suicide and homelessness, it is vital to increase the cultural competence of clinicians and to have culturally competent treatment services. Being knowledgeable about the LGBTQ community helps clinicians avoid common false assumptions which are harmful to clients and harm the therapeutic relationship (Solomon et al., 2017). Therapists knowledgeable about the LGBTQ community and relevant resources will likely be more effective with clients, which can be seen in high levels of service satisfaction of LGBTQ clients attending clinics, explicitly giving attention to sexuality and gender issues (Baams, Grossman, & Russell, 2015). Through the literature reviewed, clinics can look for evidence-based interventions to common problems faced by these youth, increase their competence and knowledge on this population, and make recommendations for ethical care.

Limitations

Some limitations from this review were finding current literature that matches the progression of the LGBTQ community. Some of the articles contained outdated terminology, and others were past the recommended time period of keeping research current within the past ten years. Other limitations were minimal research or unsupportive themes. Some articles would have protective or resilience factors listed but would not go into detail on why, which made it hard to incorporate into the review of the literature. Often articles would note more research is needed in this area, and especially in regard to protective and resilience factors. It is noted that many youths who identify as LGBTQ do not suffer from mental health concerns, but not much research states what contributes to this healthy development. The research is more focused on what does not contribute to healthy development and what the problem is. Another limitation is most information came from self-report data, which may not accurately account for all views of individuals in the LGBTQ community. In the future, it would be beneficial to the field to do individual research projects on different protective interventions to contribute to the lack of literature currently available on this topic.

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Appendix A: Tips and interventions for working with suicidal clients

This information comes from *Helping the Suicidal Person: Tips and Techniques for Professionals* (Freedenthal, 2018).

Tip #1- Confront "Suicide Anxiety": Some degree of anxiety when helping suicidal clients is healthy, when a life is at risk it is important to be attentive (Freedenthal, 2018). However, the challenge is not to overreact or become paralyzed by fear for this can lead to concerns of avoiding the topic of suicide, conducting only a intial risk assessment, or superficial interventions (Jahn et al, 2016).

What to do: Don't hide, seek out training, knowledge, and support so you can effectively work with suicidal clients even when you're afraid (Freedenthal, 2018).

Tip#2- "Maintain Hope": Suicide can lead clients to feel hopeless and at times start to persuade the clinician too, fight this, it is hard to lead someone else if you have no hope (Freedenthal, 2018).
What to do: Embrace empathy, consult, find hope in the person still being alive, recognize the potential of treatment, remember situations that seemed hopeless but proved otherwise, read memoirs by suicidal individuals (Freedenthal, 2018).
Memoir titles:

- Cracked, Not Broken: Surviving and Thriving after a Suicide Attempt by Kevin Hines
- An unquiet mind, A Memoir of Moods and Madness by Kay Redfield Jamison
- This is How it Feels: A Memoir: Attempting Suicide and Finding Life, by Craig Miller
- Darkness Visible: A Memoir of Madness

Tip #3: "Embrace Narrative Story Telling": Often times it feels necessary to ask a series of questions, which can make a client feels like they are under interrogation. Sometimes these questions serve the clinician needs for data more than the client's needs to feel heard and less alone. (Freedenthal, 2018).
What to do: Before asking a litany of questions, invite the client to share their story in a narrative approach.
Ask:

- Could you tell me how you got to the point that you wanted to put an end to your life? Feel free to start wherever there is no wrong way to tell your story.
- I would like you to tell me the story of what led to the suicidal crisis. Just let me listen to you.
- I would like you to tell me in your own words how it came about that you harmed yourself?
- Tell me your story to help understand your reasons for wanting to die? What are the events lead you to thinking that suicide is the only solution?

Tip #4: After a narrative approach follow up with questions to fill in the gaps (Freedenthal, 2018).

- Suicidal thoughts and images (do you wish you were dead? Do you see mental images or pictures related to suicide?)
- Reasons for dying and precipitations of ideation
- Frequency of suicidal thoughts or images
- Intensity of suicidal desire 0-10 scale, 10 being I 100% want to die.
- Duration, age onset, when current thoughts started if not 1st episode, how long do they last?
- Method and means
- Preparation and planning (Include asking about googling suicide, if clients have sought out information online and what information they sought out, many pro-suicide sites).
- Suicidal intent and timing
  -Intent: (How much do you intend to act on thoughts 1-10, 10 being you completely intend to kill yourself)
  -Timing: How likely are you to act on your suicidal thoughts after you leave here? Over the next day or two?
- History of attempts
- Controllability- "How well can you control whether you act on your suicidal thoughts?"
- Worst suicidal ideation ever – to mark current level

Tip #5: "Working with Resistance/Fear Disclosure": Some clients will conceal their suicidal thoughts, this could be due to fear hospitalization, judgement, embarrassment, bad past experiences with disclosing suicidal ideation, seeing the therapist as an adversary. The client's goal is relieving suffering could see the therapist as wanting to "take away thoughts before they are ready or misaligning goals, they want to die, you want to keep them alive **(**Freedenthal, 2018).
What to do: Collaborate and find common ground in your goals. Also, if you fear a client may be suicidal but they deny this the first time you ask, ask again. **(**Freedenthal, 2018).
Other ways to broach subject:

- People feeling depressed and hopeless sometimes think about death and dying, do you ever have thoughts about death and dying?

- In the future if you were thinking of killing yourself, would you feel comfortable enough telling me?
- What would make it hard to tell me if you were thinking of suicide? What are you afraid could happen?
- Have you ever had fleeting thoughts of suicide, even for a moment or two?

Tip #6: "Privilege warning signs over risk factors": Risk factors are important to explore, especially in regards to long term suicide risk but current risk for suicide it is vital to look for warning signs. In isolation these may not be meaningful but the more present the more cause for concern. **(**Freedenthal, 2018).

Warning Signs for Suicide:

- Frequent, intense suicidal thoughts
- Talking or writing about suicide
- Making preparations for suicide
- Hopelessness
- Agitation
- Anxiety
- Increased anger
- Recklessness or impulsivity
- Dramatic mood changes
- Feeling trapped
- Sense of no purpose or reason for living
- Increased use of alcohol or drugs
- Sleep disturbances
- Withdrawal from others
- Feeling like a burden to others
- Sense of disconnection to others
- An increase in high risk activities or exposure to violence

Tip #7: Seek information from Outside Sources: Collect information from family, friends, and other people in the person's life who may see sides to the individual you do not. In cases of adolescents in the US parents are entitled to know if their child is considering suicide. **(**Freedenthal, 2018).

Things to Ask:

- Has the adolescent recently talked about death or suicide? What did they say?
- Is the adolescent doing anything out of the ordinary lately, such as giving things away, not sleeping much, isolating from others, or using more alcohol or substances then usual?
- Does the adolescent have access to any firearms or lethal means such as prescription pain killers?
- Is there anything else you think we should know?
- Do you have any concerns about this person? Why or why not?

Tip #8: Collaboratively develop a safety plan: A safety plan spells out how not to act on suicidal ideations. If a person can't think of people for support on safety plan or identify coping skills or distractions this may give you further indication of suicide risk. **(**Freedenthal, 2018).

What to do: They have an app for that! Adolescents can do written version of safety plans or being that they are highly phone based, download an app on their phone to keep their safety plan. Then they will always have it with them. ***Free Apps:*** My3 (Has the National Suicide Prevention Hotline in it) & Safety plan

Tip #9: Encourage Delay: Even though suicide is always an option you can encourage the adolescent to wait. This option does not take away autonomy but rather delays and allows time for the client to give treatment a chance. **(**Freedenthal, 2018).

What to do:

- Will you be willing to give this a chance to work before doing anything to end your life?
- Would you be willing to partner with me and hold off on suicide as the solution in order to allow yourself the time you need to address these issues and give therapy a chance to healing your pain?
- I'm wondering if while we are working together you are willing to take suicide off the table temporarily and give this a try? You have everything to gain and nothing to lose.

Tip 10# When in doubt consult: Consultation shows you're not complacent or ignoring the risk of suicide, it also a second opinion, and ensure best care. **(**Freedenthal, 2018).

What to consult on:

- Risk assessment and safety planning
- Intervention or techniques to help client
- Specific challenges with client
- Emotional reactions toward client
- Risk management issues

Tip#11: Treat Chronic Suicidality different: For some suicidality is a way of life**,** this takes a different approach then acute suicidality. With chronic suicidality it is important to not encourage dependency, regression, or reinforcement of suicidal behavior. An example is with an acute suicidal crisis you may increase appointments this approach would not be effective for chronic suicidality. **(**Freedenthal, 2018).

What to do:

- Include Dialectical Behavior Therapy interventions into your practice or refer simultaneously to a skills group to help support your client. This will help with emotional regulation and finding a purpose for living.
- Explore if the client wants to give up suicide: Some people become attached to their thoughts, find comfort or peace from it. ***Ask:*** How much do you want to stop thinking of suicide, if at all? What are pros and cons of keeping suicide as an option? ***Use:*** A readiness ruler 0-10 importance of changing suicidal thinking and then rate confidence of making change.

Tip #12: Look for unmet needs: Edwin Shneidman theory about suicide is mental pain fuels from unmet psychological needs. Find the ingredients missing in the person's life and help them to get those needs met. **(**Freedenthal, 2018).

What to ask:

- What is missing from your life that if you could have tomorrow would make you want to live?
- The one thing that would help me feel no longer/less suicidal is?
- What do you need from me as your therapist?

Tip #12: Target social isolation: Much research shows perceived burdensomeness and lack of belonginess is connected to suicidal behavior and ideation (Ma, Batterham, Caler, & Han, 2016).

What to do:

- Involve loved ones in treatment
- Teach interpersonal skills
- Correct cognitive distortions
- Come up with activities to increase the adolescents' value (Ex: volunteer, make amends, get a job they like).

Tip #13: Look for the Catch: Have the suicidal person identify the catch to their reasons for committing suicide **(**Freedenthal, 2018).

Ask:

- What is the catch?
- When you say suicide would help because_____, what could the downside be?
- Is it possible that your wrong about what will happen if you kill yourself?
- Is there anything you might be leaving out?

Tip#14: Identify Coping Statements: A soothing phrase the person can say to maintain hope and resist urges.

- Life can get better
- One day at a time
- Suicidal thoughts are a symptom not a solution
- Just because I think it doesn't mean it's true
- I don't really want to die. I want the pain to end.
- I'm working on other ways to end my pain

Appendix B: LGBTQ Resources in Rochester, MN

Family Groups

- **Rochester Public Library Rainbow Families Programs q club**
  Social club for LGBTQ teens and allies in grades 7-12
  1st and 3rd Thursdays, 4:00 - 5:30 p.m., Meeting Room A
- **Rainbow Family Fun**
  Fun & games for LGBTQIA+ families
  1st Tuesdays, 6:30 p.m., Meeting Room C
- **Parents Empower Pride**
  Parents of LGBTQIA kids talking about how to support their children 3rd
  Tuesdays, 7:00 p.m., Meeting Room A
- **Transforming Families**
  Support group for transgender, gender non-conforming, and questioning youth and their families 3rd
  Saturdays, 1:00 - 3:00 p.m., Meeting Room C

Community Alliances

- **Southern MN Transgender Support**
  Contact: Jessi Wangen
  www.SMTSNetwork.com
  Info@smtsnetwork.com

- **Teen LGBT & Allies Community Group of SE Minnesota**
  Peace United Church of Christ 1503
  2nd Ave NE
  Rochester, MN 55906
  (507) 282-6117

- **RCTC Gay-Straight Alliance**
  Contact: Ben Froehling
  bafroehling@gmail.com

LGBTQ Crisis lines

- **Trevor lifeline:** The only national 24/7 crisis intervention and suicide prevention lifeline for LGBTQ young people under 25
  Call 1.866.488.7386 -

- **Trevortext**: A free, confidential, secure service in which LGBTQ young people can text a trained Trevor counselor for support and crisis intervention. If thinking of suicide and in needs of immediate support call the lifeline.
  Text "start" to 678678

Shelter

- Rochester LSS
  From the website:
  We are here to listen and here to help, no matter what you're going through. We will help you access safe and secure shelter while you explore your options and determine what's next.
  (call or text) 507.316.8273

Note: List of LGBTQ resources in Rochester, MN. By: Natalie Jech, 2019